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GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

COUNTY OF WILLIAMSON

ALL MEMBERS

Group Vision Care Expense Insurance

Print Date: 02/05/2020

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Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment card. You should keep your enrollment card, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. Please remove your enrollment material from your prior booklet, place it with this booklet, and destroy your prior booklet. If you have any questions about this new booklet, please contact your employer. In the event of future plan changes, you will be provided with a new booklet-certificate or a booklet-certificate rider.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

The group insurance policy and your insurance under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve discretion to construe or interpret the provisions of the Group Policy, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be between Us and persons covered by this group insurance. This provision does not alter or reduce your right to appeal Our decision, to file a grievance, or to seek relief from the Tennessee Department of Insurance, or to seek action in a court of law.

The insurance provided in this booklet is subject to the laws of the state of TENNESSEE.

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0001

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SUMMARY OF BENEFITS
(revised effective February 1, 2020)

VISION CARE EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you or one of your Dependents receive vision Treatment or Service, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

Class	Scheduled Benefits
All Members and their Dependents	See Maximum Payment Limits below

Benefits Payable

Benefits Payable for Treatment or Service received will not be more than the Maximum Payment Limit shown below for each examination or vision aid.

	Maximum Payment Limit
Complete Visual Analysis (one per 12-month period)	\$75
Frames (one set per 12-month period)	\$125
*Single Vision Lenses (pair)	\$50
*Bifocal Lenses (pair)	\$75
*Trifocal Lenses (pair)	\$100
*Lenticular Lenses (pair)	\$100
*Contact Lenses (in lieu of lens and frame benefit):	

If Contact Lenses are prescribed: after cataract surgery; or if vision in the better eye can be corrected to 20/70 or better only by use of contact lenses; or for Medically Necessary reasons, the maximum payment for a pair of contact lenses will be equal to the maximum payment for Single Vision Lenses plus Frames, not to exceed the following:

- Single Vision Lenses (\$50): Two lenses payable once in any period of 12 consecutive months; plus
- Frames (\$125): One set of frames payable once in any period of 12 consecutive months.

The Contact Lenses benefit will be in lieu of the lens and frame benefit. If Contact Lenses are chosen, there will be no Benefits Payable for the lens benefit for a period of 12 consecutive months from the date of service and there will be no Benefits Payable for the frame benefit for a period of 12 consecutive months from the date of service.

*Not more than two lenses (one pair) per 12-month period.

The Vision Care Maximum Payment Limit for you or your Dependents during any period of 12 consecutive months (12 consecutive months for frames) will not exceed the Maximum Payment Limits shown above.

See Page GH 431 for a complete description of Member Vision Care Expense Insurance.

See Page GH 434 for a complete description of Dependent Vision Care Expense Insurance.

HOW TO BE INSURED - MEMBERS
VISION CARE EXPENSE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

You will be eligible on the date you complete 30 consecutive days of continuous Active Work.

If you elect to waive insurance under the Group Policy because you are covered under group vision care expense coverage or coverages provided by your Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date you are eligible to request insurance as described in this section.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

However, this Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

Individual Incontestability and Eligibility

All statements made by any individual insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insured person's insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if an individual's age is misstated, We may, at any time, adjust benefits to reflect the correct age.

We may at any time terminate a person's eligibility under the Group Policy:

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, when an individual has submitted a claim which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

Effective Date

You must request insurance in a form approved by Us. The requested insurance will become effective on:

- the first of the Insurance Month coinciding with or next following the date you are eligible, if the request is made on or before that date; or
- the first of the Insurance Month coinciding with or next following the date you are eligible, if you make your request within 31 days after the date you are eligible; or
- the later of: (1) the date all other insurance under your plan is effective for you; or (2) the first of the Insurance Month coinciding with or next following the date of your request, if you make your request more than 31 days after the date you are eligible.

If request for contributory insurance is made more than 31 days after the date an individual is eligible and other than during the Annual Enrollment Period or Special Enrollment Period described below, insurance for such individual will become effective as described above.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during the Annual Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Enrollment Period."

If request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described under Court Ordered Coverage below.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described below, insurance for such individual will become effective as described below under "Special Enrollment Period".

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the date you return to Active Work.

In addition, your Vision Care Expense Insurance will be subject to the Benefit-Waiting Period provisions described below.

