**Paulus Sokolowski & Sartor, LLC**

# Your Vision Plan

Policy No. 942923 011

Underwritten by Starmount Life Insurance Company

9/21/2023

**Starmount Life Insurance Company**
8485 Goodwood Blvd.
Baton Rouge, LA 70806

## Group Vision Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your Certificate of Coverage and describes the benefits for which you are insured. Vision insurance may help reduce costs for routine preventative eye care and prescription eyewear.

**Policyholder:** Paulus Sokolowski & Sartor, LLC

**Policy Number:** 942923 011

**Policy Effective Date:** November 1, 2023

**Policy Anniversary:** November 1

**Governing Jurisdiction:** New Jersey

This Certificate is issued to you under the Policy which is a contract between us and the Policyholder. If the terms and provisions of this Certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

All references to provisions, sections, and defined terms found within this Certificate have been capitalized. If you have any questions about the terms and provisions of this Certificate, please contact your Employer or us.

**This Certificate of Coverage provides benefits under the non-participating Policy. This Certificate contains certain proof of loss requirements, limitations, and exclusions that may prevent an Insured from receiving benefits under this Certificate. Please read your Certificate carefully and keep it in a safe place.**

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the New Jersey Department of Banking and Insurance at (800) 446-7467.

## Table of Contents

This section includes highlights of an Insured's coverage. Please refer to the **Vision Details** for further information on the benefits available.

**Eligible Group(s)**

Owners in Active Employment in the United States working a minimum of 30 hours per week.

All Eligible Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

**Method of Premium Payment:** Remitted by Policyholder
You may be required to contribute, either in whole or in part, to the cost of your coverage. This is subject to the terms established by the Policyholder.

**Schedule of Benefits**

The benefits an Insured may receive for a Payable Claim are listed in the Schedule of Benefits, subject to all other terms and provisions of this Certificate.

## Group Vision Insurance Schedule of Benefits

The following Schedule of Benefits outline the Covered Services and Materials under your plan.

You are responsible for paying any applicable Co-Pay, per Insured. You are also responsible for paying any amount in excess of the Allowance, if applicable.

Please refer to the Limitations provision located in the Vision Details section of your Certificate for specific Limitations pertinent to your Plan.

| BENEFIT FREQUENCY | |
|---|---|
| Vision Exam | Once every 12 Months |
| Eyeglass Lenses | Once every 12 Months |
| Frames | Once every 24 Months |
| Contact Lenses | Once every 12 Months |
| Supplemental Benefits | Once every 12 Months |

| IN-NETWORK PROVIDER | | |
|---|---|---|
| **Covered Services and Materials** | **Co-Pay** | **Benefit after Co-Pay** |
| **Eye Exam** | | |
| By Ophthalmologist or Optometrist | $10 | Covered in Full |
| **Materials - Eyeglass Lenses** | | |
| Single Vision Eyeglass Lenses | $10 | Covered in Full |
| Bifocal Eyeglass Lenses | $10 | Covered in Full |
| Trifocal Eyeglass Lenses | $10 | Covered in Full |
| Standard Progressive Eyeglass Lenses | $75 | Covered in Full |
| Premium Progressive Lenses Tier 1 | $95 | Covered in Full |
| Premium Progressive Lenses Tier 2 | $105 | Covered in Full |
| Premium Progressive Lenses Tier 3 | $120 | Covered in Full |
| Premium Progressive Lenses Tier 4 | $75 | $120 Allowance |
| Lenticular Eyeglass Lenses | $10 | Covered in Full |
| **Materials - Frames** | | |
| Eyeglass Frames | $0 | $150 Allowance |
| **Materials - Contact Lenses** | | |
| Contact Lenses - Elective | $0 | $150 Allowance |
| Contact Lenses - Non-Elective | $0 | Covered in Full |

| OUT-OF-NETWORK PROVIDERS | |
|---|---|
| **Covered Services and Materials** | **Benefit** |
| **Eye Exam** | |
| By Ophthalmologist or Optometrist | $40 Allowance |
| **Materials - Eyeglass Lenses** | |
| Single Vision Eyeglass Lenses | $30 Allowance |
| Bifocal Eyeglass Lenses | $50 Allowance |
| Trifocal Eyeglass Lenses | $70 Allowance |
| Standard Progressive Eyeglass Lenses | $50 Allowance |
| Premium Progressive Lenses Tier 1 | $50 Allowance |
| Premium Progressive Lenses Tier 2 | $50 Allowance |
| Premium Progressive Lenses Tier 3 | $50 Allowance |
| Premium Progressive Lenses Tier 4 | $50 Allowance |
| Lenticular Eyeglass Lenses | $70 Allowance |
| **Materials - Frames** | |
| Eyeglass Frames | $105 Allowance |
| **Materials - Contact Lenses** | |
| Contact Lenses - Elective | $150 Allowance |
| Contact Lenses - Non-Elective | $210 Allowance |

