



## **Greenville ISD**

### Your Vision Plan

Policy No. 803683 011

Underwritten by Starmount Life Insurance Company

8/31/2022





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## Group Vision Insurance Certificate of Coverage

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

**Policyholder:** Greenville ISD  
**Policy Number:** 803683 011  
**Policy Effective Date:** September 1, 2022  
**Policy Anniversary:** September 1  
**Governing Jurisdiction:** Texas

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

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

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

The insurance Policy under which this certificate is issued is not a policy of Workers' Compensation Insurance. You should consult your Employer to determine whether your Employer is a subscriber to the Workers' Compensation system.

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Texas Department of Insurance at (800) 252-3439.

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right of appeal.

### Unum

To file a complaint through your insurance company or HMO:

**Call: Customer Relations**  
**Toll-Free: 800-321-3889; Option 2**  
Email: [custrel@unum.com](mailto:custrel@unum.com)  
Mail: 2211 Congress Street  
Portland, Maine 04122

### The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439  
File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)  
Mail: MC 111-1A  
P.O. Box 149091  
Austin, TX 78714-9091

## ¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar un queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### Unum

Para presentar una queja a través de su compañía de seguros o HMO:

**Llamada: Relaciones con el cliente**  
**Teléfono gratuita: 800-321-3889; Opción 2**  
Correo electrónico: [custrel@unum.com](mailto:custrel@unum.com)  
Dirección postal: 2211 Congress Street  
Portland, Maine 04122

### El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439  
Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)  
Dirección postal: MC 111-1A  
P.O. Box 149091  
Austin, TX 78714-9091

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

**Eligible Group(s)**

All Full-Time Employees in Active Employment in the United States working a minimum of 15 hours per week.

**Paying for Coverage**

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

**Schedule of Benefits**

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

**Group Vision Insurance Schedule of Benefits**

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

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

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

<b>BENEFIT FREQUENCY</b>	
Vision Exam	Once every 12 Months
Eyeglass Lenses	Once every 12 Months
Frames	Once every 12 Months
Contact Lenses	Once every 12 Months
Supplemental Benefits	Once every 12 Months

<b>IN-NETWORK PROVIDER</b>		
<b>Covered Services and Materials</b>	<b>Co-Pay</b>	<b>Benefit after Co-Pay</b>
<b>Eye Exam</b>		
By Ophthalmologist or Optometrist	\$10	Covered in Full
<b>Materials - Eyeglass Lenses</b>		
Single Vision Eyeglass Lenses	\$25	Covered in Full
Bifocal Eyeglass Lenses	\$25	Covered in Full
Trifocal Eyeglass Lenses	\$25	Covered in Full
Standard Progressive Eyeglass Lenses	\$90	Covered in Full
Premium Progressive Lenses Tier 1	\$110	Covered in Full
Premium Progressive Lenses Tier 2	\$120	Covered in Full
Premium Progressive Lenses Tier 3	\$135	Covered in Full
Premium Progressive Lenses Tier 4	\$90	\$120 Allowance
Lenticular Eyeglass Lenses	\$25	Covered in Full
<b>Materials - Frames</b>		
Eyeglass Frames	\$0	\$150 Allowance
<b>Materials - Contact Lenses</b>		
Contact Lenses - Elective	\$0	\$150 Allowance
Contact Lenses - Non-Elective	\$0	Covered in Full

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

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

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



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

**Vision Benefits**

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

**Eye Exams**

*Benefit Description*

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

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

In no event will coverage exceed the lesser of:

- the actual cost incurred; or
- the Benefits and Allowances shown in the Schedule of Benefits.

An Eye Exam is an examination of principal vision functions which includes, but is not limited to:

- case history;
- examination for pathology or anomalies;
- job visual analysis;
- refraction;
- visual field testing; or
- tonometry, if indicated.

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

**Covered Materials**

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

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

In no event will coverage exceed the lesser of:

- the actual cost incurred of the Covered Materials; or
- the Benefits and Allowances shown in the Schedule of Benefits.

**In-Network Benefits**

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

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

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

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

If an Insured does not have reasonable access to an In-Network Provider, benefits for an Out-of-Network Provider will be paid at the in network rate for their service and region.

