STATE OF GEORGIA FLEXIBLE BENEFITS PROGRAM

OptumHealth Vision Insurance

Effective January 1, 2009

TABLE OF CONTENTS

Notice Regarding Provider Directories and Provider Networks

Since your Plan utilizes a network of Providers, You may contact 1-800-839-3242 or visit www.myoptumhealthvision.com to obtain the name of a Participating Provider.

OptumHealth Vision

A UnitedHealth Group Company certifies that it insures certain Employees for the benefits provided by the following policy(s) No. 2800:

POLICYHOLDER: The State of Georgia

EMPLOYER: State Personnel Administration

Employer Account No. 2800

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pre-tax salary reduction put toward the cost of your benefits.

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

COVERAGE ELECTIONS

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within the stated deadlines of the following:

Change in Status

If you choose single coverage upon your eligibility date, you may change to family coverage upon acquisition of a newly eligible Dependent (e.g. marriage, birth, adoption). You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. The effective date of coverage for the Dependent(s) shall be the first of the month following the appropriate premium payment. Your newly eligible Dependent(s) will not be subject to the Late Entrant Limitations.

If you lose (e.g., death, divorce, child exceeding eligible age) all eligible Dependents, you may change from family to single coverage. You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. If no change request is filed with the thirty days, a change will not be permitted until the next Open Enrollment Period.

If you or your Dependent(s) lose vision coverage because the employment status of your spouse changes (e.g., termination), you may enroll in single or family coverage or change from single to family coverage, if you file the request within thirty (30) days of the event.

If your spouse gains coverage through their change of employment, you may change from family to single coverage or discontinue family or single coverage if you file the request within thirty (30) days following the event.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility.

You must, however, file a written request for a change in your coverage through your department within thirty (30) days of such change in family status. If no change request is filed within thirty days, a change will not be permitted until the next Open Enrollment Period.

CHANGE IN COST OF COVERAGE

If the cost of benefits increases or decreases during a benefit period, your Employer may in accordance with plan terms automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

CHANGES IN COVERAGE OF SPOUSE OR DEPENDENT UNDER ANOTHER EMPLOYER'S PLAN

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage.

ELIGIBILITY

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees;

- you are a full-time Employee of the State of Georgia, or a State Agency, working at least 30 hours per week, on a continuous basis, and whose employment is expected to last at least nine (9) months, or

- you are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week, or

- you are the Employee of a local school system who holds a non-certificated position and is eligible to participate in the Teachers Retirement System and working at least 20 hours a week or 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week, or

- you are an Employee who is eligible to participate in the Public School Employee Retiree System and who works at least 15 hours per week or 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week, or

- you are an Employee of a county or regional library and working 17.5 hours or more, and

- others deemed eligible by Federal or Georgia Law.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

Your dependent will become eligible for Dependent insurance on the later of:

- The day you become eligible for coverage yourself; or

- The day you acquire your first Dependent.

Waiting Period

The first of the month following one full calendar month of employment.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

ELIGIBILITY — EFFECTIVE DATE

Coverage Effective Date

If you meet the conditions of insurability, your coverage under the policy shall become effective on the latter of:

- The date of eligibility provided you are Actively at Work. If you are not Actively at Work on that day, the coverage will begin:
  - The day that you return to work; or
  - On the date of eligibility if it is your scheduled day off and that you were Actively at Work on the preceding scheduled workday.

- First day of the Plan Year, provided you are Actively at Work, following the initial Open enrollment Period if you completed, signed and submitted the Option Statement during such Open Enrollment period; or

- First day of the Plan Year, provided you are Actively at Work, following any Open Enrollment Period subsequent to the initial Open Enrollment Period, if you complete, sign, and submit an Option statement during such Open Enrollment Period.

- For new hires, on the first day of the calendar month following one full month of employment.

If you enroll for family coverage on your eligibility date, insurance for your eligible Dependents shall be effective on the same date as the effective date of your insurance.