| SUPPLEMENTAL BENEFITS<br>IN-NETWORK PROVIDERS | | |
|---|---|---|
| **Covered Materials** | **Co-Pay** | **Benefit after Co-Pay** |
| Polycarbonate upgrade for Children < 19 | $0 | Covered in Full |

| SUPPLEMENTAL BENEFITS<br>OUT-OF-NETWORK PROVIDERS | |
|---|---|
| **Covered Services and Materials** | **Benefit** |
| Polycarbonate upgrade for Children < 19 | $32 |

The information in this section provides details about the benefits that may be payable to you and any applicable Exclusions and Limitations.

## Vision Benefits

This Certificate provides coverage for Eye Exams and Vision Materials. The Covered Services and Materials, and Frequencies are shown in the Schedule of Benefits. Some of the language we use in this Certificate contains technical vision terms that will be familiar to your provider.

**Eye Exams**

*Benefit Description*

Eye Exams are shown in the Schedule of Benefits. In order for an Eye Exam to be covered, the exam must be:

- Within the allowable Frequency shown in the Schedule of Benefits; and
- By an Ophthalmologist or Optometrist, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:
- the actual cost incurred; or
- the Benefits and Allowances shown in the Schedule of Benefits.

An Eye Exam is an examination of principal vision functions which includes, but is not limited to:
- case history;
- examination for pathology or anomalies;
- job visual analysis;
- refraction;
- visual field testing; or
- tonometry, if indicated.

The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

**Covered Materials**

Covered Materials are shown in the Schedule of Benefits. In order to be a Covered Material, the Materials must be furnished to an Insured:

- Within the allowable Frequency shown in the Schedule of Benefits; and
- By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:
- the actual cost incurred of the Covered Materials; or
- the Benefits and Allowances shown in the Schedule of Benefits.

**In-Network Benefits**

When you enroll for coverage, a Provider Directory will be made available to you. The Provider Directory is made up of In-Network Providers who are available to you. You may select any of the In-Network Providers and change providers at any time without notice. A provider's status may occasionally change. You may contact us to verify a provider's participation status in the network, by calling customer service at (866) 800-5457 or online at www.eyemedvisioncare.com/unum.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, we will pay the In-Network Provider directly, based on the In-Network Benefits shown in the Schedule of Benefits. The Insured will be responsible for any required Co-Pay and any cost that exceeds the Allowance. The Co-Pay and the Allowance are both shown in the Schedule of Benefits

You will generally incur lower cost by using an In-Network Provider.

When benefits are payable for Covered Services or Materials received from an In-Network Provider and are combined with a discount, or other in-store offer, the provider may require that you pay in full and submit your receipt for the Out-of-Network reimbursement.

**Out-of-Network Benefits**

In addition to In-Network Providers, you also have access to Out-of-Network Providers. If you select an Out-of-Network Provider, you will pay more than if you select an In-Network Provider. An Out-of-Network Provider may expect payment in full for the Covered Services or Materials purchased at the time they are provided. Please refer to the Filing a Claim provision for further information on submitting a claim.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, we will reimburse you up to the amount of out-of-network benefits as shown in the Schedule of Benefits.

**Exclusions**

We will not pay benefits for the following, unless otherwise specifically listed as a Covered Service or Material in the Schedule of Benefits:

- Replacement frames and/or lenses, except at normal intervals when Covered Services are otherwise available;
- Plano or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Experimental or non-conventional treatment or device;
- Any eye examination or corrective eyewear required by an Employer as a condition of employment;
- Services for which benefits are paid by Worker's Compensation;
- Two pairs of glasses, in lieu of bifocals, trifocals, or progressives;
- Additional cost for contact lenses over the Benefit Payable;
- Additional cost for a frame over the Benefit Payable.

We will also not pay any claims incurred after:

- the Policy ends; or
- the Insured's coverage under the Policy ends, except as stated in the Policy.

**Limitations**

The Contact Lenses Benefit is paid in lieu of Eyeglass Lenses. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses Benefit is paid in lieu of the Contact Lenses Benefit. An Insured is eligible to receive benefits under the Contact Lenses Benefit only after the Eyeglass Lenses benefit Frequency has ended.

