Educational Risk and Insurance Consortium - North

Monroe Township Board of Education (Middlesex)

July 1, 2021 to July 1, 2022

Presented By
Arthur J. Gallagher Risk Mgt. Serv.,Inc.
707 State Road
P.O. Box 83
Princeton, NJ 08540

Please note: All of the casualty reinsurers on the 21-22 program (with the exception of the primary $1,000,000 E&O reinsurer) have placed "communicable disease" exclusions in their coverage agreements. In response, rather than excluding communicable disease claims, NJSIG has increased its Auto Liability and General Liability self-insured retention from $500,000 to $1,000,000 and is providing a $1,000,000 per occurrence/$9,000,000 pool aggregate sublimit applicable to damages arising out of "communicable diseases". This sublimit and aggregate apply to AL, GL and E&O. Defense costs are in addition to the $1M per occurrence sublimit. Also, the casualty reinsurer on the $10Mx$20M layer of the program has imposed a School Leaders Error & Omissions coverage retroactive date of July 1, 2012 (this applies to E&O members with a $21M limit and members with a $31M E&O limit). Additionally, the cyber liability carrier has increased the member per claim retention for all claims to $500,000. The carrier has also reduced the Cyber Extortion, Data Recovery Loss, and Business Interruption Loss per member sublimits from $1,000,000 to $500,000 and reduced the Fraudulent Instruction sublimit from $250,000 to $100,000. The annual pool aggregate limit on the 21-22 cyber program has been reduced from $20,000,000 to $10,000,000.

If the General Liability discount indicated on this Proposal is utilized we must be provided with a copy of the 2021-2022 Student Accident Declarations page or Binder within 30 days of binding. Failure to submit proper documentation will result in revocation of the credit and an invoice will follow accordingly

Reminder: Per NJSIG's bylaws, the Group is permitted to examine and audit a member district's payroll records at any time to ensure the accurate reporting of payroll information used to determine Workers' Compensation premiums

THIS QUOTE IS SUBJECT TO THE FOLLOWING AT THE TIME OF BINDING COVERAGE:
1) a fully completed "Indemnity and Trust Agreement and Resolution to Join" signed and dated by the Business Administrator Missing information must be included with the Lock and Bind request.

R354AM-01

06/18/2021

A Fund Administered by New Jersey Schools Insurance Group

6000 Midlantic Drive, Suite 300, Mount Laurel, New Jersey 08054
ph: 609.386.6060 - fx: 609.386.8877
Serviced by Arthur J. Gallagher Risk Management Services, Inc.

Educational Risk and Insurance Consortium - North
Monroe Township Board of Education (Middlesex)
Quote Number R354AM-01 July 1, 2021 to July 1, 2022

Package Options

Coverage Type	Limits	Deductibles	Premiums
Property	$307,595,900	$10,000	$242,831
Environmental Impairment Liability	$1,000,000	$50,000	$4,411
~~Underground Storage Tanks~~	~~Not Quoted~~	~~Not Quoted~~	~~Not Covered~~
Retro Active Date:			
Restart (Demolition & Rebuild)	$5,000,000	Not Applicable	$704
Crisis Management	$1,000,000	Various	$1,145
~~Cyber Liability~~	~~$2,000,000~~	~~Various~~	~~$13,938~~
Extra Expense	$50,000,000	$10,000	Included
Valuable Papers	$10,000,000	$10,000	Included
Loss of Rents	Not Quoted	Not Quoted	Not Covered
Business Income/Tuition	$1,000,000	$10,000	Included
Limited Builders Risk	$10,000,000	$10,000	Included
Equipment Breakdown	$100,000,000	$25,000	$23,034
Crime:			
Faithful Performance	$500,000	$1,000	$512
Forgery & Alteration	$500,000	$1,000	$512
Money & Securities	$100,000	$500	$380
Money Orders/Counterfeit	$100,000	$500	$380
Computer Fraud	$500,000	$1,000	$147
~~General Liability~~	~~$31,000,000~~	~~Not Applicable~~	~~$110,799~~
General Liability with SA discount	$31,000,000	Not Applicable	$104,727
Automobile Liability	$31,000,000	$0	$72,995
Auto Physical Damage	ACV Basis	$1,000	$16,869
	*Replacement Cost on Qualifying Buses		

Workers' Compensation and Supplemental Indemnity Options

	ERIC North	
Professional Payroll	$64,785,570	
Non-Professional Payroll	$9,290,588	
Workers' Compensation	Part 1:Statutory/ Part 2: $3,000,000	$688,262
Experience Modifier	0.6149	
Supplemental Indemnity (Waiting Period)	7 Days	$38,860

Quote Number R354AM-01 July 1, 2021 to July 1, 2022

School Leaders Errors and Omissions Liability

Retro Date Cov A July 1, 1986
Retro Date Cov B July 1, 1986

	Coverage A Limits		Coverage B Limits	Deductible	Premium
OBE	$1,000,000/$3,000,000	Each policy period	$100,000/$300,000	$10,000	$276,359
NUSIG	$30,000,000	Each policy period			

Educational Risk and Insurance Consortium - North
Monroe Township Board of Education (Middlesex)
Quote Number R354AM-01 July 1, 2021 to July 1, 2022

Coverage Type	Commission Percentage	Commission Dollars
Property	15.00%	$36,425
Environmental Impairment Liability	15.00%	$662
Restart (Demolition & Rebuild)	15.00%	$106
Crisis Management	15.00%	$172
Boiler & Machinery	15.00%	$3,455
Equipment Breakdown	15.00%	$3,455
Crime & Bonds		
Faithful Performance	15.00%	$77
Depositors' Forgery	15.00%	$77
Money & Securities	15.00%	$57
Money Orders/Counterfeit	15.00%	$57
Computer Fraud	15.00%	$22
General Liability	15.00%	$15,709
General Liability with SA discount	15.00%	$15,709
Automobile Liability	15.00%	$10,949
Automobile Physical Damage	15.00%	$2,530
Workers' Compensation	6.00%	$41,296
Supplemental Indemnity	10.00%	$3,886
Errors & Omissions	15.00%	$41,454

TOKIO MARINE HCC

Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436 USA
Tel: 818-382-2030

July 2, 2021

CONFIRMATION OF COVERAGE

Christen Petraitis
Arthur J Gallagher
250 Park Avenue
New York, New York 10177

Re:	Policyholder	Monroe Township BOE
	Policy Number:	H21NGP209197-00
	Effective Date:	July 1, 2021

Thank you for your bind request. This letter confirms coverage for Monroe Township BOE.

Subject to our receipt of the following no later than July 9, 2021:

- No subjectivities required.

Subject to receipt, review and acceptance of the outstanding items, we will issue the captioned policy as follows:

Insured:	Monroe Township BOE
Coverage:	NetGuard® Plus Cyber Liability Insurance
Carrier:	Houston Casualty Company rated A++ (Superior) by A.M. Best Company
Policy Period:	July 1, 2021 to July 1, 2022
Premium:	$51,247
Policy Issuance Fee	$100; non-refundable
Retroactive Date:	Full Prior Acts.
Knowledge Date:	July 1, 2021
Policy Form:	NGP (4.2020)
Producer Commission:	17.5%

Educational Risk and Insurance Consortium - North
Monroe Township Board of Education (Middlesex)
Quote Number R354AM-01 July 1, 2021 to July 1, 2022

Special Conditions: Premiums are based upon the purchase of Property, General Liability, Automobile Liability, Auto Physical Damage and Workers' Compensation. Any deviation in the purchase of the referenced lines of insurance will result in a premium recalculation.

Proposal Terms and Conditions: This proposal is for the purpose of highlighting certain aspects of coverage. Nothing contained herein is to be construed as replacing the actual policy language. This quote is valid up to the effective date. Coverage cannot be bound without a dated authorized signature (below). Coverage cannot be bound verbally. Coverage is bound only when acknowledged with a binder letter, issued by NJSIG.

Payment Terms: All premiums are payable in full with the exception of Workers' Compensation, which may be paid in twelve equal installments. All premiums are payable on or before the invoice due date.

*Please note, Replacement Cost applies to buses that are not older than ten years at inception and seat over 17 passengers.

Business Administrator signature x _____

Authorized Signature

Agency Name: Arthur J. Gallagher Risk Mgt. Serv. Inc.
Authorized Signature: _____ 6/30/2021 7:22pm
Print Full Name: George Morville

Workers' Compensation Payment Plan (Must be completed)
Annual _____ Semi-Annual XX
Monthly _____ Quarterly _____

Member District's Tax ID Number (New business only) _____

Please do not invoice your client from quote proposal(s). Invoicing to member districts should be derived from an official invoice from NJSIG. These standard operating procedures will assist in managing any unforeseen binding order anomalies, changes or billing cycle requirements.

TOKIO MARINE HCC

Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436 USA
Tel: 818-382-2030

COVERAGES AND LIMITS OF LIABILITY

"Nil" or "N/A" indicates that the Coverage is not included and that portion of the Policy will not apply.