Annual Enrollment Period

An Annual Enrollment Period will be available for any individual who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
- during any previous Annual Enrollment Period; or

- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Enrollment Period, you or your Dependent:

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable waiting period; and
- may not be covered under an alternate vision care expense coverage offered by the Policyholder, unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and accepted by Us.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be on January 1 following completion of the Annual Enrollment Period provided contribution has been received for the requested insurance.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit-Waiting Period provisions as described below will not apply to you or your Dependent Child if:

- you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and
- you have failed to enroll your Dependent Child during a previous enrollment period; and
- you are required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide vision coverage for your Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to you and/or your Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for your or your Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Special Enrollment Period

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which the individual was eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
 - (i) the individual was covered under another group vision care expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
 - (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under COBRA or a state continuation provision, due to exhaustion of the continuation); and
 - (iii) request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

NOTE: For the purpose of (ii) above:

"Loss of eligibility" does not include:

- (i) a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the vision care expense coverage); or
 - (ii) a loss due to a spouse's voluntary termination of his or her vision care expense coverage; or
 - (iii) a loss due to a spouse's voluntary termination of his or her Dependent vision care expense coverage.
- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:
 - (i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
 - (ii) a person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and
 - (iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Vision Care Expense Insurance is available to the Member under the Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of your or your Dependent's insurance will be:

- (i) in the event of marriage, the date of such marriage; or
- (ii) in the event of a Dependent Child's birth, the date of such birth; or
- (iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

During a Special Enrollment Period, your Vision Care Expense Insurance will not be subject to the Benefit-Waiting Period provisions described below.

Benefit-Waiting Period (for when you request insurance more than 31 days after (1) the date eligible; or (2) the date you elect to terminate insurance)

Other than during a Annual Enrollment Period or Special Enrollment Period or coverage required under a QMCSO or NMSN as described above, if you request insurance for yourself or your Dependent more than 31 days after the date you or your Dependent are eligible, or you elect to terminate insurance and more than 31 days later request to be insured again, benefits will be limited as follows:

- During the first 12 months, benefits will be payable only for a Complete Visual Analysis.

After insurance has been in force for 12 consecutive months, benefits will be payable for charges incurred for frames, lenses, and contact lenses (subject to Maximum Payment Limits shown under Payment Conditions on GH 102 D).

Effective Date for Benefit Changes

A change in your Scheduled Benefits amount because of a change in your status (insurance class) will normally be effective on the date of the change in status.

Any termination in your Scheduled Benefit amount due to a change in your status (insurance class) will be effective on the date of the change in status, whether or not you are Actively at Work.

A change in your Scheduled Benefits amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of change.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Termination

Unless continued as provided below or on GH 117 B, GH 117 C, and GH 117 D, your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date the last contribution is made for your insurance; or
- for contributory insurance any date desired, if requested by you before that date; or
- the date you cease to belong to a class for which insurance is provided; or
- the date you cease to be a Member; or
- the date you cease Active Work.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance until the earlier of the date you recover or the date insurance would otherwise terminate as described above.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 117 B, GH 117 C, and GH 117 D.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

HOW TO BE INSURED - DEPENDENTS

VISION CARE EXPENSE INSURANCE

Eligibility

You will be eligible for insurance for your Dependents on the later of:

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

If your Dependent is employed and is covered under group vision care expense coverage or coverages provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such coverage or coverages).

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for your Dependents will become effective under the same terms as described earlier for Member insurance, except:

- Insurance will not be effective unless you are insured for Member insurance.
- A Dependent acquired after your Dependent insurance is already in force will be insured on the date acquired.
- The Actively at Work requirement does not apply to your Dependents.

In addition, your Dependent Vision Care Expense Insurance will be subject to the Benefit-Waiting Period provisions described on GH 115 A.

Individual Incontestability and Eligibility

Your Dependents will be subject to the Individual Incontestability and Eligibility as described earlier for Member insurance.

Termination

Unless continued as provided below or on GH 117 B, GH 117 C, and GH 117 D, insurance for all of your Dependents will terminate on the earliest of:

- the date you cease to belong to a class for which Dependent insurance is provided; or
- the date Dependent Vision Care Expense Insurance is removed from the Group Policy; or
- the date your Member insurance ceases; or
- the date the last contribution is made for Dependent insurance; or
- for contributory insurance any date desired, if requested by you before that date.

Insurance for any one Dependent will terminate on the date he or she ceases to be your Dependent. However, a spouse who no longer resides with you will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent.

However, Vision Care Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

Continuation

In addition, under certain conditions, your Dependent's Vision Care Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on GH 117 B, GH 117 C, and GH 117 D.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains a group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that your group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your insurance.