***Owners***

**Waiting Period** Immediately following the first day of continuous Active Employment.

***All Eligible Full-Time Employees***

**Waiting Period** First of the month coinciding with or next following the first day of continuous Active Employment.

**Coverage Eligibility Date**

*For you*

If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

*For your Spouse*

If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

*For your Children*

If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire the Child.

Your newborn or newly adopted Children will automatically be covered for 60 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 60 days period and pay any additional premium.

Coverage of a child who is the subject of a medical support order shall be automatically covered for the first 60 days after receipt of a medical support order.

**Enrolling for Coverage**

**Initial Enrollment**

You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.

You may also apply for any coverage available for you, your Spouse, and Children during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event. Annual enrollment is a period of time specified by the Policyholder and agreed upon by us.

**Coverage Effective Date for Changes in Coverage**

*Changes in Coverage Requested by You*

Changes in coverage for an Insured will begin immediately following the later of:
- immediately following the date your applicable Enrollment Period ends;
- immediately following the date you apply for the change in coverage due to a Qualifying Life Event, if it's within 31 days of the Qualifying Life Event.

Any cancellation in coverage for an Insured will take effect on the first day of the month following the later of:
- the date the cancellation in coverage is made; or
- the date agreed upon by us and your Employer.

Any change or cancellation in coverage will not affect a Payable Claim that occurs prior to the change or cancellation.

**Coverage Effective Date if you are not in Active Employment**

You must be in Active Employment in order for coverage to become effective in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be

the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage are subject to this provision.

**Continuation of your Coverage During Extended Absences**

*Leave of Absence, other than a Family and Medical Leave of Absence or Leave of Absence due to Military Service*

You will be covered for 1 year from the date your absence begins, provided premium is paid.

*Family and Medical Leave of Absence*

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a Family and Medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

*Leave of Absence due to Military Service*

You will be covered for 1 year from the date your absence begins, provided premium is paid.

If you have not returned to work after the allotted time for continuation of coverage, your coverage will be suspended and reinstated in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

*Injury or Sickness*

You will be covered for up to 1 year from the date your absence due to an Injury or Sickness begins, provided premium is paid.

**End of Coverage**

*For You*

Your coverage under this Certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision.

We will provide coverage for a Payable Claim that occurs while you are covered under this Certificate.

*For your Spouse*

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this Certificate, your Spouse's coverage will end on the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:

- the date your coverage under this Certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this Certificate.

*For your Children*

If, while your coverage is in force, you choose to cancel your Children's coverage under this Certificate, your Children's coverage will end on the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the earliest of:

- the date your coverage under this Certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this Certificate.

**Filing a Claim**

We encourage early notification of a claim for benefits under this Certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact the Administrator or your Employer.

*In-Network Claims*

When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for you. In-Network Providers submit charges directly to the Administrator.

*Out-of-Network Claims*

In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, we must receive Written proof of loss. The claim must identify the Insured, the name of the Policyholder and the Group Policy Number. If you choose to submit your own claim, claim forms are available from the Administrator or you may submit itemized receipts from the provider for services.

*Step 1 - Starting a Claim*

Notice of a claim may be provided in Writing or by contacting the Administrator directly at (866) 800-5457. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

*Step 2 - Claim Forms*

After receiving notice of a claim, we will send a claim form to you, the provider, or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from the Administrator online at: https://www.eyemedvisioncare.com/oon/EMVC_OON_Form.pdf.

If you or your authorized representative do not receive a claim form from the Administrator within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to the Administrator within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to the Administrator by mail:

Mailing Address: First American Administrators, Inc., Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

*Step 3 - Proof of Loss*

Proof of Loss must be sent to the Administrator no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided as soon as reasonably possible. In any event, proof must be given to the Administrator within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this Certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- the extent of the Covered Loss;
- the date of Covered Loss;
- the name and address of any provider where treatment was received.

If the Proof of Loss is not complete, we will request additional information.

**Claim Procedures**

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim within 30 days. Benefits will be

paid in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this Certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice of denial will state the specific reason for the denial of benefits.

**Payment of Benefits**

Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

If there are legal impediments to Payment of Benefits under this Certificate which depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient Proof of Loss of the same is provided to us.

In the event of your death, any unpaid benefits will be paid to your estate. If benefits are payable to your estate, we can pay benefits up to $1,000 to someone related to you by blood or marriage whom we consider entitled to the benefits. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

**Payments to a Minor or Incompetent Insured**

If an Insured is a minor or is incompetent, we can pay up to $1,000 to the person or institution that appears to have assumed the custody and main support of the Insured or the minor unless or until that Insured, or minor's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

**Overpayment of Claims**

We have the right to recover any overpayments due to:
- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments. This applies to payments made to you, your Spouse and your Children or to the provider of the Covered Services or Materials.