A. Limits Per Insuring Agreement:

Third Party Liability Insuring Agreements
(Claims Made and Reported Coverage)

	Each **Claim**	Aggregate
Multimedia Liability Coverage	$2,000,000	$2,000,000
Security and Privacy Liability Coverage	$2,000,000	$2,000,000
Privacy Regulatory Defense and Penalties Coverage	$2,000,000	$2,000,000
PCI DSS Liability Coverage	$2,000,000	$2,000,000
Bodily Injury Liability Coverage	$250,000	$250,000
Property Damage Liability Coverage	$50,000	$50,000
TCPA Defense Coverage	$50,000	$50,000

First Party Insuring Agreements
(Event Discovered and Reported Coverage)

	Each **Claim**	Aggregate
Breach Event Costs Coverage	$2,000,000	$2,000,000
Post Breach Remediation Costs Coverage	$25,000	$25,000
BrandGuard® Coverage	$2,000,000	$2,000,000
System Failure Coverage	$2,000,000	$2,000,000
Dependent System Failure Coverage	$1,000,000	$1,000,000
Cyber Extortion Coverage	$2,000,000	$2,000,000
Cyber Crime Coverage		
A. Financial Fraud Sublimit	$250,000	$250,000
B. Telecommunications and Utilities Fraud Sublimit	$250,000	$250,000
C. Phishing Fraud Sublimits		
1. Your Phishing Fraud Loss Sublimit	$250,000	$250,000
2. Client Phishing Fraud Loss Sublimit	$50,000	$50,000
3. Phishing Fraud Aggregate Sublimit (C.1. & C.2. combined)		$250,000
Cyber Crime Aggregate Limit (A., B., & C. combined)		$250,000
Bricking Loss Coverage	$2,000,000	$2,000,000
Property Damage Loss Coverage	$50,000	$50,000
Reward Expenses Coverage	$50,000	$50,000
Court Attendance Costs Coverage	$25,000	$25,000

B. Maximum Policy Aggregate Limit: $2,000,000

C. Additional Defense Costs Limit: NIL
(Not applicable to Bodily Injury Liability, Property Damage Liability or TCPA Defense Coverage)

D. Breach Event Costs Outside the Limit Enhancement: INCLUDED

DEDUCTIBLES, WAITING PERIODS, PERIODS OF INDEMNITY AND PERIOD OF RESTORATION

A. Each Insuring Agreement:

TOKIO MARINE HCC

Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436 USA
Tel: 818-382-2030

Multimedia Liability Coverage Deductible	$25,000 each **Claim**
Security and Privacy Liability Coverage Deductible	$25,000 each **Claim**
Privacy Regulatory Defense and Penalties Coverage Deductible	$25,000 each **Claim**
PCI DSS Liability Coverage Deductible	$25,000 each **Claim**
Bodily Injury Liability Coverage Deductible	$25,000 each **Claim**
Property Damage Liability Coverage Deductible	$25,000 each **Claim**
TCPA Defense Coverage Deductible	$25,000 each **Claim**
Breach Event Costs Coverage Deductible	$25,000 each **Claim**
Post Breach Remediation Costs Coverage Deductible	$25,000 each **Claim**
BrandGuard® Coverage	
Waiting Period:	2 weeks
Period of Indemnity:	6 months
System Failure Coverage	
A. Data Recovery Deductible	$25,000 each **Claim**
B. Non-Physical Business Interruption	
Waiting Period:	8 hours
Period of Restoration:	6 months
Dependent System Failure Coverage	
A. Data Recovery Deductible	$25,000 each **Claim**
B. Non-Physical Business Interruption	
Waiting Period:	12 hours
Period of Indemnity:	4 months
Cyber Extortion Coverage Deductible	$25,000 each **Claim**
Cyber Crime Coverage Deductible	$25,000 each **Claim**
Bricking Loss Coverage Deductible	$25,000 each **Claim**
Property Damage Loss Coverage Deductible	$25,000 each **Claim**
Reward Expenses Coverage Deductible	$25,000 each **Claim**
Court Attendance Costs Coverage Deductible	None

B. Aggregate Deductible: None

TOKIO MARINE HCC

Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436 USA
Tel: 818-382-2030

ENDORSEMENTS:

NGP1078-52020	Nuclear Incident Exclusion
NGP1076-42020	Policyholder Disclosure Notice of Terrorism Insurance Coverage
NGP1075-42020	Service of Suit

Payment is due per the accompanying invoice. Please call if you have any questions.

Sincerely,
Nicholas Calnon
Senior Underwriting Assistant - Cyber
E-mail: ncalnon@tmhcc.com

Selective Insurance Company of America
40 Wantage Avenue
Branchville, New Jersey 07890
973-948-3000

CONTINUATION CERTIFICATE

The Selective Insurance Company of America (hereinafter called the Company) hereby continues in force its Bond/Policy No. B 1151373

in the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00),

on behalf of Michael Charles Gorski

18 Pine Knoll Dr. Lawrenceville, NJ 08648

in favor of Monroe Twp Board of Education

for the (extended) term beginning on the 1st, day of July, 2021,

and ending on the 1st day of July, 2022 subject to all the covenants and conditions of said Bond/Policy.

This continuation is executed upon the express condition that the Company's liability under said bond/Policy and this and all continuations thereof shall not be cumulative and shall in no event exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00)

IN WITNESS WHEREOF, the Company has caused this instrument to be signed by its officers proper for the purpose and its corporate seal to be hereto affixed this 5th day of April, 2021.

SELECTIVE INSURANCE COMPANY OF AMERICA

By _____
Attorney-in-Fact
Timothy A. Marchio

SELECTIVE INSURANCE COMPANY OF AMERICA
CORPORATE SEAL 1926 NEW JERSEY

B-69 (10/90)

Selective Insurance Company of America
40 Wantage Avenue
Branchville, New Jersey 07890
973-948-3000

CONTINUATION CERTIFICATE

The Selective Insurance Company of America (hereinafter called the Company) hereby continues in force its Bond/Policy No. B 1152938

in the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00),

on behalf of Laura Anne Allen

31 Pine Knoll Drive Larenceville, NJ 08648

in favor of Monroe Township Board of Education

for the (extended) term beginning on the 23rd, day of August, 2021.

and ending on the 23rd day of August, 2022 subject to all the covenants and conditions of said Bond/Policy.

This continuation is executed upon the express condition that the Company's liability under said bond/Policy and this and all continuations thereof shall not be cumulative and shall in no event exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00)

IN WITNESS WHEREOF, the Company has caused this instrument to be signed by its officers proper for the purpose and its corporate seal to be hereto affixed this 25th day of May, 2021.

SELECTIVE INSURANCE COMPANY OF AMERICA

By Timothy A. Marchio

Attorney-in-Fact
Timothy A. Marchio

SELECTIVE INSURANCE COMPANY OF AMERICA
CORPORATE SEAL 1926 NEW JERSEY

TRAVELERS

Travelers Casualty and Surety Company of America
Hartford, CT 06183

CONTINUATION CERTIFICATE
FIDELITY OR SURETY BONDS/POLICIES

License No. N/A

In consideration of **$1,819.00** dollars renewal premium, the term of Bond/Policy No. **106713881** in the amount of **$750,000.00**, issued on behalf of **Dyana Barnosky**, whose address is **1 Madison Ave.,SPOTSWOOD, NJ 08884**, in favor of **Monroe Township Board of Education**, whose address is **423 Buckelew Ave.**, in connection with **Public Official Bond** is hereby extended to **December 1, 2022**, subject to all covenants and conditions of said bond/policy.

This certificate is designed to extend only the term of the bond/policy. It does not increase the amount which may be payable thereunder. The aggregate liability of the Company under the said bond/policy together with this certificate shall be exactly the same as, and no greater than it would have been, if the said bond/policy had originally been written to expire on the date to which it is now being extended.

Signed, sealed and dated **October 28, 2021**

Travelers Casualty and Surety Company of America

By: T S

Terrence H Simmons Attorney-in-Fact

F-58-M (06-08)

This notice provides no coverage, nor does it change any policy terms. To determine the scope of coverage and the insured's rights and duties under the policy, read the entire policy carefully. For more information about the content of this notice, the insured should contact their agent or broker. If there is any conflict between the policy and this notice, the terms of the policy prevail.

Independent Agent And Broker Compensation Notice

For information on how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html.

Or write or call:

Travelers, Agency Compensation
P.O. Box 2950
Hartford, Connecticut 06104-2950

(866) 904.8348

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SELECTIVE
BE UNIQUELY INSURED℠

Selective Insurance Company of America
Branchville, NJ 07890

BondNo.B 1152938

SURETY BOND TRANSACTION REPORT

PRINCIPAL

Laura Anne Allen

31 Pine Knoll Drive Lawrenceville, NJ 08648

OBLIGEE

Monroe Township Board of Education

BOND

EFF DATE: **08/23/2021** BILLED EFF DATE: STATE: NJ

EXP DATE: **08/23/2022** TYPE: **Account Supervisor**

RENEWAL METHOD:

RATING SUMMARY

KIND OF BOND	CLASS	BOND AMT	PREMIUM	COMM %
Accounts/Control Manager	**102**	**$750,000.00**	**$2,100.00**	**25.00%**

TOTAL PREM: **$2,100.00** TOTAL COMM:

REMARKS

AGENT

NAME AND ADDRESS **ARTHUR J GALLAGHER RISK MGMNT SERVICES**
200 JEFFERSON PARK WHIPPANY, NJ 07981-1054

NUMBER: **000150200000**

RENEWAL COMMENTS

B-869 (4/92)

AMENDATORY RIDER

Dearborn National® Life Insurance Company

ATTACHED TO AND MADE A PART OF POLICY NUMBER: F008091-0001

Policyholder: MONROE BOARD OF EDUCATION

Effective Date of Change: MARCH 1, 2013

The above Group Policies are amended to read as follows:

The Annual Enrollment period will be June 1 through June 30 each year.

All other conditions and provisions remain unchanged.

DEARBORN NATIONAL® LIFE INSURANCE COMPANY

Michael J. Morrow

President

3-37-881
03.06.2013

FORT DEARBORN LIFE
Insurance Company®

Administrative Office:
1020 31st Street
Downers Grove IL 60515-5591

(A stock life insurance company, herein called the "We" "Us" or "Our")

Policyholder:	**MONROE BOARD OF EDUCATION**
Policy Number:	**F008091-0001**
Policy Effective Date:	**March 1, 2012**
Anniversary Date:	**August 1**

We agree with the *Policyholder* to insure certain eligible Members of the Policyholder. We promise to pay benefits for loss covered by the Policy in accordance with its provisions. The *Policyholder* should read this Policy carefully and contact Fort Dearborn Life Insurance Company® promptly with any questions.

Policyholder means the *Employer* to whom the Policy is issued and who sponsored the coverage for its Members.

Employer means the *Policyholder* and includes any division, subsidiary, or affiliated company named in the Policy.

This policy is delivered in the State of New Jersey and is subject to the laws of that jurisdiction.

POLICY EFFECTIVE DATE AND TERM

The Policy takes effect on the Policy Effective Date stated above subject to any participation requirement stated in the Policy. All insurance periods will be computed from that date. The Policy remains in force for the period for which premium has been paid. It may be renewed for further successive periods by payment of premium as stated in the Policy.

All periods of insurance begin and end at 12:01 A.M., Standard Time, at the *Policyholder*'s address as stated in the Policy, and on the Application.