**Out-of-Network Benefits**

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

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

## Vision Details | Exclusions and Limitations

### Exclusions

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

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

We will also not pay any claims incurred after:

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

### Limitations

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

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

<b>Waiting Period</b>	First of the month following the first day of continuous Active Employment.
<b>Coverage Eligibility Date</b>	<p><i>For you</i> If you are in an Eligible Group, you are eligible for coverage on the later of:</p> <ul style="list-style-type: none"><li>- the Policy Effective Date; or</li><li>- the day after any applicable Waiting Period has been satisfied.</li></ul> <p><i>For your Spouse</i> If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:</p> <ul style="list-style-type: none"><li>- the date you are eligible for coverage; or</li><li>- the date you first acquire a Spouse.</li></ul> <p><i>For your Children</i> If you elect coverage for yourself, your Children are eligible for coverage on the later of:</p> <ul style="list-style-type: none"><li>- the date you are eligible for coverage; or</li><li>- the date you first acquire the Child.</li></ul> <p>Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.</p> <p>If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.</p> <p>Coverage of a child who is the subject of a medical support order shall be automatically covered for the first 31 days after receipt of a medical support order.</p>
<b>Enrolling for Coverage</b>	<p><b>Initial Enrollment</b> You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.</p> <p>You may also apply for any coverage available for you, your Spouse, and Children during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event. Annual enrollment is a period of time specified by the Policyholder and agreed upon by us.</p>
<b>Coverage Effective Date for Changes in Coverage</b>	<p><i>Changes in Coverage Requested by You</i> Changes in coverage for an Insured will begin immediately following the later of:</p> <ul style="list-style-type: none"><li>- immediately following the date your applicable Enrollment Period ends;</li><li>- immediately following the date you apply for the change in coverage due to a Qualifying Life Event, if it's within 31 days of the Qualifying Life Event.</li></ul> <p>Any cancellation in coverage for an Insured will take effect on the first day of the month following the later of:</p> <ul style="list-style-type: none"><li>- the date the cancellation in coverage is made; or</li><li>- the date agreed upon by us and your Employer.</li></ul> <p>Any change or cancellation in coverage will not affect a Payable Claim that occurs prior to the change or cancellation.</p>
<b>Coverage Effective Date if you are not in Active Employment</b>	<p>You must be in Active Employment in order for coverage to become effective in accordance with the Coverage Effective Date provision.</p> <p>If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.</p> <p>Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage are subject to this provision.</p>

**Continuation of your Coverage During Extended Absences**

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

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

*Family and Medical Leave of Absence*

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

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

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

We will not apply a new Waiting Period.

*Leave of Absence due to Military Service*

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

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

*Injury or Sickness*

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

**End of Coverage For You**

Your coverage under this Certificate ends on the earliest of:

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

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

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

*For your Spouse*

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

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

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

## **End of Coverage**

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

### *For your Children*

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

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

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

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

**Filing a Claim**

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

***In-Network Claims***

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

***Out-of-Network Claims***

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

***Step 1 - Starting a Claim***

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

***Step 2 - Claim Forms***

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

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

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

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

***Step 3 - Proof of Loss***

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

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

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

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

**Claim Procedures**

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

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

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

### **Payment of Benefits**

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

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

Benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

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

### **Payments to a Minor or Incompetent Insured**

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

### **Overpayment of Claims**

We have the right to recover any overpayments due to:

- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

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

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

### **Underpayment of Claims**

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

### **Grievance Procedures**

#### *Complaints*

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

#### *Claim Denial*

If we deny all or any part of your claim, you can access the claim status detail on [www.eyemedvisioncare.com/unum](http://www.eyemedvisioncare.com/unum), you have the right to receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- a description of the appeal procedures and time limits;



## Claim Provisions

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

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

### *Claim Denial Grievance*

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

The request must be made within 180 days following your receipt of the Written notification of adverse benefits determination (includes a denial based on medical necessity, the services or materials are experimental or investigational) and should contain sufficient information to identify the person for whom the claim was denied, including:

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

You will receive a letter of receipt no later than 5 working days after your request for review is received by us. You may request, free of charge, any documents held by us regarding the denial of your claim. You may also submit Written comments or supporting documentation concerning the claim to assist in our review. Our response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you no later than 30 days after receipt of a request for review from you. For a request for review that involves urgent care, we will make an expedited review decision and notify you no later than one working day from the date all information necessary to complete the appeal is received.

**Independent Review Option:** If your final internal appeal to reverse an adverse benefit decision is denied, you may have the right to seek review of that determination by an independent review organization assigned to the appeal in accordance with Chapter 4202 of the Texas Insurance code.