A. Qualified Persons/Qualifying Events

Continuation of group vision care coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

- (1) a Member (and any covered Dependents) following the Member's:
 - (a) termination of employment for a reason other than gross misconduct; or
 - (b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, continuation due to sickness or injury, or when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

- (2) a Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
- (3) a Member's surviving spouse (and any Dependent Children), following the Member's death; and
- (4) a Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
- (5) a Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and
- (6) a Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
- (7) if the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree vision care benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, vision care coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

- (1) 36 months dating back to the Member's entitlement to Medicare; or
- (2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

- (1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
- (2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A (2) through A (5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or Placement for Adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or Placement for Adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

- (1) the date the maximum continuation period ends; or
- (2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A (7); or
- (3) the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
- (4) the date the Group Policy is terminated (and not replaced by another group vision care plan); or
- (5) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group vision care plan; however, this does not apply to a person who is already covered by the other group vision plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group vision plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 60-day period following a premium due date. Except for the first payment, a Grace Period of 60 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Vision Plan: COUNTY OF WILLIAMSON Insurance Plan
Contact Name/Area: COUNTY OF WILLIAMSON Benefits Department
Address: PO BOX 869
FRANKLIN TN 37065
Phone Number: 615-628-3377

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours during the year preceding the start of the leave; and
- at a worksite where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child;
- The placement of a child with the Eligible Employee for adoption or foster care;
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";

- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- Because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty to a foreign country or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to eligible employees to care for a "covered military member" with a "serious injury or illness". Covered military member means a current member of the Armed Forces and the National Guard or Reserves. It also includes a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves), and was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date an employee takes FMLA leave.

Eligible Employers are required to allow 15 days of unpaid leave during any 12-month period to eligible employees to spend time with a military member on "rest and recuperation" leave.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your insurance would otherwise end because you enter into active military duty or inactive military duty for training, you may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because you enter active military duty, insurance may be continued until the earliest of:

- for you and your Dependents:
 - the date the Group Policy is terminated; or
 - the end of the premium period for which premium is paid if you fail to make timely payment of a required premium; or
 - the date 24 months after the date you enter active military duty; or
 - the date after the day in which you fail to return to Active Work or apply for reemployment with the Policyholder.
- for your Dependents:
 - the date Dependent Vision Care Expense Insurance would otherwise cease as provided on GH 125 D; or
 - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

Reinstatement

For Vision Care Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects your Group Policy. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS
VISION CARE EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided, for an insured class, you and your Dependents must:

- be insured in that class on the date vision Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS.

DESCRIPTION OF BENEFITS

MEMBER VISION CARE EXPENSE INSURANCE

Payment Conditions

If you undergo a Complete Visual Analysis or purchase any of the listed vision aids, We will pay the provider's charges to the Maximum Payment Limits as described in the SUMMARY OF BENEFITS Section.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis or vision aids that are not for Medically Necessary Care; or
- a visual analysis performed by other than a Physician or Optometrist; or
- vision aids not prescribed by a Physician or Optometrist; or
- a visual analysis or vision aids provided by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- sunglasses (prescribed or not); or
- duplication or replacement of a vision aid that is broken, lost, or stolen; or
- more than one Complete Visual Analysis in any period of 12 consecutive months; or
- more than two lenses (one pair) in any period of 12 consecutive months or more than one set of frames in any period of 12 consecutive months; or
- a visual analysis or vision aids for which you have no financial liability or that would be provided at no charge in the absence of coverage; or
- a visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or other medical assistance plans for the needy or indigent or as required under Federal law); or
- a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war; or
- a visual analysis or vision aids provided as the result of participation in criminal activities; or
- a visual analysis or vision aids provided as the result of:
 - an injury arising out of or in the course of any employment for wage or profit if you are eligible to be covered under a Workers' Compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
 - a sickness covered by a Workers' Compensation Act or other similar law; or

- a visual analysis or vision aids provided outside the United States, unless you are outside the United States for one of the following reasons:
 - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment, and travel is for a period of six months or less; or
 - a business assignment, provided you are temporarily outside the United States for a period of six months or less; or
 - full-time student status, provided you are either:
 - enrolled and attending an accredited school in a foreign country; or
 - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- medical or surgical treatment of the eyes.

DESCRIPTION OF BENEFITS

DEPENDENT VISION CARE EXPENSE INSURANCE

Payment Conditions

If one of your Dependents undergo a Complete Visual Analysis or purchases any of the listed vision aids, We will pay the provider's charges to the Maximum Payment Limits as described in the SUMMARY OF BENEFITS Section.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis or vision aids that are not for Medically Necessary Care; or
- a visual analysis performed by other than a Physician or Optometrist; or
- vision aids not prescribed by a Physician or Optometrist; or
- a visual analysis or vision aids provided by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- sunglasses (prescribed or not); or
- duplication or replacement of a vision aid that is broken, lost, or stolen; or
- more than one Complete Visual Analysis in any period of 12 consecutive months; or
- more than two lenses (one pair) in any period of 12 consecutive months or more than one set of frames in any period of 12 consecutive months; or
- a visual analysis or vision aids for which your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or
- a visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or other medical assistance plans for the needy or indigent or as required under Federal law); or
- a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war; or
- a visual analysis or vision aids provided as the result of participation in criminal activities; or
- a visual analysis or vision aids provided as the result of:
 - an injury arising out of or in the course of any employment for wage or profit if your Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
 - a sickness covered by a Workers' Compensation Act or other similar law; or