If you acquire a dependent after enrollment, you may add them to coverage within the timeframe allowed under “Change in Status” and their coverage will be effective the first of the month after adding them.

ELIGIBILITY — Enrolling for Coverage

Open Enrollment Period

Open Enrollment Period means an annual enrollment period specified by the State Personnel Administration during which you have an opportunity to enroll or change coverage.

Choice of Participating Vision Care Provider

When you elect vision Insurance, you may utilize any Participating Vision Care Provider from the list provided by OptumHealth Vision.

You and each of your insured Dependents may select your own designated Participating Vision Care Provider.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order.

You must notify your Employer and elect coverage for that child and yourself if you are not already enrolled, within 30 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

(1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

(2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

(3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(4) the order states the period to which it applies; and

(5) if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93) (Continued)

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with State laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

VISION BENEFITS – OPTUMHEALTH VISION CARE

How the Plan Works

When you are ready to obtain vision care services, call your OptumHealth Vision participating provider. If you need to locate an OptumHealth Vision participating provider, visit OptumHealth's Vision Web site at www.myoptumhealthvision.com, or call OptumHealth's Vision provider locator at (800) 839-3242.

When making an appointment, identify yourself as an OptumHealth Vision member. The participating provider will also need the primary insured's Social Security Number, and the primary insured's group name. The participating provider will contact OptumHealth Vision to verify that you are eligible for service and materials.

At your appointment, the participating provider will provide an eye examination and determine if eyewear is necessary. If so, the participating provider will coordinate the prescription with an OptumHealth Vision-approved, contract laboratory. The participating provider will itemize any non-covered charges and have you sign a form to document that you received services. OptumHealth Vision will pay the participating provider directly for covered services and materials.

You are responsible for paying the provider any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating provider from OptumHealth Vision's network assures direct payment to the provider and helps to insure quality services and materials.

Covered Benefits

Standard Eye Examination includes:

- Case History of Patient
- Examination for Eye Pathology and Abnormalities
- Visual Analysis (Refraction)
- Diagnosis and Prescription
- Visual Skill Testing

Frequency

Eye examination: Once each 12 months*
Spectacle Lenses: Once each 12 months*
Frame: Once each 24 months*
**from your last date of service*

Spectacle Lenses and Frames

OptumHealth Vision covers in-full, a pair of standard single lined bifocal or multifocal lenses, when received from a participating provider. OptumHealth Vision covers a wide selection of frames, but not all frames will be covered-in-full. When a patient selects a frame that exceeds the plan's allowance, these additional charges are administered at controlled costs. OptumHealth Vision also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating provider about lens options which may be cosmetic in nature, and may result in additional charges.

Elective or Necessary contact lenses may be provided instead of glasses.

Contact Lenses

OptumHealth Vision covers a wide variety of contact lenses in-full, when obtained from a participating provider location. If you elect contact lenses outside of OptumHealth's Vision covered selection, you will receive an allowance of $105 toward the usual retail cost of the dispensing, fitting and materials. Any amount over the allowance is the patient's responsibility.

The frequency for contacts is the same as spectacle lenses. Under this plan, if you elect contact lenses, you will be eligible for a frame 12 ***months after*** the last date of obtaining the contact lenses.

Necessary Contact Lenses

OptumHealth Vision covers necessary contacts lenses in full when prescribed by a participating provider for one of the following conditions:

- Following cataract surgery;
- To correct extreme vision problems that cannot be corrected with spectacle lenses;
- With certain conditions of anisometropia; or
- With certain conditions of keratoconus.

OptumHealth Vision recommends that the participating provider verify that necessary contact lenses are appropriate before submitting the claim.

Non-Participating Provider

You may select any licensed vision care provider for services. Your reimbursement schedule may not provide full payment, nor can OptumHealth Vision help to insure patient satisfaction, when services are obtained from a non-participating provider.