### **ERISA**

If your Plan is governed by ERISA, claim denial and appeal procedures as well as your right to lawsuit should comply with ERISA requirements, which might be different from the state requirements stated above.

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

### *Other Remedies*

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

## **Legal Actions**

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

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has

## Claim Provisions

been given to us and up to three years from the latest of when:

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

unless otherwise provided under federal law.

<b>When Days Begin and End</b>	For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.
<b>Certificate of Coverage Contents</b>	Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of: <ul style="list-style-type: none"><li>- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;</li><li>- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;</li><li>- the Policyholder's application for group insurance; and</li><li>- Employee's signed applications, if applicable.</li></ul>
<b>Your Certificate of Coverage</b>	We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your Certificate describes: <ul style="list-style-type: none"><li>- the coverage to which an Insured may be entitled;</li><li>- to whom we will make a payment; and</li><li>- the limitations, exclusions, and requirements that apply to an Insured's coverage.</li></ul> <p>If any of the terms and provisions of this Certificate are different than in the Policy, the Policy will govern.</p>
<b>Cancellation or Modification to the Policy and this Certificate of Coverage</b>	The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or Certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.  All Policy and Certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.
<b>Representation in Applications</b>	Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you.
<b>Assignment</b>	An Assignment transfers all or part of your legal title and rights under the Policy and this Certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this Certificate if: <ul style="list-style-type: none"><li>- the Written form has been signed by you and the assignee and the form is acceptable to us; and</li><li>- a signed or certified copy of the Written Assignment has been filed with us.</li></ul> <p>An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage.</p> <p>We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.</p>
<b>Contestability</b>	We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.
<b>Misstatement of Information</b>	If you or your Employer provide us information about an Insured that is incorrect, we will: <ul style="list-style-type: none"><li>- use the facts to decide whether the Insured has coverage under this Certificate and the Policy and in what amounts; and</li><li>- if necessary, make the applicable premium adjustments.</li></ul>
<b>Fraud</b>	We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means

## General Provisions

necessary to support fraud detection, investigation, and prosecution.

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

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

### **Agency**

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

### **Communicating with you or your Employer**

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

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

<b>Active Employment</b>	<p>You are working for your Employer for earnings that are paid regularly, and you are performing the usual and customary duties of your job. You must be regularly scheduled to work at least the minimum number of hours as determined by your Eligible Group Employer.</p> <p>Your work site must be:</p> <ul style="list-style-type: none"> <li>- your Employer's usual place of business in the United States;</li> <li>- an alternative work site in the United States at the direction of your Employer; or</li> <li>- a location in the United States to which your job requires you to travel.</li> </ul> <p>Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.</p> <p>For purposes of this Certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- inclement weather;</li> <li>- power outage; and</li> <li>- public health agency orders.</li> </ul> <p>Temporary and seasonal workers are excluded from coverage.</p>
<b>Administrator</b>	<p>The entity which provides complete service to review and pay claims under the Policy as agreed to in a contract with us.</p>
<b>Allowance</b>	<p>The maximum amount we will pay for Covered Services or Materials as shown in the Schedule of Benefits.</p>
<b>Certificate of Coverage or Certificate</b>	<p>The document issued to the Employee describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.</p>
<b>Children</b>	<p>Any child to the end of the year in which they reach age 26 who is:</p> <ul style="list-style-type: none"> <li>- your own natural offspring;</li> <li>- your Spouse's child;</li> <li>- your lawfully adopted child as of the earliest of the date:             <ul style="list-style-type: none"> <li>- the child is placed in your home or in a medical facility;</li> <li>- a petition is filed for you to adopt the child; or</li> <li>- an adoption agreement signed by you that includes your binding obligation to assume financial responsibility for the child;</li> </ul> </li> <li>- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;</li> <li>- grandchildren, nieces, and nephews that are dependent for federal income tax purposes at the time of application; or</li> <li>- any other child residing with you through legal mandate that is dependent on you for financial support.</li> </ul> <p>Coverage for your Child may be continued past the end of the year in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.</p> <p>You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.</p> <p>Your Children may not be Insured as both a Child and an Employee.</p> <p>Your Children may not be Insured by more than one Employee.</p>