- a visual analysis or vision aids provided outside the United States, unless your Dependent is outside the United States for one of the following reasons:
 - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment, and travel is for a period of six months or less; or
 - a business assignment, provided your Dependent is temporarily outside the United States for a period of six months or less; or
 - full-time student status, provided your Dependent is either:
 - enrolled and attending an accredited school in a foreign country; or
 - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- medical or surgical treatment of the eyes.

COORDINATION WITH OTHER BENEFITS

VISION CARE EXPENSE INSURANCE

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when you or one of your Dependents have vision care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applied, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Definitions

*"Plan" is any of these which provides benefits or services for, or because of, vision care or treatment:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party vision expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts, including the self-insured equivalent of any minimum benefits required by law.

The term Plan will not include benefits provided under a student accident policy, group or group-type hospital indemnity benefits of \$100 per day or less, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

*In the event a husband and wife are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

"This Plan" is the vision expense benefits described in this booklet.

"Primary Plan/Secondary Plan." The order of benefit determination rules state whether This Plan is a Primary or a Secondary Plan as to another plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

- When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
- When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for vision care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

"Claim Determination Period" means the part of a calendar year during which you or a Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose, benefits payable under other Plans will include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- Nondependent/Dependent. The Plan which covers the person as an employee, Member, or subscriber (that is, other than a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - secondary to the Plan covering the person as a Dependent; and
 - primary to the Plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.
- Dependent Child--Parents Not Separated or Divorced. If a child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the

Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If a child of legally separated or divorced parents is covered under two or more Plans, benefits for the child are determined in this order:
 - first, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child; and
 - finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.
- Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:
 - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);
 - second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

How COB Works

Example 1: The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for vision care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. We would then determine the benefits payable, if any, under This Plan.

Example 2: Mrs. Smith has filed a claim for \$100.00 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 50% of covered charges. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

<u>Company A</u>		
Allowable Expenses	\$	100.00
Less Frame Benefit	-	<u>50.00</u>
Benefit Payable	\$	50.00

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

<u>Company B</u>		
Allowable Expenses	\$	100.00
Less Company A's benefit	-	<u>50.00</u>
Benefit Payable	\$	50.00

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide appropriate forms to assist you in filing claims. If the forms are not provided within 15 calendar days after We receive such notice of claim, you will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date proof is otherwise required.

Payment, Denial, and Review

We permit up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a Written explanation prior to the expiration of the 30 calendar days. The Claimant is then allowed up to 45 calendar days to provide all additional information requested. We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for our denial.

A Claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a Claimant may request a voluntary appeal. The appeal must be requested in Writing. The Claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for the Claimant's Signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required

by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the Claimant's right to bring civil action following the first appeal, nor does it have any effect on the Claimant's right to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the Claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "Claimant" means you or your Dependent.

Facility of Payment

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's Treatment or Service, We may make payment to the Dependent. Assignment of benefits will be allowed, if written notice is received. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent, or a provider of vision services.
- If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.

Medical Examinations

We may have the person whose loss is the basis for claim examined by a Physician during the course of a claim. We will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 60 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Active Work; Actively at Work means the active performance of all of your normal job duties at the Policyholder's usual place or places of business.

Benefit-Waiting Period means the period of time that must pass before an individual is covered for specified benefits under the Group Policy.

Complete Visual Analysis includes:

- case history and professional consultation; and
- examination for disease or abnormalities; and
- determination of the ranges of clear single vision; and
- measurement of refraction, eye muscle coordination, and balance; and
- special working distance analysis.

Dependent means:

- Your spouse, if your spouse is not in the Armed Forces of any country.
- Your Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children means:

- Your natural child, if that child:
 - is not insured under the Group Policy as a Member; and
 - is less than 26 years of age.
- Your stepchild, if that child:
 - meets the requirements above; and
 - receives principal support from you.
- Your foster child, if that child:
 - meets the requirements above; and
 - lives with you; and
 - receives principal support from you; and
 - is under legal guardianship of you or your spouse; and

- is approved in Writing by Us as a Dependent Child.
- Your adopted child, if that child meets the requirements above and you:
 - are a party in a lawsuit in which you are seeking the adoption of the child; or
 - have custody of the child under a court order that grants custody of the child to you.