General Claims Filing

In general, in-network providers handle the claims process for you. If you receive services and/or materials out-of-network, however, you will have to pay the provider and seek reimbursement through the claims process. Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt. For reimbursement for out-of-network services, you must submit receipts to OptumHealth's Vision Claims department via facsimile number 248-733-6060 or via mail to: OptumHealth Vision Claims Department, P. O. Box 30978, Salt Lake City, UT 84130. Receipts for services received together must be submitted together. Receipts for services and materials purchased on different dates must be submitted together.

Follow these steps if you obtain services and/or materials from a non-participating provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame.
- Send a copy of the itemized bill(s) to OptumHealth Vision. The following information **must** also be included in your documentation.
- Primary Insured's name and mailing address;

- Primary Insured's Social Security number;
- Primary Insured's employer or group name; and
- Patient's name, relationship to member, and date of birth.

If you choose a **Non-Network Provider**, you will need to send your itemized receipts, with the primary-insured's Social Security number and the patient's name and date of birth to:

OptumHealth's Vision Claims Department
P. O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Plan Limitations

This plan is designed to cover your vision needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses;
- Cosmetic lenses;
- A frame that exceeds the plan allowance;
- Certain limitations on low vision care;
- Optional cosmetic processes; or
- UV protected lenses.

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing;

- Plano lenses (non-prescription)

- Two pair of glasses in lieu of bifocals;

- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; or

- Corrective vision services, treatments, and materials of an experimental nature.

This is only a summary. For additional information, see your employer's benefits representative.

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 any rights you may have under the Employee Retirement Income Security Act of 1974 (ERISA) or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about any rights and responsibilities you may have under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

COORDINATION OF BENEFITS

Under this vision plan Coordination of Benefits rules do not apply.

MISCELLANEOUS

Certain Participating Vision Facilities may provide discounts on services not listed on the Patient Charge Schedule, including a discount on Lasik services. You should contact your Participating Vision Facility to determine if such discounts are offered.

TERMINATION OF INSURANCE - EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

- the last day of the calendar month following the month for which you have made any required contribution for the insurance.

- the date the policy is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

On the date you are no longer Actively at Work except that:

- while you are sick or injured, and in an approved leave without pay period, your employment will be deemed to continue for up to 12 months from the date your disability began, as long as premium payments are made on your behalf; and

- while you are on an approved leave of absence (except a leave of absence to enter military or naval service), your employment will be deemed to continue, as long as premium payments are made, for up to 12 months, unless your Employer cancels your insurance before the end of that time.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Vision Insurance)

If your Active Service ends because you retire, your insurance will be discontinued.

TERMINATION OF INSURANCE - DEPENDENTS

Your insurance for your Dependents will cease on the earliest date below:

- the date your insurance ceases.

- the date you cease to be eligible for Dependent Insurance.

- the last day of the calendar month following the month for which you have made any required contribution for the insurance.

- the date Dependent Insurance is canceled.

- the date upon a determination of fraud or misuse of vision services and/or vision facilities.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

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

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical, dental and vision coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

You may choose to discontinue vision coverage while on Military Leave, or continue coverage through personal premium payments. You may pay personal premium payments as long as you are on the Military Leave. Since both the commencement and completion of Military Leave is considered a Qualified Change of Status, you may also select a different vision option at these times.

If you do not continue coverage through personal premium payments, upon return to employment, you will be reinstated for the type of vision coverage for which you enrolled prior to activation, unless a different option is selected. No penalties for non-payment will be applied.

The administration of the vision benefit described above is based on returning to work during the same plan year that you were placed on Military Leave. If you return in a different plan year, you are to be provided a thirty (30) day Open Enrollment Period for the new plan year. You are guaranteed coverage for benefits in effect prior to the onset of your Military Leave.

If a qualifying change in status occurs while on Military Leave, you are to report the change to the personnel/payroll office upon return to active pay status. If you do not report the change at that time, it should be reported within the allowable timeframe. Generally, a request for an increase in coverage must be made within thirty (30) days; a request for a decrease in coverage must be made within thirty (30) days.