We will not recover more money than the amount we paid you.

**Underpayment of Claims**

We have the responsibility to make additional payments if any underpayments have been made. Any underpayments will be paid in accordance with the Payment of Benefits provision.

**Grievance Procedures**

*Complaints and Grievances*
You shall report any complaints and/or grievances to us in Writing at Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040, by fax at (513) 492-3259, by e-mail at eyemedqa@eyemed.com, or by phone at (877) 226-1115. Complaints and grievances may be submitted to us verbally or in Writing. You may submit Written comments or supporting documentation concerning your complaint or grievance to assist in our review. We will address the complaint or grievance within 30 days after receipt or, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 days after our receipt of the complaint or grievance.

*Claim Denial*
If we deny all or any part of your claim, you can access the claim status detail on www.eyemedvisioncare.com/unum, you have the right to receive a Written notice of denial setting forth:
- the specific reasons for the denial;

- the specific Policy provisions on which the denial is based;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review; and

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive:

- copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary.

*Claim Denial Appeal*
If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to us by you, or by your authorized representative, for a full review of the denial. You may designate any person, including your provider, as your authorized representative. References in this section to "you" include your authorized representative, where applicable.

The request must be made within 180 days following your receipt of the Written notification of adverse benefits determination and should contain sufficient information to identify the person for whom the claim was denied, including:

- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the provider of services; and
- the claim number.

You may request, free of charge, any documents held by us regarding the denial of your claim. You may also submit Written comments or supporting documentation concerning the claim to assist in our review. Our response to your appeal, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you as follows:

> Within 60 days after receipt of a request for an appeal from you, unless, due to special circumstances, we need an extension of time to process your appeal. In the event that we do request an extension of time, notice will be provided to you prior to the expiration of the initial 60 day period, and the extension will not exceed a period of 60 days from the end of the initial 60 day time period.

*Other Remedies*
When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation. One way to find out what may be available is to contact the U.S. Department of Labor and your State insurance regulatory agency.

Additionally, under the provisions of ERISA (Section 502(a)) 29 U.S.C. 1132(a), you have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole, and you disagree with the outcome.

**Legal Actions**

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

**When Days Begin and End**

For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.

**Certificate of Coverage Contents**

Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:

- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;
- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;
- the Policyholder's application for group insurance; and
- Employee's signed applications, if applicable.

**Your Certificate of Coverage**

We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your Certificate describes:

- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If any of the terms and provisions of this Certificate are different than in the Policy, the Policy will govern.

**Cancellation or Modification to the Policy and this Certificate of Coverage**

The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or Certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All Policy and Certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.

**Representation in Applications**

Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you.

**Assignment**

An Assignment transfers all or part of your legal title and rights under the Policy and this Certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this Certificate if:

- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

**Contestability**

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.

**Misstatement of Information**

If you or your Employer provide us information about an Insured that is incorrect, we will:

- use the facts to decide whether the Insured has coverage under this Certificate and the Policy and in what amounts; and
- if necessary, make the applicable premium adjustments.

**Fraud**

We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means

necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Agency**

For purposes of the Policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

**Communicating with you or your Employer**

We may provide notices, information, and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

**Active Employment**

You are working for your Employer for earnings that are paid regularly, and you are performing the usual and customary duties of your job. You must be regularly scheduled to work at least the minimum number of hours as determined by your Eligible Group Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this Certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

**Administrator**

The entity which provides complete service to review and pay claims under the Policy as agreed to in a contract with us.

**Allowance**

The maximum amount we will pay for Covered Services or Materials as shown in the Schedule of Benefits.

**Certificate of Coverage or Certificate**

The document issued to the Employee describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.

**Children**

Any child from live birth to the end of the year in which they reach age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past the end of the year in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**Co-Pay**
The amount an Insured must pay to a provider before benefits are payable for Covered Services or Materials. The Co-Pay is paid directly to the provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.

**Contact Lenses, Elective**
Contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

**Contact Lenses, Non-Elective**
Contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.
- High Ametropia exceeding -10D or +10D in meridian spectacle Rx powers;
- Anisometropia of 3D in meridian spectacle Rx powers;
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses;
- Vision improvement for members whose vision can be corrected by 2 lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.

Medically necessary contact lenses are available in lieu of ophthalmic lenses and are subject to plan copayments and frequency limits. The provider determines the member's qualifying criteria at examination and evaluation.