Signed for Fort Dearborn Life Insurance Company

Secretary

President

Voluntary Group Term Life Insurance Policy
with
Accidental Death & Dismemberment and Dependent Life Insurance with Dependent Accidental Death and Dismemberment Benefits
Non-Participating

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Premium	
Premium Rate Guarantee	
Policy Termination	
Additional Provisions	
Rate Addendum	
Application	*Attached*

ATTACHMENTS:

- Master Application
- Certificate of Insurance

PREMIUM

How is the initial premium calculated?
Initial life, AD&D and Dependent Life insurance premium is calculated in accordance with the rates set forth on the attached Rate Addendum.

When is premium paid?
The Policy is issued in consideration of the payment to the *Policyholder* or the *Policyholder's* designated representative in advance of premium on the premium due date indicated on the *Application*. Payment shall be remitted by the *Policyholder* on or before the due date as shown on the *Application* or before the end of the grace period.
If an addition, termination or change in insurance takes place other than on a regular due date, any premium adjustment will take effect on the next due date.

Is premium payable while an Insured receives benefits?
We will waive premium for an insured Member in accordance with the Waiver of Premium provision of the Policy.

Is there a grace period for premium payment?
We will allow a grace period of 31 days for the payment of any premiums due except the first. Insurance coverage shall continue in force during the grace period unless the *Policyholder* has given Us advance written notice of cancellation in accordance with the terms of this Policy.
The *Policyholder* is liable for premium due on coverage provided during the grace period.
If *We* receive written notice during the grace period that the Policy is to be canceled, *We* will cancel it as of the later of:

1. the date requested in the cancellation notice; or
2. the date *We* receive such notice. The *Policyholder* must pay a pro rata premium for any coverage provided during the grace period.

PREMIUM RATE GUARANTEE

What is the initial premium rate guarantee?
A change in premium rates will not take effect before August 1, 2012. However, *We* may change premium rates if the risk assumed changes. Premium rates may change if the following occurs:

1. a change in the Policy design;
2. a change in the terms of the Policy;
3. addition or deletion of a division, subsidiary or affiliated company;
4. a change in the number of *Insureds* by 10% or more from the number of *Insureds* on the initial Effective Date;
5. a change in the laws or regulations or other government action which applies to the Policy;
6. for reasons other than 1-5 above such as but not limited to a change in factors bearing on the risk assumed.

The *Policyholder* must furnish notice and documentation satisfactory to *Us* within 31 days of the occurrence of any event which would cause a change in rates as described above. If the *Policyholder* fails to provide such timely notice, we will apply new rates retroactively to the date of the event.

We will notify the *Policyholder* in writing at least 31 days in advance of any premium rate changes. A change may take effect on an earlier date if both the *Policyholder* and *We* agree.

POLICY TERMINATION

Who may cancel the Policy or a plan under the Policy?
The Policy or a plan under the Policy can be canceled by the *Policyholder* with 31 days written notice delivered to *Us*. This Policy will terminate for any of the following reasons:

1. If the *Policyholder* fails to pay any premium within the 31-day Grace Period, this Policy will terminate in accordance with the terms set forth in the Grace Period provision.
2. We may terminate this Policy on any premium due date if:
   a. coverage is *Contributory* and less than 25% of the eligible Members participate; or
   b. the *Policyholder* fails to perform any of its obligations that relate to the Policy; or
   c. the *Policyholder* does not promptly provide Us with information that is reasonably required; or

If *We* cancel the Policy, for reasons other than the *Policyholder's* failure to pay premium, a written notice will be delivered to the *Policyholder* at least 31 days prior to the cancellation date.

Termination of the Policy under any conditions will not prejudice a covered loss which began while the coverage was in force.

ADDITIONAL PROVISIONS

Changes to this Policy
No changes in this Policy shall be valid unless approved by one of *Our* officers and evidence by endorsement on the Policy, or by amendment to the Policy signed by the *Policyholder* and *Us*.

What happens if an inadvertent error occurs?
Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent an Member from receiving coverage, if he is entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for an Member when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about an Member that is incorrect, *We* will:

1. Use the facts to decide whether the Member has coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Will certificates be issued?
We will deliver certificates of insurance to the *Policyholder* for issuance to each insured Member. The certificates will describe the benefits, to whom they are payable, the Policy limitations and where the Policy may be inspected.

What is considered to be the entire policy?

This entire Policy consists of:

1. all Policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the *Policyholder*'s signed Application which is attached to the Policy when issued; and
4. the *Employee's* signed enrollment forms.

RATE ADDENDUM

(All Rates Per $1,000 Per Month unless otherwise stated)

Class 01 Voluntary Child Life:

$5,000 benefit	$1.00 per family unit
$10,000 benefit	$2.00 per family unit

Class 01 Voluntary Accidental Death and Dismemberment:

Individual Plan:	$0.05
Family Plan:	$0.08

Class 01 Voluntary Term Life:

Age Range	**Rate**
Under 30	$0.08
30 to 34	$0.08
35 to 39	$0.12
40 to 44	$0.20
45 to 49	$0.29
50 to 54	$0.48
55 to 59	$0.83
60 to 64	$1.30
65 to 69	$2.05
70 to 74	$3.27
75 to and above	$5.79

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

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

DISCLAIMER

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

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

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

The New Jersey Life and Health Insurance Guaranty Association

One Gateway Center 9th Floor

Newark, NJ 07102

State of New Jersey

Department of Banking and Insurance

20 West State Street

CN-325

Trenton, NJ 08625

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

COVERAGE

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

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

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

EXCLUSIONS FROM COVERAGE

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

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

The Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

AMENDATORY RIDER

Dearborn National® Life Insurance Company

ATTACHED TO AND MADE A PART OF POLICY NUMBER: F008091-0001

Policyholder: MONROE BOARD OF EDUCATION

Effective Date of Change: MARCH 1, 2013

The above Group Policies are amended to read as follows:

The Annual Enrollment period will be June 1 through June 30 each year.

All other conditions and provisions remain unchanged.

DEARBORN NATIONAL® LIFE INSURANCE COMPANY

Michael J. Morrow

President

3-37-881
03.06.2013

FORT DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company)
Administrative Office:
1020 31st Street, Downers Grove, IL 60515-5591

POLICYHOLDER NAME: **MONROE BOARD OF EDUCATION**

GROUP POLICY NUMBER: F008091-0001

EFFECTIVE DATE: August 1, 2005

SUBJECT TO THE TERMS AND CONDITIONS *contained in this Policy,* **FORT DEARBORN LIFE INSURANCE COMPANY,** *on approval at its Home Office of the Application of the Policyholder, and on payment of premiums when due, agree to pay the benefits provided by this Policy.*

THIS POLICY, *the written Application made by the Policyholder (a copy of which is attached), the individual applications, if any, and any Amendatory Riders form the entire contract between the parties.*

THE FORT DEARBORN LIFE INSURANCE COMPANY *has by its President and Secretary signed and by its Registrar countersigned this Policy.*

President

Secretary

GROUP LONG TERM DISABILITY INCOME INSURANCE POLICY

POLICY INDEX

Section I..... Application

Section II..... Definitions

Section III.....Eligibility and Effective Dates

Section IV..... Benefits

Section V..... Termination Provisions

Section VI.....General Policy Provisions

Section VII..... Premiums

FORT DEARBORN LIFE INSURANCE COMPANY

Administrative Office:
1020 31st Street, Downers Grove, IL. 60515-5591
1-800-348-4512

APPLICATION FOR GROUP LONG TERM DISABILITY INSURANCE

1. A. Legal Name of Policyholder
MONROE BOARD OF EDUCATION

B. Policy Number
F008091-0001

2. Address of Policyholder
423 BUCKELEW AVENUE, MONROE TOWNSHIP, NJ 08831

3. Name of Subsidiaries, Divisions or Affiliates To Be Covered
None

4. A. Effective Date 12:01 A.M.: **August 1, 2005**
B. Policy Anniversary: **August 1, 2007**
C. Will Employees Contribute Towards Cost? [ ] Yes [**X**] No

5. Eligible Classes (Describe Below) (The insurer reserves the right to review and terminate all classes insured under this policy if any class ceases to be covered).

1-01 **All active full-time Administrative employees.**

Working a Minimum of **30** Regularly Scheduled Hours Per Week.

6. Eligibility Waiting Period (Should an employee enter another eligible class he will not be eligible for any additional benefits until he has completed a 30-day waiting period and has been actively at work one full day in the new class).

A. PRESENT EMPLOYEES **None**
B. NEW EMPLOYEES **First of the Insurance month following 30 days.**

7. Number of Employees
A. ELIGIBLE **48** Maximum Covered Payroll Per Employee: **$8,333** Per Month
B. ENROLLED **48**

8. Amount of Insurance

60% (Benefit Percentage) of Basic Monthly Earnings not to exceed a Maximum Monthly Benefit of **$5,000**.

Less Other Income Benefits Stated In The Policy Including

[ ] PRIMARY SOCIAL SECURITY
[**X**] PRIMARY AND FAMILY SOCIAL SECURITY
[ ] PRIMARY AND FAMILY SOCIAL SECURITY WITH 70% ALL SOURCES
[ ] BACKDOOR INTEGRATION

The Minimum Monthly Benefit is **$100**.

9. Elimination Period **60** Days

10. Pre-existing Condition Exclusion

[ ]6/12/24***[ ]12/6/24** [**X**]3/6/12 [ ]12/12* [ ]5 DAY [ ]3/12
[ ]3/6/24****

****Only available in Oregon
***Only available in Texas
** Not available in Maryland, Montana, Oregon, Pennsylvania, South Carolina, Wisconsin, or Washington.
* Not available in Oregon, Pennsylvania or South Carolina.