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence. For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

Since your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

Following continuation of health coverage per COBRA or USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

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

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, a. you gave your Employer advance written or verbal notice of your military service leave, and b. the duration of all military leaves while you are employed with your current Employer does not exceed 5 years. You and your Dependents will be subject to only the balance of a Preexisting Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply. Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

Time Frames for Requesting Reemployment

When a leave ends, you must report your intent to return to work as follows:

- for leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- for leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- for leaves of more than 180 days, by submitting an application
- to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for re-employment.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered under the Vision Plan for the State of Georgia Flexible Benefits Program (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under COBRA you should contact your Flexible Benefits Program Administrator ("Program Administrator").

The Program Administrator's address is Flexible Benefits Program, State Personnel Administration, 2 Martin Luther King Jr., Drive, Suite 1016 West Tower, Atlanta, Georgia 30334. The Program Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event:" Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because one of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced from your spouse. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because one of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced; or

(6) The child stops being eligible for coverage under the plan as a "dependent child, upon attainment of age 19, or 26 if a fulltime “student".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Program Administrator has been **timely** notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Program Administrator within sixty (60) days after the later of the qualifying event or loss of coverage.

IMPORTANT: For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a

dependent child), you must notify the Program Administrator. The Plan requires you to notify the Program Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage, using the procedures specified in the box below. If these procedures are not followed or if the notice is not provided in writing to the Program Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail your notice to the Program Administrator at the Flexible Benefits Program, of the State Personnel Administration at this address: 2 Martin Luther King Jr., Drive, Suite 1016 West Tower, Atlanta, Georgia 30334.

You may contact the Program Administrator to obtain a form, if any, used to provide notice to the Program Administrator of a qualifying event.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan (Group Vision Plan), the name and address of the employee covered under the Plan, and the name(s) and address (es) of the qualified beneficiary (ies). Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Once the Program Administrator receives **timely** notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who **timely** elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. **If you or your spouse or dependent children do not elect continuation coverage within this 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B. or both), your divorce or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to

18 months. There are several ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan 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 maximum 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. The Plan requires you to follow the procedures specified in the box above, entitled "Notice Procedures." Your notice must address the determination of disability by the Social Security Administration and the date it happened. In the disability determination **if these procedures are not followed or if the notice is not provided in writing to the Program Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO THE DETERMINATION OF DISABILITY BY THE SOCIAL SECURITY ADMINISTRATION.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow the procedures specified in the box above, entitled "Notice Procedures." Your notice must also name the second qualifying event and the date it happened. In the second qualifying event **if these procedures are not followed or if the notice is not provided in writing to the Program Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO THE SECOND QUALIFYING EVENT.**

Medicare extension for spouse and dependent children

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Children born to or placed for adoption with the covered employee during COBRA period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Program Administrator during the covered employee's period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Program Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

TERMINATION OF INSURANCE REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Vision Insurance During Leave

Your vision insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and

- you are an eligible Employee under the terms of that Act.

The cost of your vision insurance during such leave must be paid by you.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled vision insurance will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

RETIREE AND SURVIVING SPOUSE/DEPENDENT CONTINUATION OF COVERAGE

Employees and their dependents that are eligible to participate and were enrolled in the vision plan at the time of retirement may elect to continue their coverage through **COBRA**.

VISION CONVERSION

There is no conversion privilege under the Vision Plan.

DENIALS & APPEALS

Denials

If a claim is partially paid, you will receive a written notice explaining how the claim was processed and giving notice of your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to you. This notice will include:

- The address and timeframe for submitting an appeal.
- A statement that an appeal must be submitted in writing, and any other information that should be included with the appeal request.
- A statement that you have a right to submit written comments, documents, records and other information relating to the claim.
- A statement that you will be provided, at no charge and upon request, reasonable access to and copies of all documents, records and other information relevant to the claim.
- A statement that you and the plan may have other voluntary dispute resolution options, such as mediation, and information about how to obtain information about such options.
- A statement that you may have a right to bring a civil action under section 502(a) of ERISA following a denial of an appeal.