**Contributory Coverage**
Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

**Covered in Full**
The In-Network Provider has agreed to accept a negotiated amount for the Covered Services or Materials as payment in full. The Insured is not responsible for any charges for the Covered Services or Materials other than the applicable Co-Pay.

**Covered Services or Materials**
The Vision Exam services and Materials that qualify for benefits under the Policy. Covered Services or Materials are shown in the Schedule of Benefits.

**Covered Loss**
Benefits will be paid only for losses identified in the Schedule of Benefits.

**Employee**
A person, also referred to as "you," who is in Active Employment in the United States with the Employer.

**Employer**
The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

**Enrollment Period**
A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

**Eyeglass Lenses**
A standard plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

**Injury and Sickness**
A bodily Injury, illness, infection, disease, or any other abnormal physical condition, which:
-occurs on or after the initial effective date;
-occurs while coverage is in force; and
is not excluded by name or specific description in the Certificate.

**Insured**
Any person who has coverage under this Certificate.

**In-Network Provider**
An Ophthalmologist, Optometrist or Optician who has entered into an agreement with the network selected by the plan to provide Covered Services or Materials at an agreed to cost.

**Leave of Absence**

Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.

**Ophthalmologist**

A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Ophthalmologist for a claim that you send to us.

**Optician**

A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optician for a claim that you send to us.

**Optometrist**

A person licensed to practice optometry, as defined by the laws of the state in which services are rendered.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optometrist for a claim that you send to us.

**Out-of-Network Provider**

An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with us to limit their charges. They are not listed in the In-Network Provider Directory.

**Payable Claim**

A claim for which we are liable for under the terms of this Certificate.

**Policy Year**

November 1, 2023 to November 1, 2024 and each following November 1 to November 1.

**Plano Lens**

A lens that has no refractive power.

**Policy**

The Group Vision Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.

**Policyholder**

The entity to which the Policy is issued.

**Provider Directory**

A list of In-Network Providers for your plan. You can verify if a provider is an In-Network Provider by calling customer service at (866) 800-5457 or online at www.eyemedvisioncare.com/unum.

**Qualifying Life Event**

An event including, but not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- cessation of a Civil Union [or Domestic Partnership];
- a change in employment status; or
- death of an Insured.

Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.

| | |
|---|---|
| **Spouse** | The person who is your partner through lawful marriage, civil union, registered domestic partnership, unregistered domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.<br><br>Your Spouse may not be insured as both a Spouse and an Employee. |
| **Starmount Life Insurance Company** | Referred to as "Starmount" and "we," "us," or "our." |
| **Writing** or **Written** | A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law. |

## Summary Plan Description - Supplement Information

This Supplement is intended to provide you with additional information regarding the vision benefit plan (the "Plan") that is not addressed in your Certificate of Coverage. Capitalized terms not defined in this Supplement have the meaning set forth in the Certificate of Coverage.

This Supplement, together with your Certificate of Coverage, constitutes the Summary Plan Description ("SPD") for the Plan. An SPD is intended to provide you with important Plan information as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Plan document consists of the Certificate of Coverage and the Policy and, if applicable, your employer's umbrella or "wrap" plan document. Benefits are determined by the Policy, your Certificate of Coverage and the information contained in this document.

If there is a conflict between the SPD and Policy, the terms of the Policy will control with the exception that the grant of discretionary authority in the SPD will always control with respect to the interpretation and administration of the Policy and all benefit determinations made under the Policy.

This SPD and the Plan document, Policy, Certificate of Coverage, and other applicable documentation may be amended at any time.

**Name of Plan**

Paulus Sokolowski & Sartor, LLC Plan

**Name and Address of Employer**

Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey
07059

**Plan Identification Number**

a. Employer IRS Identification #: 90-0590653
b. Plan #: 503

**Type of Welfare Plan**

Vision

**Type of Administration**

The Plan is administered by the Plan Administrator. Benefits are administered by the Claims Administrator, and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends**

October 31

**Plan Administrator, Name, Address, and Telephone Number**

Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey
07059
(732) 584-0421

Paulus Sokolowski & Sartor, LLC is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan if Plan assets are held in trust, in which case the Administrator will advise you separately of the name, title and address of each Trustee. In the event the benefits under the Plan are subject to collective bargaining, You may request a copy, or request to examine a copy, of the collective bargaining agreement by contacting the Plan Administrator.

**Agent for Service of Legal Process on the Plan**

Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey

07059

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

Benefits are provided through an insurance contract issued by Starmount Life Insurance Company, 8485 Goodwood Blvd., Baton Rouge, LA 70806 under policy number  under 942923 011. Contributions to the Plan are made as stated under Paying for Coverage Method of Premium Payment in the Certificate of Coverage.