11. Maximum Benefit Period

[ ]Reducing Benefit Duration

Age at Disability	Benefit Duration
Less than Age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

[ ] 65/5/70

Age at Disability	Benefit Duration
Less than Age 60	To age 65
60 - 64	5 Years
65 - 69	To age 70 (but not less than 1 Year)
70 and Over	1 Year

[ ] To Age 70

Age at Disability	Benefit Duration
Less than Age 69	To age 70
69 and older	1 Year

[ ] 2 Years /To Age 70

Age at Disability	Benefit Duration
Less than Age 68	2 Years
68 - 69	To age 70 (but not less than 1 Year)
70 and Over	1 Year

[ ] 5 Years/To Age 70

Age at Disability	Benefit Duration
Less than Age 65	5 Years
65-69	To age 70 (but not less than 1 Year)
70 and over	1 Year

[X] Social Security Benefit Duration

Age at Disability	Benefit Duration
Less than Age 60	To Normal Social Security Retirement Age (NSSRA)*
Age 60	60 months or to NSSRA*, whichever is greater
Age 61	48 months or to NSSRA*, whichever is greater
Age 62	42 months or to NSSRA*, whichever is greater
Age 63	36 months or to NSSRA*, whichever is greater
Age 64	30 months or to NSSRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*Age at which the Insured is entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

None of the above options extend the Maximum Benefit Period beyond the age selected except for a minimum one year benefit.

12. Optional Policy Features

A.	[**X**]	YES	[ ]	NO	FULL MATERNITY
B.	[ ]	YES	[**X**]	NO	MINIMUM INDEMNITY PROVISION
C.	[**X**]	YES	[ ]	NO	3 MONTH SURVIVOR BENEFIT
D.	[**X**]	YES	[ ]	NO	MENTAL ILLNESS LIMITATION
E.	[**X**]	YES	[ ]	NO	DRUG/ALCOHOL LIMITATION
F.	[ ]	YES	[**X**]	NO	YEAR FAMILY INCOME BENEFIT
G.	[**X**]	YES	[ ]	NO	2 YEAR RATE GUARANTEE
H.	[ ]	YES	[**X**]	NO	LIFETIME ACCIDENT BENEFIT
I.	[ ]	YES	[**X**]	NO	EXTENSIVE OWN OCCUPATION BENEFIT
J.	[**X**]	YES	[ ]	NO	60 MONTH OWN OCCUPATION BENEFIT
K.	[ ]	YES	[**X**]	NO	36 MONTH OWN OCCUPATION BENEFIT
L.	[ ]	YES	[**X**]	NO	24 MONTH OWN OCCUPATION BENEFIT
M.	[ ]	YES	[**X**]	NO	12 MONTH OWN OCCUPATION BENEFT
N.	[ ]	YES	[**X**]	NO	PARTIAL DISABILITY
O.	[ ]	YES	[**X**]	NO	EDGE
P.	[ ]	YES	[**X**]	NO	EDGE I INDEXATION
Q.	[**X**]	YES	[ ]	NO	PROGRESSIVE PARTIAL DISABILITY BENEFIT
R.	COLA				
	[ ]	YES	[**X**]	NO	5 ADJUSTMENTS Option I
	[ ]	YES	[**X**]	NO	(END MAXIMUM BENEFIT PERIOD) Option II
S.	[ ]	YES	[**X**]	NO	CONVERSION PRIVILEGE

REMARKS

13. Is This A Replacement of Similar Coverage? [**X**] Yes [ ] No
Prior Insurance Credit Included? [**X**] Yes [ ] No
(If yes, a copy of prior carrier's plan is required for PIC administration)

14. Previous Company: Fortis Termination Date Of Prior Plan: 7/31/2005

15. A. Premium is due monthly, unless otherwise agreed upon.
B. Deposit of n/a to apply on the first premium.

16. Monthly Premium: **0.46%** of total covered payroll

It is understood and agreed that this application shall be made Section I. of the Policy applied for and that no insurance shall be effective until approved by Fort Dearborn Life's Home Office. If the Policyholder is a Trust, the undersigned Applicant (Participating Employer) applies for membership in the Trust, including group insurance provided by the Policy issued to the Trust.

Licensed Resident Agent (if required) Signature and Title

Agent or Broker For: Applicant

Dated At Date Signature of Witness

SECTION II - DEFINITIONS

For the purpose of this policy:

ACTIVE EMPLOYMENT means the employee must be working:

1. for the employer on a permanent full-time basis and paid regular earnings;
2. at least the minimum number of hours shown in the application; and either:
   a. at the employer's usual place of business; or
   b. at a location to which the employer's business requires the employee to travel.

ANNUAL SALARY means the insured's earnings in effect from the employer for the twelve month period immediately prior to the date disability begins. Annual Salary includes all earnings before any reductions. It does not include bonuses, overtime pay, and extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date disability begins.

APPLICATION is the document showing the eligible classes, the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the policyholder. This document, designated Section I, is attached to and is part of this policy.

BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means the insured's monthly rate of earnings from the employer in effect immediately prior to the date disability begins. It does not include bonuses, overtime pay, and extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date disability begins.

CERTIFICATE means a written statement prepared by the Company including all amendments, riders, and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

COMPANY means Fort Dearborn Life Insurance Company.

DISABILITY BENEFIT, when used with the term retirement plan, means money which:

1. is payable under a retirement plan due to disability as defined in that plan; and

2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit in this policy).

ELIGIBILITY DATE means the date an employee becomes eligible for insurance under this policy. Classes are shown in the application.

ELIMINATION PERIOD means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the application and begins on the first day of disability.

Note: If the insured returns to work for any 7 or less days during the elimination period and cannot continue, we will count only those days the insured is disabled to satisfy the elimination period.

EMPLOYEE means a person in full-time active permanent employment with the employer.

EMPLOYER means the policyholder and includes any division, subsidiary or affiliated company in the application.

EVIDENCE OF INSURABILITY means a statement or proof of an employee's medical history upon which acceptance for insurance will be determined by the Company.

GRACE PERIOD is the 31 day period which begins on the day following the due date of any premium due other than the first premium. During this period the premium due must be paid in order to prevent this policy from ending.

GROSS MONTHLY BENEFIT means the insured employee's monthly benefit before any reduction for other income benefit and earnings.

HOME OFFICE means Fort Dearborn Life Insurance Company, 300 E. Randolph St., Chicago, Illinois 60601-5099.

INDEXED PRE-DISABILITY EARNINGS means the insured's basic monthly earnings in effect just prior to the date disability began adjusted on the first anniversary of benefit payments and each anniversary thereafter.

SICKNESS means illness or disease, pregnancy or complications of pregnancy. The sickness must begin while the employee is insured under this policy.

INJURY means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur and disability must begin while the employee is insured under this policy.

EXCEPTION: Any disability which begins more than 60 days after an injury will be considered a sickness for the purpose of determining benefits under this policy.

INSURED means an employee insured under this policy.

MALE PRONOUN whenever used includes the female.

MONTHLY BENEFIT means the amount payable by the Company to the disabled insured.

OWN OCCUPATION See Total Disability or Totally Disabled definition.

PHYSICIAN means to be a person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. is legally qualified as a medical practitioner operating within the scope of his license; and
3. is not an employee or his spouse, daughter, son, father, mother, sister, or brother.

PREDISABILITY EARNINGS - See Basic Monthly Earnings definition.

RETIREMENT BENEFIT, when used with the term retirement plan, means money which:

1. is payable under a retirement plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by an employee (payments which represent employee contributions are deemed to be received over the employee's expected remaining life regardless of when such payments are actually received); and
3. is payable upon:
   a. early or normal retirement; or
   b. disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

RETIREMENT PLAN means a plan which provides retirement benefits to employees and which is not funded wholly by Employee contributions. The term shall not include: a 401(k), profit-sharing plan, informal salary continuation plan, thrift plan, individual retirement account (IRA), tax sheltered annuity (TSA), stock ownership plan, or a non-qualified plan of deferred compensation.

EMPLOYER'S RETIREMENT PLAN is deemed to include any retirement plan:

1. which is part of any federal, state, county, municipal or association retirement system; or

2. for which the Employee is eligible as a result of employment with the Employer.

TOTAL COVERED PAYROLL is the total amount of basic monthly earnings for which all Employees are insured under this policy.

WAITING PERIOD as shown in the Application means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date. Credit will be given for any portion of the Waiting Period satisfied prior to an approved family or medical leave of absence.

All full-time active employees are eligible for the 60 month own occupation benefit.

TOTAL DISABILITY or **TOTALLY DISABLED** means that during the elimination period and the next 60 months of disability the insured is:

1. unable to perform all of the material and substantial duties of his occupation on a full-time basis because of a disability:

   a. caused by injury or sickness;
   b. that started while insured under this coverage; and

2. after 60 months of benefits have been paid, the insured is unable to perform with reasonable continuity all of the material and substantial duties of his own or any other occupation for which he is or becomes reasonably fitted by training, education, experience, age and physical and mental capacity.

SECTION II - DEFINITIONS
(Continued)

With respect to insureds employed as pilots, co-pilots and crew of aircraft:

"Total disability" or "totally disabled" means because of injury or sickness the insured cannot perform the material duties of any gainful occupation for which he is or becomes reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute total disability.

SECTION III

ELIGIBILITY AND EFFECTIVE DATES

A. ELIGIBLE CLASSES

The classes eligible for insurance are shown in the application.

B. ELIGIBILITY DATE

An employee in an eligible class will qualify for insurance on the later of:

1. the policy effective date; or
2. the day after the employee completes the waiting period.

SECTION III

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

C. EFFECTIVE DATES OF INSURANCE

1. Insurance will be effective at 12:01 a.m. on the day determined as follows, but only if the employee's written application for insurance is:

   a. made with the Company through his employer; and
   b. on a form satisfactory to the Company.

2. An employee will be insured for noncontributory insurance on his eligibility date.

3. An employee will be insured for contributory insurance on the latest of these dates:

   a. the employee's eligibility date, if he makes written application for insurance on or before the 31st day after his eligibility date.

   b. the date the Company gives its approval, if the employee:

      i. makes written application for insurance more than 31 days after his eligibility date; or
      ii. terminated his insurance while continuing to be eligible.

   In the case of i. and ii. above, the employee must submit an application and evidence of insurability to the Company for approval. This will be at the employee's expense.

4. Delayed Effective Date for Insurance - The effective date of any initial, increased or additional insurance will be delayed for an employee if he is not in active employment because of a disability. The initial, increased or additional insurance will start on the date that the employee returns to active employment.

5. If an insured employee enters another eligible class, he will not be eligible for any additional benefits until he has completed a 30-day waiting period, and has been actively at work one full day in the new class.

