



STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE GROUP EYE CARE INSURANCE

The Policyholder **VERMILION ASSOCIATION FOR SPECIAL EDUCATION AKA: VASE
VASE**

Policy Number **160-762967** **Insured Person**

Plan Effective Date **January 1, 2024** **Certificate Effective Date**

Class Number 2

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

STANDARD INSURANCE COMPANY



Daniel J. McMillan
President and CEO

Notice of Grievance Procedures

In accordance with the Dental Care Patient Protection Act of the Illinois Insurance Code

Quality Assurance
P.O. Box 82629
Lincoln, NE 68501-2629
888-418-6811 (Toll-Free)
402-309-2580 (FAX)

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. If you have questions, please feel free to contact the toll-free number shown above.

Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767. You can contact the Illinois Department of Insurance by toll-free phone at 877-527-9431.

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

"Covered Person" means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

- (a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;
- (b) claims payment, handling, or reimbursement for health care services; or
- (c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Review Process

You may ask your insurer to review its decisions involving your requests for benefit estimates or your requests to have your claims paid.

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer's control, the insurer may take up to an additional 15 working days to issue a written decision.

III. Written Decision

When a decision is issued after the review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
4. notice of the covered person's right to contact the Illinois Department of Insurance.

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**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
Class 2	Eligible Employee Electing Vision

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:

Exams - Each Benefit Period	\$10
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$25

When a Non-Participating Provider is used:

Exams - Each Benefit Period	\$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$25

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CIVIL UNION Refers to a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to Illinois law.

Illinois law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. Illinois also recognizes a marriage between persons of the same sex, a civil union, or a substantially similar legal relationship other than common law marriage legally entered into in another jurisdiction.

CHILD. Child refers to the child of the Insured, a child of the Insured's spouse or party to a Civil Union, or a child of the Insured's Domestic Partner, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

- a. an Insured's spouse, including a party to a Civil Union or Domestic Partner
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse, or party to a Civil Union, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption or from the date the child is in custody of the insured, pursuant to an interim court order of adoption, whichever comes first, vesting temporary care of the child in the insured, is an adopted child, regardless of whether a final order granting adoption is ultimately issued; and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental disability or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing vision working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. A child who is in the custody of the insured, pursuant to an interim court order of adoption or, in the case of group insurance, placement of adoption, whichever comes first, vesting temporary care of the child in the insured, is an adopted child, regardless of whether a final order granting adoption is ultimately issued.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child or from the date the child is in the custody of the insured.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing vision working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period or at a special enrollment period, including those that allow for the addition of a new family member. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE

Death, Divorce or Separation For Spouses and Dependents

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:
 - a. the death of the Insured; or
 - b. the dissolution of a marriage with, or legal separation from, the Insured.
 - c. the retirement of the Insured. (In this instance, the spouse must be at least age 55 on the date of retirement in order to elect continuation under this provision.)

provided:

- i. the spouse makes election for continuation of coverage in the required time frames;
and
- ii. any required premium is paid.

2. Benefits

This continuation applies to all benefits payable under the policy.

3. How to Apply

- a. Within 30 days of the entry of judgment of divorce or legal separation, or the death or retirement of the Insured, the spouse must notify the employer, including a mailing address, if he or she wishes to elect continuation of coverage.
- b. Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the dissolution of the marriage or the death or retirement of the Insured.

- c. Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing the following:
 - i. an election form;
 - ii. the premium due;
 - iii. when and how payments must be made;
 - iv. instructions on returning the election form.
- d. The spouse must affirmatively elect continuation with payment of the first monthly premium within 30 days of the date the notice is mailed by the insurer. Failure to elect continuation of coverage during this period shall terminate any future right to continuation.

4. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent.

5. Premiums

- a. For former spouses who have not attained the age of 55 at the time coverage begins, the monthly premium shall be equal to the amount charged an employee if the former spouse were a current employee plus the amount the employer would contribute toward the premium if the former spouse were a current employee.
- b. For former spouses who have attained the age of 55 at the time coverage begins, the monthly premium shall be based on the same calculation as defined in 5.a. above. However, beginning 2 years after coverage begins, the monthly premium shall be based on this same calculation, plus an additional amount, not to exceed 20% of this calculation for costs of administration.