<b>Co-Pay</b>	The amount an Insured must pay to a provider before benefits are payable for Covered Services or Materials. The Co-Pay is paid directly to the provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.
<b>Contact Lenses, Elective</b>	Contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.
<b>Contact Lenses, Non-Elective</b>	<p>Contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.</p> <ul style="list-style-type: none"> <li>- High Ametropia exceeding -10D or +10D in meridian spectacle Rx powers;</li> <li>- Anisometropia of 3D in meridian spectacle Rx powers;</li> <li>- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses;</li> <li>- Vision improvement for members whose vision can be corrected by 2 lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.</li> </ul> <p>Medically necessary contact lenses are available in lieu of ophthalmic lenses and are subject to plan copayments and frequency limits. The provider determines the member's qualifying criteria at examination and evaluation.</p>
<b>Contributory Coverage</b>	Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.
<b>Covered in Full</b>	The In-Network Provider has agreed to accept a negotiated amount for the Covered Services or Materials as payment in full. The Insured is not responsible for any charges for the Covered Services or Materials other than the applicable Co-Pay.
<b>Covered Services or Materials</b>	The Vision Exam services and Materials that qualify for benefits under the Policy. Covered Services or Materials are shown in the Schedule of Benefits.
<b>Covered Loss</b>	Benefits will be paid only for losses identified in the Schedule of Benefits.
<b>Employee</b>	A person, also referred to as "you," who is in Active Employment in the United States with the Employer.
<b>Employer</b>	The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.
<b>Enrollment Period</b>	A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.
<b>Eyeglass Lenses</b>	A standard plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.
<b>Injury and Sickness</b>	<p>A bodily Injury, illness, infection, disease, or any other abnormal physical condition, which:</p> <ul style="list-style-type: none"> <li>-occurs on or after the initial effective date;</li> <li>-occurs while coverage is in force; and</li> </ul> <p>is not excluded by name or specific description in the Certificate.</p>
<b>Insured</b>	Any person who has coverage under this Certificate.
<b>In-Network Provider</b>	An Ophthalmologist, Optometrist or Optician who has entered into an agreement with the network selected by the plan to provide Covered Services or Materials at an agreed to cost.

<b>Leave of Absence</b>	<p>Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.</p> <p>Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.</p>
<b>Ophthalmologist</b>	<p>A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Ophthalmologist for a claim that you send to us.</p>
<b>Optician</b>	<p>A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optician for a claim that you send to us.</p>
<b>Optometrist</b>	<p>A person licensed to practice optometry, including therapeutic optometrists, as defined by the laws of the state in which services are rendered.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optometrist for a claim that you send to us.</p>
<b>Out-of-Network Provider</b>	<p>An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with us to limit their charges. They are not listed in the In-Network Provider Directory.</p>
<b>Payable Claim</b>	<p>A claim for which we are liable for under the terms of this Certificate.</p>
<b>Policy Year</b>	<p>September 1, 2022 to September 1, 2023 and each following September 1 to September 1.</p>
<b>Plano Lens</b>	<p>A lens that has no refractive power.</p>
<b>Policy</b>	<p>The Group Vision Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.</p>
<b>Policyholder</b>	<p>The entity to which the Policy is issued.</p>
<b>Provider Directory</b>	<p>A list of In-Network Providers for your plan. You can verify if a provider is an In-Network Provider by calling customer service at (866) 800-5457 or online at <a href="http://www.eyemedvisioncare.com/unum">www.eyemedvisioncare.com/unum</a>.</p>
<b>Qualifying Life Event</b>	<p>An event including, but not limited to:</p> <ul style="list-style-type: none"> <li>- birth, adoption, or addition of a Child;</li> <li>- a change in legal marital status;</li> <li>- a change in employment status; or</li> <li>- death of an Insured.</li> </ul> <p>Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.</p> <p>For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.</p>

<b>Spouse</b>	The person who is your partner through lawful marriage, civil union, or your legally separated Spouse.  Your Spouse may not be Insured as both a Spouse and an Employee.
<b>Starmount Life Insurance Company</b>	Referred to as "Starmount" and "we," "us," or "our."
<b>Writing or Written</b>	A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law.



# Privacy Notice

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

## COLLECTING INFORMATION

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

## SHARING INFORMATION

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

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

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

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

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

## SAFEGUARDING INFORMATION

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

## ACCESS TO INFORMATION

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

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

## CORRECTION OF INFORMATION

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

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

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

### **COVERAGE DECISIONS**

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

### **CONTACTING US**

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

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

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

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[unum.com](http://unum.com)

MK-1883 (06-2020)

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts)

**This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

**For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:**

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**  
515 Congress Avenue, Suite 1875  
Austin, TX 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**  
P.O. Box 149104  
Austin, TX 78714-9104  
1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.