SECTION IV - BENEFITS

PROOF OF DISABILITY

When the Company receives proof that an insured is disabled due to sickness or injury and requires the regular attendance of a physician, the Company will pay the insured a monthly benefit after the end of the elimination period. The benefit will be paid for the period of disability if the insured gives to the Company proof of continued:

1. disability; and
2. regular attendance of a physician.

The proof must be given upon request and at the insured's expense.

The monthly benefit will not:

1. exceed the insured's amount of insurance; or
2. be paid for longer than the maximum benefit period.

The amount of insurance and the maximum benefit period are shown in the application.

The monthly benefit will never be less than the minimum monthly benefit shown in the application, or more than the total disability benefit payable under this policy.

MONTHLY BENEFIT

To figure the amount of monthly benefit:

1. Take the amount of monthly benefit elected.

2. Take the lesser of:

   a. the amount figured in step (1) above; or
   b. the maximum monthly benefit shown in the application; and then

3. Deduct other income benefits, shown on the next page from this amount.

This is the total disability benefit which the insured may receive.

The monthly benefit will never be less than the minimum monthly benefit shown in the application.

OTHER INCOME BENEFITS

Other income benefits mean those benefits shown below:

1. The amount for which the insured is eligible under:

   a. Workers' or workmen's Compensation Law;
   b. Occupational disease law; or
   c. Any other act or law of like intent.

2. The amount of any disability income benefits for which the insured is eligible under any compulsory benefit act or law.

3. The amount of any disability income benefits for which the insured is eligible under:

   a. any other group insurance plan of the employer;
   b. any governmental retirement system as a result of his job with the employer.

4. The amount of benefits the insured receives under the employer's retirement plan as follows:

   a. any disability benefits;
   b. any retirement benefits.

5. The amount of disability or retirement benefits under the United States Social Security Act, the Canada Pension Plan, or the Quebec Pension Plan, or any similar plan or act, as follows:

   a. disability or unreduced retirement benefits for which:

      i. the insured is eligible; and
      ii. his spouse, child or children are eligible because of his disability; or
      iii. his spouse, child or children are eligible because of his eligibility for unreduced retirement benefits; or

   b. reduced retirement benefits received by:

      i. the insured; and
      ii. his spouse, child or children because of his receipt of reduced retirement benefits.

6. The amount of earnings the insured earns or receives from any form of employment.

7. The amount of earnings the insured receives from any sick leave or formal salary continuation plan paid by the employer.

These other income benefits except retirement benefits, must be payable as a result of the same disability for which we pay a benefit.

COST OF LIVING FREEZE

After the first deduction for each of the other income benefits, the monthly benefit will not be further reduced due to any cost of living increases payable under these other income benefits. This provision does not apply to increases received from any form of employment.

LUMP SUM PAYMENTS

Other income benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the expected lifetime of the insured. In each case, the amount to be prorated will be calculated by an actuary based on a morbidity table, with interest, or a mortality table, with interest, depending on the source of the lump sum.

TERMINATION OF DISABILITY BENEFITS

The monthly benefit will cease on the earliest of:

1. the date the insured is no longer disabled; or
2. the date the insured dies; or
3. the end of the maximum benefit period; or
4. the date the insured's current earnings exceed 85% of his pre-disability earnings.

NOTE: Because the insured's current earnings may fluctuate, the insurance company may average earnings over (3) consecutive months rather than immediately terminating his/her benefit once 85% of pre-disability income has been reached.

BENEFIT PERIOD EXTENSION

The maximum benefit period is shown in the Application. However, benefits will be extended beyond the end of the maximum benefit period if a totally disabled employee attains the age specified in the benefit duration and has not received twelve monthly benefit payments. In this event, the benefit period will be extended during the continuance of total disability until twelve monthly payments have been paid.

RECURRENT DISABILITY

"Recurrent Disability" means a disability which is related or due to the same cause(s) as a prior disability for which a monthly benefit was payable.

A recurrent disability will be treated as part of the prior disability if, after receiving disability benefits under this policy, an insured:

1. returns to his regular occupation on a full-time basis for less than six months; and

2. performs all material duties of his occupation.

To qualify for a recurrent disability benefit, the insured must experience more than a 20% loss of predisability earnings.

Benefit payments will be subject to the terms of this policy for the prior disability.

If an insured returns to his regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability. The insured must complete another elimination period.

If an insured becomes eligible for coverage under any other group long term disability policy, this recurrent disability section will cease to apply to that insured.

THREE MONTH SURVIVOR BENEFIT

The Company will pay a lump sum benefit to the eligible survivor when proof is received that an insured died:

1. after the disability had continued for 180 or more consecutive days; and
2. while receiving a monthly benefit.

The lump sum benefit will be an amount equal to three times the insured's last monthly benefit.

"Eligible survivor" means the insured's spouse, if living, otherwise the insured's children under age 23.

If the payment becomes due to the insured's children, payment will be made to:

1. the children; or
2. a person named by the Company to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

"Last monthly benefit" means the monthly benefit paid to the insured immediately prior to his death but not including any reduction for earnings.

MENTAL ILLNESS AND/OR SUBSTANCE ABUSE LIMITATION

Benefits for disability due to mental illness and substance abuse will not exceed 24 months of monthly benefit payments unless the insured meets one of these situations.

1. The insured is in a hospital or institution at the end of the 24 month period. The monthly benefit will be paid during the confinement.

   If the insured is still disabled when he is discharged the monthly benefit will be paid for a recovery period of up to 90 days.

   If the insured becomes reconfined during the recovery period for at least 14 days in a row, benefits will be paid for the confinement and another recovery period up to 90 more days.

2. The insured continues to be disabled and becomes confined:

   a. after the 24 month period; and

   b. for at least 14 days in a row.

   The monthly benefit will be payable during confinement.

   The monthly benefit will not be payable beyond the maximum benefit period.

HOSPITAL or INSTITUTION means a facility licensed to provide care and treatment for the condition causing the insured's disability.

MENTAL ILLNESS means psychiatric, nervous or emotional diseases or disorders of any type.

SUBSTANCE ABUSE means a pattern of pathological use of alcohol or other psychoactive drugs resulting in: impairment of social and/or occupational functioning; debilitating physical condition; inability to abstain from or reduce consumption of the substance; or the need for daily substance use for adequate functioning.

PROGRESSIVE PARTIAL DISABILITY BENEFIT

The Company will pay a Progressive Partial Disability Benefit for a disability which is caused by an injury or sickness once an insured has met his Elimination Period. The Elimination Period can be a combination of total and partial disability, or all total or all partial disability. The insured does not have to be totally disabled prior to receiving a Progressive Partial Disability Benefit.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means as a result of the sickness or injury which caused total disability, the insured is:

1. able to perform one or more, but not all of the material and substantial duties of his own or any other occupation on a full-time or part-time basis; or

2. able to perform all of the material and substantial duties of his own or any other occupation on a part-time basis.

To qualify for a Progressive Partial Disability benefit the insured must be earning less than 80% of his pre-disability earnings at the time partial disability employment begins.

PROGRESSIVE PARTIAL DISABILITY MONTHLY BENEFIT

During the first 12 months, the monthly benefit will be figured as shown:

1. Multiply the insured's pre-disability earnings by the benefit percentage shown in the application.

2. Take the lesser of:
   a. the amount determined in step (1) above; or
   b. 100% of the insured's pre-disability earnings less other income benefits; or
   c. the maximum monthly benefit shown in the application.

The Progressive Partial Disability Benefit will never be less than the minimum monthly benefit shown in the application.

After 12 months, the following formula will be used to figure the monthly benefit:

1. Multiply the insured's pre-disability earnings by the benefit percentage shown in the application.

2. Take the lesser of:
   a. the amount determined in step (1) above; or
   b. the maximum monthly benefit shown in the application.

This is the gross monthly payment.

3. Subtract from the gross monthly payment:
   a. 100% of any other income amounts except any income earned or received by the insured from any form of employment; and
   b. 50 % of any income earned or received by the insured from any form of employment obtained after the date of disability or from a return to work in his former occupation.

Loss of earnings must be as a result of or due to the same sickness or injury for which the insured is disabled.

GENERAL EXCLUSIONS

This policy will not cover disability due to:

1. war, declared or undeclared or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot;
4. the insured individual's committing of or the attempting to commit a felony.

PRE-EXISTING CONDITION EXCLUSION

This policy will not cover any disability:

1. which is caused or contributed to by, or results from a pre-existing condition; and

2. which begins in the first 12 months after the insured's effective date, unless he received no treatment of the condition for 6 consecutive months after his effective date.

"Treatment" means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

"Pre-existing Condition" means a sickness or injury for which the insured received treatment within 3 months prior to the insured's effective date.

The Pre-existing Condition does not apply if:

1. prior to becoming a member of this group the insured was enrolled as a member under another group policy written by the same insurer; and

2. benefits had been paid under the previous group policy for this same condition for which application for benefits is now made.

CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

In order to prevent loss of coverage for an employee because of a transfer of insurance carriers, this policy will provide coverage for certain employees as follows:

Failure to be in Active Employment Due to Injury or Sickness

This policy will cover, subject to premium payments, employees:

1. insured with the prior carrier at the time of transfer; and
2. who are not in active employment due to a injury or sickness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Disability due to a Pre-existing Condition

Benefits may be payable for a total disability due to a pre-existing condition for an employee who:

1. was insured by the prior carrier at the time of transfer; and
2. was in active employment and insured under this policy on its effective date.

The benefits will be determined as follows:

1. The Company will apply this policy's pre-existing condition exclusion. If the employee qualifies for benefits, he will be paid according to this policy's benefit schedule.
2. If the employee cannot satisfy this policy's pre-existing condition exclusion, the prior carrier's pre-existing condition exclusion will be applied.
    a. If the employee satisfies the prior carrier's pre-existing condition exclusion, giving consideration towards continuous time insured under both policies, he will be paid according to the prior carrier's benefit schedule.
    b. If he cannot satisfy the pre-existing condition exclusion of this policy or that of the prior carrier, no benefit will be paid.