- A statement that you will be provided, at no charge and upon request, a copy of any specific internal rules, guidelines or protocols that were relied upon in denying the claim.
- A statement that you will be provided, upon request and at no additional charge, an explanation of any scientific or clinical basis for denying the claim.

Appeals

You, or your duly authorized representative, may appeal the denial. Appeals should be submitted to: OptumHealth Vision Appeals, Claims Department, 6220 Old Dobbin Lane, Liberty 6, Suite 200, Columbia, MD 21045.

Appeals must be in writing and received by OptumHealth Vision within 180 days after your receipt of the Notice of Benefit Determination. If this Notice is not received by you within 30 days of submission of the original claim, you may submit an appeal within 180 days after this 30-day period has expired.

Appeals will be decided within 60 days after receipt by OptumHealth Vision. If an appeal is denied, a written Notice of Benefit Appeal Determination will be sent to you.

This notice will include similar information as the Notice described in the Denials section above.

Telephone inquiries concerning appeals should be made to: OptumHealth Vision Claims, Appeals Department, 1-800-638-3120.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against OptumHealth Vision in federal court until you have completed the Appeal process.

DEFINITIONS

Active Service

You will be considered in Active Service if:

- you are able to do the normal tasks of your job on a full-time basis for a full work day on the day your insurance is to begin, and
- you are able to do such tasks at one of your employer's normal places of business or at a location to which you must travel to do your job; and
- you are not absent from work because of sickness, disability or temporary lay-off.

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is less than 19 years old.
- 19 years but less than 26 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to OptumHealth Vision as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, OptumHealth Vision may require such proof at least once each year until he/she attains age 26.
- 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to OptumHealth Vision within 30 days after the date the child ceases to qualify above. During the next two years OptumHealth Vision may, from time to time, require proof of the continuation of such condition and dependence. After that, OptumHealth Vision may require proof no more than once a year.
- A child includes a legally adopted child. It also includes a stepchild who lives with you.
- Anyone who is eligible as an Employee will not be considered as a Dependent. No one may be considered as a Dependent of more than one Employee.

Employee

The term Employee means someone who:

- completes the waiting period (described in the Date of Eligibility section); and
- is a full-time employee of the State of Georgia, or a State Agency. "Full-time" means someone who works at least 30 hours a week, on a continuous basis, and whose employment is expected to last at least nine (9) months. The following are certain categories of employees specifically excluded: student, seasonal, part-time, short-term and sheltered workshop; or
- is a public school teacher who is employed in a professionally certificated capacity working 17.5 hours or more per week.
- is an employee of a local school system who holds a noncertificated position and who is eligible to participate in the Teachers Retirement System or its equivalent and working at least 20 hours a week (or 60% of the time necessary to carry out the duties of the position if that's more than 20 hours); or
- is an employee who is eligible to participate in the Public School Employee Retirement System as defined by 20 of Section 47-4-2 of the Official Code of Georgia, Annotated and who works at least 15 hours a week (or 60% of the time necessary to carry out the duties of the position); or
- is an employee of a county or regional library and working at least 17.5 hours or more; or
- is deemed eligible by Federal or Georgia law.

Employer

The terms Employer and Participating Employer mean any Employer who has signed a Request for Participation in the OptumHealth Vision Plan and whose request has been approved by the Insurance Company. These terms also include Affiliated Employers.

Affiliated Employers are those employers specified as affiliated employers in the participating Employer's Request for Participation in accordance with its terms.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Plan Year (Contract Year)

The period beginning January 1 and ending on December 31.

Provider

The term Provider means a person practicing optometric care within the scope of his/her license. It will also include a physician operating within the scope of his/her license when he/she performs any of the Vision Services described in the policy.

OptumHealth Vision

OptumHealth Vision is a wholly-owned subsidiary of the UnitedHealth Group that contracts with Participating Providers for the provision of vision care. OptumHealth Vision also provides management and information services to Policyholders and Participating Vision Facilities.