6. Termination

For former spouses who have not attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date that coverage would terminate under the terms of the existing policy if the Insured and spouse were still married to each other;
- c. the date the spouse becomes insured under another group health plan;
- d. the date the spouse remarries;
- e. the expiration of 2 years from the date coverage began;
- f. the date the policy terminates.

For former spouses who have attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date on which coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the Insured and spouse were still married to each other;
- c. the date the spouse becomes insured under another group health plan;
- d. the date the spouse remarries;
- e. the date the spouse is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;

f. the date the policy terminates.

7. Replacement of Policy

A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

Death of the Insured
Attainment of Limiting Age
Dependent Children

1. The Insured's dependent child may continue coverage under this policy

- a. in the event of the death of the Insured and the child is not eligible for coverage as a dependent under the provisions stated above; or
- b. the dependent child has attained the limiting age under the policy.

2. This continuation applies to all benefits payable under the policy.

3. How to Apply

a. Death of the Insured

Within 30 days of the death of the Insured, the dependent child or a responsible adult acting on behalf of the child must notify the employer or the insurer if he or she wishes to elect continuation of coverage.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the death of the Insured and the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

b. Attainment of Limiting Age

In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the request to continue coverage under this provision including the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence

4. Responsibilities of the Insurer

Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing by certified mail, return receipt requested, notification to the dependent child or responsible adult that the policy may be continued. In addition, the notice will include:

- i. an election form;
- ii. the premium due;
- iii. when and how payments must be made;
- iv. instructions on returning the election form within thirty (30) days after the date it is received.

5. Electing Coverage

The dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue coverage within such 30 day period shall terminate the continuation of benefits and the right to continuation.

6. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent and benefits will continue under the terms and provisions of the policy except where the benefits in existence at the time the company's notice was to be sent are terminated as to all employees.

7. Premiums

The monthly premium will be equal to:

- a. an amount, if any, that would be charged an employee if the dependent child were a current employee of the employer, plus;
- b. an amount, if any, that the employer would contribute toward the premium if the dependent child were a current employee.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice as defined in subsection (4) of this provision terminates the continuation benefits and the right to continuation benefits.

8. Termination

Coverage under this provision will terminate upon the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date that coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the employee;
- c. the date on which the dependent child first becomes, or after the date of election, an insured employee under any other group policy; or
- d. the expiration of 2 years from the date continuation coverage began.

9. Replacement of Policy

If the group policy is cancelled and another insurance company contracts to provide group coverage to the employer, and continuation coverage is in effect for the dependent child at the time of cancellation, and the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this provision.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

COVERED EXPENSES

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED

An expense is incurred at the time a service is rendered or a supply item furnished.

PROOF OF LOSS

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

TELEHEALTH SERVICES

All services under this plan are covered when appropriately delivered through telehealth services and are subject to the same deductible and annual or lifetime dollar maximum (if applicable) as for equivalent services that are not provided through telehealth.

LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS

This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		<i>Participating Provider</i>	<i>Non-Participating Provider¹</i>
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to \$ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to \$ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to \$ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to \$100.00
Frames			
Single Frame	Once every 24 months	Up to \$150.00	Up to \$ 75.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to \$150.00	Up to \$120.00
Medically Necessary ²	Once every 12 months	Covered in Full	Up to \$210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

¹Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

²The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- (1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
- (2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- (3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- (4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of nine percent per year on benefits for valid claims not paid within 30 days until the claim is settled. Interest amounting to less than one dollar will not be paid. If we fail to comply with this provision, the insured is entitled to interest at the rate of 9% per annum from the 30th day.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly. No provision of the Illinois Insurance Code, or any other law, prohibits an insured from making an assignment of all or any part of his/her rights and privileges under the policy.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

ACCESS TO PARTICIPATING PROVIDERS.

If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No such action shall be brought after 3 years from the date of due proof of loss is required

to be furnished. The individual designating a beneficiary retains the right to change that designation unless he/she makes that designation irrevocable.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No fraud or intentional misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the fraud or intentional misrepresentation.

The validity of the Policy is contestable for two years, except fraudulent or intentional misstatements made by the applicant on the application.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.



TheStandard®

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Eye Care Insurance policy ("Health Plan") with Standard Insurance Company

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at www.standard.com/hipaa.

Permitted Uses and Disclosures of Your Health Information

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

Public Health Activities. We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes. We may disclose health information for research purposes.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

Sale of Protected Health Information. We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes require your authorization.

Marketing. We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Right to Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.