SECTION V
TERMINATION PROVISIONS

A. TERMINATION OF EMPLOYEE'S INSURANCE

An Employee will cease to be insured at 12:00 midnight on the earliest of the following dates:

1. the date this policy terminates;
2. the date the Employee is no longer in an eligible class;
3. the date the Employee's class is no longer included for insurance;
4. the last day for which any required Employee contribution has been made;
5. the date employment terminates. Cessation of active employment will be deemed termination of employment, except:

    a. the insurance will be continued for the Employee absent due to total disability during:

        i. the Elimination Period; and
        ii. the period during which premium is being waived.

    b. the Employer may choose to continue the Employee's insurance by paying the required premiums, subject to the following:

        i. insurance may be continued for Employees during an approved family or medical leave of absence, but not beyond the end of the approved leave of absence period;

        ii. insurance may be continued for Employees who are temporarily laid off or given any other leave of absence, but not beyond the end of the month following the month the lay-off or leave of absence begins;

        iii. the Employer must act so as not to discriminate unfairly among Employees in similar situations.

6. the date the Employee ceases active work due to labor dispute, including any strike, work slowdown or lockout.

The insurer reserves the right to review and terminate all classes insured under this policy if any class(es) ceases to be covered.

B. TERMINATION OF POLICY

1. Termination of this policy under any conditions will not prejudice any claim which occurs while this policy is in force.

2. If the policyholder fails to pay any premium within the grace period, this policy will terminate at 12:00 midnight of the last day of the grace period. The policyholder may terminate this policy by advance written notice delivered to the Company at least 31 days prior to the termination date. But, this policy will not terminate during any period for which premium has been paid. The policyholder will be liable to the Company for all premiums due and unpaid for the full period for which this policy is in force.

3. The Company may terminate this policy on any premium due date by giving written notice to the policyholder at least 31 days in advance if:

   a. the number of employees insured is less than 10; or

   b. less than 100% of the employees eligible for any noncontributory insurance are insured for it; or

   c. less than 75% of the employees eligible for any contributory insurance are insured for it; or

   d. the policyholder fails:

      i. to furnish promptly any information which the Company may reasonably require; or

      ii. to perform any other obligations pertaining to this policy.

4. Termination may take effect on an earlier date when both the policyholder and the Company agree.

SECTION VI

GENERAL POLICY PROVISIONS

A. STATEMENTS

All statements made in any application are considered representations and not warranties (absolute guaranteed). No representation by:

1. the policyholder in applying for this policy will make it void unless the representation is contained in the application; or

2. any employee in applying for insurance under this policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the employee, is or has been given to the employee.

B. COMPLETE CONTRACT - POLICY CHANGES

1. This policy is the complete contract. It consists of:

   a. all of the pages;

   b. the attached application of the policyholder;

   c. each employee's application for insurance (employee retains his own copy).

2. This policy may be changed in whole or in part. Only an officer or registrar of the Company can approve a change. The approval must be in writing, endorsed by both the Policyholder and the Company, and attached to this policy.

3. Any other person, including an agent, may not change this policy or waive any part of it.

C. EMPLOYEE'S CERTIFICATE

The Company will provide a certificate to the policyholder for delivery to each insured. If the terms of a certificate and this policy differ, this policy will govern.

SECTION VI

GENERAL POLICY PROVISIONS
(Continued)

D. FURNISHING OF INFORMATION - ACCESS TO RECORDS

1. The employer will furnish at regular intervals to the Company:

   a. information relative to employees:

      i. who qualify to become insured;

      ii. whose amounts of insurance change; and/or

      iii. whose insurance terminates.

   b. any other information about this policy that may be reasonably required.

   The employer's records which, in the opinion of the Company, have a bearing on the insurance will be opened for inspection at any reasonable time.

2. Clerical error or omission will not:

   a. deprive an employee of insurance;

   b. effect an employee's amount of insurance; or

   c. effect or continue an employee's insurance which otherwise would not be in force.

E. MISSTATEMENT OF FACTS

If relevant facts about any employee were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid under this policy.

F. NOTICE AND PROOF OF CLAIM

1. Notice

   a. Written notice of claim must be given to the Company within 30 days of the date disability starts, if that is possible. If that is not possible, the Company must be notified as soon as it is reasonably possible to do so.

b. When the Company has written notice of claim, the Company will send the insured its claim forms. If the forms are not received within 15 days after written notice of claim is sent, the insured can send the Company written proof of claim without waiting for the form.

2. Proof

a. Proof of claim must be given to the Company. This must be done no later than 90 days after the end of the elimination period.

b. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.

c. Proof of continued disability and regular attendance of a physician must be given to the Company within 30 days of the request for the proof.

d. The proof must cover:

i. the date disability started;

ii. the cause of the disability; and

iii. the degree of the disability.

G. EXAMINATION

The Company, at its own expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of a claim, examined by a physician of its choice. This right may be used as often as reasonably required.

H. LEGAL PROCEEDINGS

A claimant or the claimant's authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor

2. more than 3 years after the time proof of claim is required.

I. TIME OF PAYMENT OF CLAIMS

When the Company receives proof of claim, benefits payable under this policy will be paid monthly during any period for which the Company is liable. Any balance remaining unpaid at the termination of the period of liability will be paid immediately on a pro-rata basis.

J. PAYMENT OF CLAIMS

All benefits are payable to the employee. But if a benefit is payable to an employee's estate, an employee who is a minor, or an employee who is not competent, the Company has the right to pay up to $1,000 to any of the employee's relatives whom the Company considers entitled. If the Company pays benefits in good faith to a relative, the Company will not have to pay such claims again.

K. RIGHT OF RECOVERY

If LTD benefits have been overpaid on any claim, it will be required that reimbursement be made to Fort Dearborn Life Insurance Company within 60 days, or Fort Dearborn Life Insurance Company has the right to reduce future benefits until such reimbursement is received. Fort Dearborn Life Insurance Company also has the right to recover such overpayments from the insured's estate.

L. WORKERS' or WORKMEN'S COMPENSATION

This policy does not relieve the policyholder of any requirements to provide workers' or workmen's compensation insurance.

M. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

N. CONFORMITY WITH LOCAL STATUTES

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which this Policy was delivered is hereby amended to conform to the minimum requirements of such statute.

O. INCONTESTABILITY

The validity of the policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the policy after such insurance has been in force for two years during such person's lifetime and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

O. INCONTESTABILITY

The validity of this policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of this policy shall not be contested on the basis of a statement made relating to insurability by any person covered under this policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

P. DISCRETIONARY AUTHORITY

In making any determination regarding the benefits under this policy, the Insurance Company shall have the discretionary authority to determine an individual's eligibility for benefits and to interpret the terms of this policy.

SECTION VII - PREMIUMS

A. PREMIUM RATES

The initial premium is determined on the basis of the rates shown in the application.

The Company may establish new rates for all future premiums as well as the one then due:

1. when the terms of this policy are changed;

2. when a division, subsidiary, or affiliated company is added to this policy; or

3. when the number of Insured Persons changes by 25% or more from the number insured on the Policy Effective Date; or

4. for reasons other than 1., 2., or 3. above, such as but not limited to change in factors bearing on the risk assumed. But, the rates may not be changed within the first 24 months following the policy effective date.

No premium may be increased unless the Company notifies the employer at least 31 days in advance. Premium increases may take effect on an earlier date when both the Company and the employer agree.

B. PAYMENT OF PREMIUMS

1. Premium payment calculations will be based on the coverage provided under this policy. Both are determined by the definition of basic monthly earnings.

2. All premiums due under this policy, including adjustments, if any, are payable by the employer on or before their due dates at the Company's home office. The due dates are specified in the application.

3. Premiums payable to the Company will be paid in United States dollars.

4. If premiums are payable on a monthly basis, premiums for additional or increased insurance becoming effective during a policy month will be charged from the next premium due date.

5. The premium charge for insurance terminated during a policy month will cease at the end of the policy month in which such insurance terminates. This manner of charging premium is for accounting purposes only. It will not extend insurance coverage beyond a date it would have otherwise terminated as shown in the "Termination of Employee's Insurance" section of this policy.

6. If the premiums are payable on other than a monthly basis, premiums for additional, increased, reduced or terminated insurance will cause a pro-rata adjustment on the next premium due date.

7. Premium adjustments, refunds or charges will be made only for:

   a. the current policy year; and

   b. the prior policy year.

C. WAIVER OF PREMIUM

Premium payments for an employee who is totally or partially disabled are waived during any period for which benefits are payable. If coverage is to be continued, premium payments may be resumed following a period during which they were waived.

AMENDATORY RIDER

ATTACHED TO AND PART OF POLICY NUMBER: F008091-0001

Policyholder: MONROE BOARD OF EDUCATION

Effective Date of Change: Effective Date of the Policy

The above Policy is amended as follows:

If an Employee is on a family or medical leave of absence, We will continue coverage, in accordance with the Policyholder's Human Resource policy on family and medical leaves of absence, as if the Employee were in active employment, if the following conditions are met:

1. premiums are paid; and
2. the Employee has written, approved leave from the Employer.

Coverage will be continued for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments; or
2. the leave period required by applicable state law.

For the purpose of claims determination should an Employee become disabled while on an approved Family and Medical Leave of Absence, Basic Monthly Earnings will be based on the Employee's earnings just prior to the date the leave of absence began.

If coverage is not continued during a family or medical leave of absence, upon the Employee's return to active employment:

1. no new waiting period will apply, including new waiting periods for coverage of pre-existing conditions; and
2. no evidence of insurability will be required to reinstate the coverage in effect before the leave began.

All other conditions and provisions remain unchanged.

FORT DEARBORN LIFE INSURANCE COMPANY

President

FORT DEARBORN LIFE INSURANCE COMPANY

AMENDMENT (NJ)

This Amendment is made a part of the Policy to which it is attached. It is subject to all the provisions of the Policy which are not in conflict with the provisions of this Amendment.

SECTION II – DEFINITIONS: The following new or replacement definitions are added to Section II:

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

1. are normally required for the performance of the insured's Own Occupation; and
2. cannot be reasonably omitted or modified, except that if the insured is required to work on an average in excess of 40 hours per week, the Company will consider the insured able to perform that requirement if the insured is working or has the capacity to work 40 hours per week.

REGULAR ATTENDANCE OF A PHYSICIAN means the insured is attended by a Physician who is not the insured or related to him:

1. with medical training and clinical experience suitable to treat the insured's disabling condition; and
2. whose treatment is:
   a. consistent with the diagnosis of the disabling condition; and
   b. according to guidelines established by medical, research and rehabilitative organizations; and
   c. administered as often as needed, to achieve the maximum medical improvement.