**Eligibility for Participation and Summary of Benefits**

Refer to the Certificate of Coverage (including its Schedule of Benefits) for provisions dealing with eligibility for benefits and for a description of benefits payable under the vision options under the Plan.

**QMCSO Procedures**

A qualified medical child support order ("QMCSO") is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits, which may include vision benefits, and meets certain requirements under ERISA. Generally, a QMCSO is issued as a part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO and then take steps to notify you of the QMCSO determination and corresponding enrollment if required.

You may obtain, without charge, a copy of procedures governing QMCSOs from the Plan Administrator.

**Extension of Certain Deadlines Due to COVID-19**

Certain deadlines provided in this document and in the Certificate of Coverage may be extended due to guidance provided by the Internal Revenue Service, Department of Labor, Department of the Treasury, Department of Health and Human Services, or other governmental body with proper authority to extend such deadlines (the "Departments"). Pursuant to guidance issued by the Departments on May 4, 2020, the Departments have extended deadlines for you to file certain claims and appeals, certain deadlines related to COBRA, and certain deadlines related to your special enrollment rights under HIPAA, due to COVID-19. The Departments require the otherwise applicable deadlines to be disregarded during the "Outbreak Period." Subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A, "Outbreak Period" is the period beginning on March 1, 2020, and ending 60 days after the announced end or the expiration of the National Emergency. The Plan will comply with all deadline extensions provided by the Departments, now and in the future. Please contact the Claims Administrator with any questions about the extension of these deadlines.

**Filing a Claim Under Your Plan**

If you wish to file a claim for benefits, you should follow the claims procedures described in the Certificate of Coverage. If your Certificate of Coverage has been lost or misplaced, please contact the Employer identified above.

**Claims and Appeals Procedures for Plans Covered by ERISA**

If your Plan is subject to ERISA, the following requirements will apply (in addition to the requirements in your Certificate of Coverage) with respect to claims made under the Plan. "Your" and "you" in this section include any Insured (as defined in the Certificate of Coverage) or an authorized representative of an Insured. The term "claimant" may also be used for this purpose.

You are not required to get prior approval before incurring vision care expenses under the Plan. The rules for relating to claims for benefits are specified below.

*Notification of Initial Decision*

You will receive a response within 30 days after the claim is received by the Claims Administrator unless it determines that additional time is necessary (of up to 15 days) to make a decision regarding the claim due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension and the date by which it expects to render a decision. If an extension is necessary because you failed to

include the information necessary to decide the claim, the notice of extension will describe the information necessary from you and will provide at least 45 days to provide the specified information.

For all types of claims, the time period beginning on the date which the Claims Administrator notifies you of the need for additional information and ending on the date you provide such additional information is not included in computing the time frame in which the Claims Administrator will respond to the claim.

*Denial of Initial Claim*
If the Claims Administrator denies all or any part of your claim, you can access the claim status detail on eyemedvisioncare.com/unum. You have the right to receive a Written notice of denial setting forth:
- the specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following the denial of your claim on appeal;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive copies of all documents, records, and other information relevant to your claim for benefits.

*Appeal*
If, under the terms of the Plan, a claim is denied in whole or in part, a request may be submitted to the Claims Administrator by you, or by your authorized representative, for a full and fair review of the denial (i.e., an appeal). You may designate any person, including your Provider, as your authorized representative.

The request must be made within 180 days following your receipt of adverse benefit determination, must be written, and should contain sufficient information to identify the person for whom the claim was submitted, including:
- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the Provider of services; and
- the claim number.

An Insured may request, free of charge, any documents held by the Claims Administrator regarding the denial of your claim. You or your Spouse or Children or an authorized representative may also submit Written comments, documents, records, or other information concerning the claim.

An appeal will not afford deference to the initial denial of the claim, and will be decided by someone who is different from, and who is not a subordinate of, the individual who made the initial decision on the claim. Also, if the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate, then the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same as any health care professional who was consulted in connection with the initial claims denial, nor a subordinate of that professional. If the appeal is denied, you will be advised if any medical or vocational expert's advice was obtained on behalf of the Plan, including the identity of any such medical or vocational expert, in connection with the appeal, regardless of whether the advice was relied on by the Plan.

The Claims Administrator's response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you or your Spouse or Children no later than 60 days after receiving the request for a review.

The Claims Administrator will consider the appeal, taking into account all comments, documents, records, and other information submitted, including information not submitted or considered in the initial decision on the claim. The Claims Administrator will not defer to the initial decision to deny the claim. Any decision made by the Claims Administrator on appeal will be final and conclusive.