An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

- A minor child for which you or your insured spouse is the court ordered guardian, if you or your insured spouse is a resident of Tennessee and the child is in your custody.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, as determined by Us, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Full-Time Employee means any person, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 30 hours a week for All Other Active Members; or 12 hours a week for Elected Officials or BOE C-10 employees. You must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week for All Other Active Members; or 12 hours a week for Elected Officials or BOE C-10 employees and otherwise meets the definition of Full-Time Employee.

Generally Accepted means Treatment or Service, which is the subject of the claim, that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed vision and scientific literature; and
- is in general use in the relevant vision community; and
- is not under scientific testing or research.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

Immediate Family means an insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month

Calendar month.

Medically Necessary Care means, as determined by Us, any Treatment or Service that is prescribed by a Physician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

Member means any PERSON including an Elected Official or BOE C-10 employee who is a Full-time Employee of the Policyholder.

Member will also include any such person who is retired and maintains continuous coverage with the Policyholder under the Group Policy.

Any such retired person will also need to meet the following requirements:

- Retired with a hire date prior to July 1, 2009.
- Retired with coverage in effect a minimum of one year prior to retirement.
- Retired with 10 continuous years of full-time service with the Williams County Government or the Board of Education and is age 55 on his/her date of retirement; or have 30 continuous years of full-time service with Williams County Government or the Board of Education regardless of age.

Optometrist means a person who is licensed to practice optometry.

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by Us, which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O).

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policyholder means COUNTY OF WILLIAMSON.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Us.

Treatment or Service, when used in this booklet, will be considered to mean: treatment, service, substance, material or device.

We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

BOOKLET-CERTIFICATE NOTICE

Tennessee insurance law requires that, if a group policy covers any residents of Tennessee, the certificate must include the address and telephone number of the insurance company issuing the policy. The information is as follows:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0001

Vision claim-related inquiries:
Attn: Group Claim - Vision Info Line Services
Telephone: 1-800-247-4695

For administration-related inquiries:
Attn: Group Call Center
Telephone: 1-800-843-1371

If you call or write, please provide all relevant information pertaining to your inquiry, including the group account number and your full name and address.

This Notice is for your information only and does not become a part or condition of this booklet-certificate.

Notice of Privacy Practices for Health Information

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

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable health information. The terms of this Notice apply to members, their spouses and dependents for their group dental expense, group vision care expense and/or group critical illness insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective May 15, 2019.

We are required by law to maintain the privacy of our members' and dependents' health information and to provide notice of our legal duties and privacy practices with respect to their health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by our insurance. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Health Information

Authorization. Except as explained below, we will not use or disclose your health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. Once we receive your request, a form to revoke an authorization will be sent to your attention for completion.

Disclosures for Treatment. We may disclose your health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your health information as necessary for payment purposes. For instance, we may use your health information to process or pay claims, for subrogation, to provide a pre-determination of benefits or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf. Unless we agree in writing to do otherwise, we will send all mail regarding a member's spouse or dependents to the member, including information about the payment or denial of insurance claims.

Uses and Disclosures for Health Care Operations. We will use and disclose your health information as necessary for health care operations. For instance, we may use or disclose your health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with the health plan of a member's employer. We may disclose your health information to your health plan for certain functions of its health care operations. This Privacy Notice does not cover the privacy practices of that plan. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any genetic information we obtain about you or provided from your family history. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your health information. Principal Life Insurance Company may itself be a business associate of your health plan or health insurance company. We may disclose your health information to your health plan or insurance company and its business associates as needed to fulfill our contractual obligations to them. Please see the notice of privacy practices issued by your plan or insurance company for information about how it uses and discloses your health information.

Plan Sponsor. We may disclose your health information to the plan sponsor the minimum necessary amount of your health information that it needs to perform administrative functions on behalf of the plan (if any), provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your health information without your approval. We may also disclose your health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;

- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Health Information. You have the right to request communications regarding your health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests.

Access to Your Health Information. You have the right to inspect and/or obtain a copy of your health information we maintain in your designated record set, with a couple of exceptions. A fee will be charged for copying and postage.

Amendment of Your Health Information. You have the right to request an amendment to your health information to correct inaccuracies. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us during the 6 year period before your request. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Exercising your rights. To exercise any of the above rights, you must submit a written request indicating which rights you are requesting to: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, Principal Life Insurance Company, 711 High Street, Des Moines IA 50392-0002. Once we receive your request, a form(s) will be sent to your attention for completion.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 843-1371.

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002