OWN OCCUPATION means the occupation the insured is routinely performing when the insured's disability begins. We will look at the insured's occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific Employer or at a specific location.

The TOTAL DISABILITY definition is amended to include the following statement: To qualify for a Total Disability benefit, the insured, as a result of his Total Disability, must be earning less than 20% of his Basic Monthly Earnings.

SECTION IV – BENEFITS:

Item (1) of the **"Other Income Benefits"** provision is deleted in its entirety and is replaced with the following:

1. The amount for which the insured is eligible under:
   a. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits;
   b. permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits;

The following *Note* is added to Item (5) of the "Other Income Benefits" provision:

Note. The insured will be required to apply for Social Security disability benefits when the duration of his Disability meets the minimum duration required to apply for such benefits. If the Social Security Administration denies eligibility for benefits, he will be required:

a. to follow the process established by the Social Security Administration to reconsider the denial; and
b. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals; and the Company agrees to pay the costs.

If the insured does not follow the *application for Social Security disability benefits* steps outlined above, the Company will estimate the amount for which the insured would be eligible when calculating his monthly benefit.

The following Rehabilitation provision is added to Section IV:

Rehabilitation is a process of the Company's claims examiner and rehabilitation counselor working together with the insured to plan, adapt, and put into use, options and services to meet the insured's return to work needs.

A Rehabilitation program includes but is not limited to, when we consider it to be appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
   a. support groups;
   b. physical therapy;
   c. occupational therapy;
   d. speech therapy;
4. work-place modification to the extent not otherwise provided; and/or
5. job placement.

The insured may elect to participate in a Rehabilitation program if requested and a qualified physician agrees that the rehabilitation program is appropriate to the insured's medical limitations.

The "Termination of Disability Benefits" provision is deleted in its entirety and replaced with the following **Termination of Disability Benefits** provision.

We will terminate benefit payment on the first to occur of:

1. the date the insured is no longer Disabled.
2. the date the insured fails to furnish Proof of Loss, when requested by the Company;
3. the date the insured is no longer under the Regular Attendance of a Physician, or refuses our request to submit to an examination by a Physician;
4. the date the insured dies;
5. the date the insured's monthly earnings while disabled exceed 80% of his Pre-disability Earnings.
6. the date determined by the Maximum Benefit Period shown on the Application; or
7. the date no further benefits are payable under any provision in this policy that limits benefit duration.

The following *Note* concerning earnings received while disabled is added to Section IV immediately following the "Termination of Disability Benefits" provision:

Note: Monthly earnings received while disabled means the monthly earnings the insured received from:

1. the Employer while Disabled; and
2. other employment.

   However, if the other employment is a job the insured held in addition to full-time Active Employment with the Employer, then:

   a. during the Elimination Period, and while eligible to receive benefits for being Disabled from his Own Occupation;
   b. any earnings from this other employment will be monthly earnings received while disabled only to the extent that they exceed the average monthly earnings received from this other job during the 6 month period immediately prior to becoming Disabled.

SECTION VI - GENERAL INFORMATION

Section (2), Proof, of Item (F), **Notice and Proof of Claim** is deleted in its entirety and replaced by the following:

2. Proof
   a. The insured must give us proof of claim no later than 90 days after the end of the Elimination Period.
   b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible.
   c. The insured must give us proof of continued disability and Regular Attendance of a Physician within 30 days of the date we request the proof.
   d. All proof submitted must be satisfactory to us. Proof of Loss includes but is not limited to the following:
      i. documentation of:
         (a) the date the insured's Disability began;
         (b) the cause of the Disability;
         (c) the prognosis of the Disability;
         (d) the insured's Earnings or income, including but not limited to copies of his filed and signed federal and state tax returns; and
         (e) evidence that the insured is under the Regular Attendance of a Physician;
      ii. any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations, and treatment notes;
      iii. the names and addresses of all:
         (a) Physicians and practitioners of healing arts that have been seen or consulted; and
         (b) hospitals or other medical facilities in which seen or treated; and
         (c) pharmacies which have filled prescriptions within the past three years; and
      iv. the insured's signed authorization for us to obtain and release:
         (a) medical, employment and financial information; and
         (b) any other information we may reasonably require;
      v. the insured's signed statement identifying all Other Income Benefits;
      vi. proof that the insured and his dependents have applied for all Other Income Benefits which are available. He will not be required to claim any retirement benefits which may only be received on a reduced basis.

The following paragraph is added to Item (G), Examination:

We have the right, at our expense, to have the insured examined or evaluated by:
1. a physician or other health care professional of our choice; or
2. a vocational expert or rehabilitation specialist of our choice.

Nothing contained in this Amendment shall be held to alter or affect any provision or condition of the Policy other than as stated above.

President

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

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

DISCLAIMER

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

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

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

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center 7th Floor
Newark, NJ 07102

State of New Jersey
20 West State Street
CN-325
Trenton, NJ 08625

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

COVERAGE

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

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long term care insurance contract, annuity contract, or if they are insured by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

-they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

-the insurer was not authorized to do business in this state;

-the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

-any policy guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

-any policy of reinsurance (unless an assumption certificate was issued);

-interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;

-dividends;

-credits given in connection with the administration of the policy by a group contractholder;

-employers plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

*ERISA

To the extent these provisions conflict with any provision of the Policy, these provisions take precedence over the Policy. The Employer has established this Benefit Plan (the "Plan") as an Employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"). The Plan consists of an insurance policy(ies), including the Master Application and any Amendments (collectively, the "Policy").

ALLOCATION OF AUTHORITY

Plan Administrator

The Employer shall be the Plan Administrator and Named Fiduciary of the Plan. As such, the Employer has full discretionary and final authority and control over the Plan. This authority includes all of the power and authority contemplated by ERISA with respect to the Plan, including but not limited to the authority to:

1. Appoint or employ those parties necessary to administer the Plan;
2. Prescribe the rules and procedures under which the Plan shall operate;
3. Communicate with employees about their participation in the Plan;
4. Review and approve any financial or other reports prepared by any party appointed under paragraph (1);
5. Establish a funding policy consistent with the purposes of the Plan and ERISA; and
6. Amend, terminate or suspend the Plan in accordance with the procedure set forth herein.

The Plan Administrator appoints the Insurer to:

1. Resolve all matters when a review pursuant to the claims procedures has been requested;
2. Interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
3. Determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits under the Policy.

The Insurer shall not be a fiduciary for any other purpose. Nothing in the Plan shall affect the obligations of the Insurer with respect to the Policy. If any uncertainty shall arise between the information in the certificate or the Summary Plan Description ("SPD") and the Policy, or if any point is not covered in the certificate or SPD, the terms of the Policy will govern in all cases. Benefits will be paid under this Plan only if the Plan Administrator, or the Insurer if so delegated by the Plan Administrator, decides in its full discretion and final authority that the applicant is entitled to them.

AMENDMENT & TERMINATION

Without consent of the participants and their beneficiaries, the Employer may amend or terminate, in whole or in part, the Plan at any time. Any such amendment or termination shall be according to the Employer's authorized procedures. Any such authorization may be either specific to such Plan or persons authorized to act on behalf of the Employer or may be general as to the duties of such person. Any amendment or termination shall be in writing and attached to the Plan. Except for termination, any amendments affecting the Policy must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing, by the Employer and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

FUNDING

The Policy is a guaranteed benefit policy as defined in Sec.401(b)(2) of ERISA. The Policy is an asset of the Policyholder (or Employer Member). No assets of the Insurer are assets of or under the Plan. The Plan may be contributory or non-contributory as stated in the Policy.

CLAIMS REVIEW PROCEDURES: Disability Insurance Plans

When the Insured or the Insured's Beneficiary are eligible to receive benefits, the Insured or the Insured's Beneficiary or their authorized representative (collectively, the "claimant") must notify the Plan Administrator by submitting the proper form. This may be done by sending notice of the claim to the Plan Administrator who has been appointed to assist the Insurer in the claims processing for this Plan or by contacting the Insurer directly at:

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

The Insurer will give the claimant a written response to the claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurer notifies the claimant in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If the claim is extended due to the claimant's failure to submit information necessary to decide the claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to the claimant until the date the Insurer receives the claimant's response to the request. This period will be no longer than 45 days after the Insurer has requested the information. At that time the Insurer will decide the claimant's claim based on the information the Insurer has at that time.

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that have to be followed to have the claim reviewed;
- a statement concerning the right to bring a civil action under section 502(a) of ERISA after the appeal is filed and a written denial on appeal is given; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to the claimant upon request; and
- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided to the claimant free of charge upon request.

If the claim has been denied, in whole or in part, it may be appealed to the Insurer for a full and fair review. The claimant has at least 180 days to appeal from the claim denial.

The claimant may:

a) request a review upon written application within 180 days of the claim denial;
b) request, free of charge, copies of all documents, records and other information relevant to the claim; and
c) submit written comments, documents, records and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurer will make a decision no more than 45 days after receiving the appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurer notifies the claimant in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If the claim is extended due to the claimant's failure to submit information necessary to decide the claim on appeal, the time for the Insurer's decision shall be tolled from the date on which the notification of the extension is sent to the claimant until the date the Insurer receives the claimant's response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.



FORT DEARBORN LIFE INSURANCE COMPANY

1020 31st Street • Downers Grove, Illinois 60515-5591

VSP Vision Care for Life

VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
CLIENT VISION CARE POLICY

Client Name	**MONROE TOWNSHIP BOARD OF EDUCATION**
Policy Number	**30029388**
State of Delivery	**NEW JERSEY**
Effective Date	**JULY 1, 2018**
Premium Due Date	**FIRST DAY OF MONTH**
Policy Period	**FORTY-EIGHT (48) MONTHS**

In consideration of the statements and agreements contained in the Client Application, if applicable, and in consideration of payment by the Client of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Client Vision Care Policy ("Policy") for the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Policy.

COPY

Kate Renwick-Espinosa, President

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I.

TERM, RENEWAL AND TERMINATION

1.01. **Term**: This Policy shall commence on the Effective Date noted on the front page of this Policy, and shall remain in effect for the Policy Period, also noted on the front page of this Policy.