If the Claims Administrator denies all or any part of your claim on appeal, you can access the claim status detail on eyemedvisioncare.com/unum. You have the right to receive a Written notice of denial setting forth:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions upon which the denial was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a statement describing any other voluntary appeal procedures offered under the Plan and your right to obtain the information about such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

**Legal Action**

If you believe your claim under the Plan is being improperly denied in whole or in part, you have the right to bring a legal action, subject to any time bar to bringing suit set forth in the Certificate of Coverage. However, no legal action can be brought until you have exhausted all the steps in the appeal process provided under the Plan.

**Plan Administration**

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, having the sole discretionary authority (except to the extent delegated) to interpret the Plan, prescribe applicable procedures, determine eligibility for and the amount of benefits, authorize benefit payments, gather information necessary for administering the Plan, and determine all questions in the administration, interpretation and application of the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan grants to itself the discretionary authority to make all benefit determinations under the Plan.

All determinations of the Plan Administrator or its delegate shall be conclusive and binding on all parties.

**Claims Administrator**

The Plan, acting through the Plan Administrator, delegates to the Starmount Life Insurance Company and its affiliate Unum Group (collectively, the Claims Administrator") the discretionary authority to make all benefit determinations pursuant to the Plan documents, which include insurance policies and other documents evidencing funding for benefits provided under the Plan. The Claims Administrator may act directly or through its parents, affiliates, employees and agents or further delegate its authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual

disputes, and interpreting and applying Plan terms and conditions. Exercising discretionary authority requires that a benefit determination must be made on a principled and reasoned basis, consistent with a reasonable interpretation of the terms of the Plan or insurance policy, and supported by the facts and circumstances of each claim.

Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806
(888) 400-9304

**COBRA Administrator**

The Plan, acting through the Plan Administrator, has delegated to the COBRA Administrator the authority to administer COBRA continuation coverage (described below). The COBRA Administrator is identified in the initial COBRA notice that is provided to employees (and spouses, as applicable) at the time coverage is commenced under the Plan ("Initial COBRA Notice").

**Employer's Right to Amend the Plan**

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. No provision of the Plan or any of its related documents shall create any vested rights in any employee, retiree, participant, or any other person. No consent of any participant is required to terminate, modify, amend or change the Plan. The Plan many be amended, modified or terminated by written instrument duly adopted by the Employer or any of its delegates.

**Family Medical Leave Act of 1993 (FMLA)**

If a covered employee ceases active employment due to an employer-approved Family Medical Leave of Absence in accordance with the requirements of the FMLA, coverage will be continued under the same terms and conditions which would have applied had the employee continued in active employment, provided the employee continues to pay his share of the premium for the cost of coverage, in accordance with the rules for any required contributions. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification).

**Continuation of Coverage under COBRA**

A federal law called "COBRA" requires the Plan to offer employees and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event".

You and your covered spouse or domestic partner and covered dependents will be entitled to continue benefits under this Plan upon the occurrence of a qualifying event, as described further below. You may continue only the Plan coverage in effect at the time and must pay required premiums.

**General**

If you are a Qualified Beneficiary, you have the right to continue your coverage under the Plan if you lose that coverage due to a "Qualifying Event". If you are an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event that is your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are the spouse or domestic partner (in the event domestic partner coverage is provided under the Plan) or dependent child of an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary.

A "Qualifying Event" means each of the following events, if it causes a Qualified Beneficiary to lose coverage under the Plan: (i) your reduced hours of employment, (ii) your employment ends for any reason other than gross misconduct, (iii) your death, (iv) your entitlement to Medicare benefits (v) your divorce or legal separation from your spouse or termination of domestic partnership, or (vi) for a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

If you are a Qualified Beneficiary and you lose coverage under the Plan due to the first four Qualifying Events listed above, you will automatically receive a Qualifying Event notice from the COBRA Administrator

of your right to elect COBRA continuation coverage. However, if you are a Qualified Beneficiary and you lose coverage under the Plan due to a divorce or legal separation, or due to a child's loss of dependency status, you must notify the COBRA Administrator of the event within 60 days after the Qualifying Event occurs or you will lose your right to elect COBRA continuation coverage.

**Electing COBRA Coverage**

If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event Notice and election form describing your rights to elect COBRA continuation coverage. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the COBRA Administrator of the event before this notice will be sent to you. If you do not receive a Qualifying Event Notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the COBRA Administrator of a Qualifying Event, if applicable), you should contact the COBRA Administrator.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event Notice and election form will usually only be sent to the employee and spouse or domestic partner, at the employee's address shown in the records of the Plan. For this reason, it is very important that you keep the COBRA Administrator informed of your current address and the addresses of your spouse and covered dependents. Covered employees may elect COBRA continuation coverage on behalf of their spouses and domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice and election form is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment.

**Paying for COBRA Coverage**

Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage (which may change at the beginning of each Plan Year) depends on the type of coverage that is being continued and will be communicated to you.

In order to maintain your right to COBRA coverage, the first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage (including payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received).

Payments for subsequent one-month periods are due on the first day of those periods. You will have a 30-day grace period to make monthly payments otherwise COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. Please refer to the Initial COBRA Notice for further details on coverage in the event payment is received during the grace period.

**Duration of COBRA Coverage**

When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the COBRA Administrator is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must notify the COBRA Administrator of that determination within 30 days of the date you receive the determination from the SSA.

- If your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse (or domestic partner) and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse (or domestic partner) or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified of the second Qualifying Event within 60 days of the event. Only individuals who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances: (i) the first day of a coverage period for which timely payment is not made, (ii) the date the Plan Sponsor ceases to provide any group health plan to you, (iii) the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan or entitled to Medicare benefits; (iv) the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or (v) the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the COBRA Administrator will send a notice regarding the termination of COBRA coverage to you as soon as practicable.

**How to Notify the COBRA Administrator**

You must send written notice* of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the COBRA Administrator within 60 days of the event. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the COBRA Administrator. Notice must be sent by first class mail or other nationally-recognized courier service, by fax, e-mail or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the COBRA Administrator.

Any notices required to be provided to the COBRA Administrator may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

*The COBRA Administrator will determine the form of the written notice. For example, the COBRA Administrator may determine that written notice includes providing notice through the COBRA Administrator's online platform.

The contact information for the COBRA Administrator is in the Initial COBRA Notice.

**If You Have Questions**

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Continuation of Coverage Under USERRA**

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, you have certain rights regarding continuance of Plan benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a "military leave of absence"). The terms "uniformed services" or "military service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If you are absent from work for less than 31 days due to your active military service, your Plan participation will be continued at active employee rates. If your absence is for 31 days or more, you and your covered family members will have the opportunity to elect continuation group health coverage for up to 24 months or the period of your military service, whichever is shorter; provided, you pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under the Plan, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

USERRA continuation coverage is considered to be alternative coverage for COBRA purposes. As a result, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Please refer to the applicable booklet for more information about continuation coverage available under USERRA.

**Successors and Assigns**

Except as otherwise provided in the Plan or under applicable law, all benefits, rights, or interests of Participants under the Plan are expressly non-assignable, non-transferable, including to any vision care provider, and shall not be subject to anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such participants, and accordingly the right of any Participant to receive any benefits under the Plan shall not be subject to any claims by any creditor of or claimant against the participant. Any attempt to assign, transfer, anticipate, alienate, sell, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to benefits, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by a participant under or related to the Plan. Nothing in this provision prevents a Claims Administrator, in its sole discretion, from paying vision benefits directly to a vision care provider that provides services to a participant, but a participant has no authority or right to obligate the Claims Administrator to make direct payment to a vision care provider and any attempt to obligate a Claims Administrator to make direct payment to a vision care provider is void and unenforceable. Further, the Plan does not create any right or legal relationship or third-party beneficiary status between the Employer or any Claims Administrator and any vision care providers.

**Tax Consequences and Withholding**

The Employer does not guarantee the federal, state, or local tax treatment of any benefits provided under the Plan. Benefits provided under the Plan shall be subject to federal, state, or local income tax

withholding or employment tax withholding in accordance with the rules applied to such benefits as interpreted by the Employer under applicable federal, state, or local laws.

**Your Rights Under ERISA**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Vision Coverage

Continue vision care coverage for yourself, spouse or domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event if the Plan is subject to COBRA. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,

200 Constitution Avenue N.W., Washington, D.C. 20210.  You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

**COLLECTING INFORMATION**
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

**SHARING INFORMATION**
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

**SAFEGUARDING INFORMATION**
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**ACCESS TO INFORMATION**
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**CORRECTION OF INFORMATION**
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

**COVERAGE DECISIONS**
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

**CONTACTING US**
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.



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**NOTICE**
**NEW JERSEY LIFE AND HEALTH INSURANCE**
**GUARANTY ASSOCIATION ACT**

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.**

**The New Jersey Life and Health Insurance Guaranty Association**
**One Gateway Center, 9th Floor**
**Newark, New Jersey 07102**

**State of New Jersey Department of Banking & Insurance**
**20 West State Street**
**CN-325**
**Trenton, New Jersey 08625**

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

## COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.