1.02. **Renewal**:

(a) VSP shall issue written renewal notice to Client at least sixty (60) days before the end of the Policy Period. If Client fails to accept the renewal terms and/or rates in writing prior to the end of the Policy Period, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Period.

(b) If Client wishes to renew the Policy but acceptance of the renewal cannot be formalized before the end of the Policy Period, or if the parties continue to negotiate renewal terms after the Policy Period, Client may submit a written request to have the Policy renew on a temporary month- to- month basis under the expired contract terms, not to exceed six months, until Client's acceptance of the renewal is formalized in writing and a new Policy is issued. Once renewal is accepted, VSP reserves the right to bill Client retroactively at the renewal premium for the temporary month-to-month renewal period. During the temporary month to month period, either party may terminate the Policy by providing thirty (30) days advance written notice to other party.

1.03. **Termination**:

(a) This Policy may be terminated by either the Client or VSP upon expiration of a Policy Period as set forth in paragraph 1.02.

(b) This Policy may also be terminated by VSP immediately upon written notice, if Client fails to:

(i) Pay premiums by the dates defined in paragraph 3.04.

(ii) Report a material change in accordance with paragraph 3.03.

(c) If Client terminates this Policy as of any date other than the end of the Policy Period, such termination will be treated by VSP as a breach by Client.

(d) If this Policy is terminated under paragraph 1.03(b) or (c), coverage is terminated and VSP is released from all obligations of this Policy, effective as of the termination date (except for preexisting obligations specifically set forth in Section 1.03 (e), below). Client will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Client would have paid for the remaining term of this Policy, not to exceed one year. A deficit

incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Client over the current term. Net premiums shall mean premiums paid by Client minus any applicable retention amounts and/or broker commissions. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

(e) If this Policy is terminated for any cause as stated in this section 1.03, VSP is not required to pay for services provided after such termination date, except for any outstanding, unexpired benefit that is authorized before termination, or any other claim obligations that arose prior to termination.

II.

OBLIGATIONS OF VSP

2.01. Coverage of Covered Person: VSP will enroll for coverage, as directed by Client, each eligible Enrollee and his/her Eligible Dependents (if dependent coverage is provided), all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Client to complete, sign and forward to VSP a Client Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums.

Following the enrollment of the Covered Persons, VSP will provide Client with an Evidence of Coverage for distribution to Covered Persons by Client. Such Evidence of Coverage and Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

2.02. Administration of Plan Benefits: Through VSP Preferred Providers (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from, an Open Access Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A(s)) and when purchased by Client, the Additional Benefit Rider (Schedule C(s)) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. VSP Preferred Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials. Notwithstanding any other provision, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits, and when purchased by Client, the Additional Benefit Rider.

When a Covered Person seeks Plan Benefits from a VSP Preferred Provider, the Covered Person must schedule an appointment and identify himself/herself as a VSP Covered Person.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days by providing notice to the claimant of the reasons for the extension.

2.03. Open Access Provider Services: When Covered Persons elect to utilize the services of an Open Access Provider, benefit payments for services from such Open Access Provider will be determined according to the Plan's Open Access Provider benefit fee schedule if Open Access Provider reimbursement is available. COVERED PERSONS MAY BE

LIABLE FOR MORE THAN THE COPAYMENT. The Open Access Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of VSP's Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Open Access Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Open Access Provider reimbursement schedule shown on the attached Schedule of Benefits (Exhibit A (s)) and Additional Benefit Rider (Schedule C(s)) (if purchased by Client), less any applicable Copayments.

2.04. Information to Covered Persons: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and instructions for use. A copy of this Policy shall be provided to Client and will be made available at the offices of VSP for any Covered Persons. Covered Persons may obtain information on VSP's Preferred Providers through VSP's website at www.vsp.com, VSP's Customer Care toll-free number (1-800-877-7195), or by written request. If Client supplies email addresses of Covered Persons to VSP, VSP may use the email addresses to communicate information to Covered Persons about their vision benefits.

2.05. Preservation of Confidentiality: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, VSP Preferred Providers, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is permitted or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law.

2.06. Urgent Vision Care: In the event a Covered Person seeks Emergency Care from an Open Access Provider, the Covered Person is liable only for the applicable in-network copayment and the in-network percentage of allowable expense for out-of-network services. When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider, if Open Access benefits are available. Services for conditions of a medical nature are covered by VSP only under supplemental eyecare plans. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider (Schedule C). If Client has not purchased one of these plans, Covered Persons are not covered by VSP for such services and should contact a physician under Covered Persons' medical insurance plan for care.

For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person should call VSP's Customer Care toll-free number (1-800-877-7195) for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

III.

OBLIGATIONS OF CLIENT

3.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified by the Client, and in accordance with applicable state and federal law. Client shall provide VSP with required eligibility information, in a mutually agreed upon timeframe, format and medium, to identify all Enrollees who are eligible for coverage under this Policy.

3.02. Retroactive Eligibility Terminations: Retroactive eligibility changes are limited to the month in which notification is received by VSP, plus two prior months. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

3.03. Change of Client Composition: Client's percentage of Enrollees covered under the Policy as well as Client's contribution and eligibility requirements are factors used to determine rates and are considered material to VSP's obligations under this Policy. During the term of this Policy and in accordance with section 1.03, Client must provide VSP with written notification of any changes that will significantly impact utilization of the benefits and such changes must be agreed upon by VSP. All new employees or new members, as the case may be, in the groups or classes eligible for vision insurance must be added to such eligible groups or classes pursuant to N.J.S. 17B:27-36. Nothing in this section shall limit Client's ability to add Enrollees or Eligible Dependents under the terms of this Policy.

3.04. Payment of Premiums: Upon receipt of VSP's billing statement, Client shall remit to VSP the premiums as set forth in Exhibit B. The premiums set forth in Exhibit B shall remain in effect for the term of this Policy unless the Client requests a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Client), or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by VSP. Client premium payments are due upon receipt of VSP's billing statement and shall become delinquent after thirty-one (31) days. If the premium payment remains unpaid the coverage may be cancelled and the Client will be responsible for payment for all Plan Benefits provided to Covered Persons. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy. All premiums due under the Policy shall be remitted by the employer or employers of the person insured by the policy holder, or by some other designated person acting on behalf of the association or group insured to VSP, on or before the due date thereof with a grace period of 31 days.

3.05. Distribution of Required Materials: Client shall provide to Enrollees any materials required by any regulatory authority, within the timeframe required under applicable law.

3.06. Communication Materials: Communication materials created by Client which relate to this Vision Care Policy may be submitted to VSP for review and approval. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Client's materials meet any applicable legal or regulatory requirements including, but not limited to, ERISA requirements. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

3.07. Converting to an Administrative Services Program In the event Client wishes to convert its method of funding from a fully insured Risk Program to a self insured Administrative Services Program, Client shall establish an appropriate level of reserves as determined by VSP, prior to conversion. Upon conversion to an Administrative Services Program, all claims for vision care begun on and after the effective date of conversion will be paid through the Administrative Services Program.

IV.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

4.01. General: This Policy provides coverage for Client's Enrollees. If Client offers dependent coverage, this Policy will also cover Enrollees' Eligible Dependents. This Policy may be amended or terminated by agreement between VSP and Client without the consent or concurrence of Covered Persons. This Policy with any and all Exhibits and/or attachments constitutes the entire obligation of VSP to Covered Persons.

4.02. Copayments for Services Received: Any Copayments required under this Policy shall be the personal responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed Plan allowances, annual maximum benefits or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

4.03. Obtaining Services from VSP Preferred Providers: To utilize Plan Benefits, Covered Persons must select a VSP Preferred Provider, schedule an appointment and inform the doctor's office that they are Covered Persons of VSP. The VSP Preferred Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from a VSP Preferred Provider without a Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Open Access Provider.

4.04. Open Access Provider Benefits: If required by state law, or if purchased by Client, this Policy provides Plan Benefits for services and materials received from Open Access Providers. Covered Persons or Open Access Providers may submit requests for reimbursement to VSP. VSP will pay available Plan Benefits to Covered Persons, or directly to Open Access Providers when claims include a valid Assignment of Benefits. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided.

4.05. Complaints and Grievances: Complaints and grievances may be submitted by Covered Persons to VSP in writing, by telephone, online or through Covered Persons' VSP Preferred Providers, as explained in the Evidence of Coverage for this Policy. VSP will resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, VSP will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the final resolution of all complaints and grievances.

4.06. Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal .

b) Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. VSP's communication to the Covered Person shall include the specific reasons for the determination.

c) **Other Remedies**: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

4.07. Time of Action: There shall be a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the policy.

V.
CONTINUATION OF COVERAGE

5.01. **COBRA**: If, and only to the extent, COBRA applies to the parties to this Policy, VSP shall make the required COBRA continuation coverage available to Covered Persons in accordance with the provisions of COBRA.

5.02. **Replacement Coverage**: VSP reserves the right to offer replacement VSP coverage to individuals whose previous VSP coverage has terminated or is subject to termination. Any such offer of replacement coverage shall be separate and distinct from, and not in lieu of, any COBRA-required offer of continuation coverage.

5.03. **Extension of Benefits**: In the event of total disability of a Covered Person which exists as of the date of termination, the Covered Person shall have ninety (90) days from the said date to obtain Plan Benefits subject only to the attached Schedule of Benefits.

VI.

DISPUTE RESOLUTION

6.01. Dispute Resolution: VSP and Client agree that all disputes arising out of or relating to this Policy shall be resolved, wherever possible, through mediation. When such negotiation is not successful, both parties agree to try in good faith to settle disputes by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures. All efforts shall be made by both parties to avoid arbitration, litigation, or other dispute resolution procedures.

6.02. Choice of Law: If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of this Policy shall be the applicable law.

VII.

NOTICES

7.01. Notices: Any notices required under this Policy to either Client or VSP shall be in written format. Notices sent to the Client will be sent to the address or email address shown on the Client's Application unless otherwise directed by Client. Notices to VSP shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

VIII.
STANDARD PROVISIONS

8.01. Entire Agreement: This Policy, the Client Application, the Evidence of Coverage, and all Exhibits and attachments hereto, constitute the entire agreement of the parties and supersede any prior understandings and agreements between them, either written or oral. All statements made in the Client Application shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense of a claim under the Policy unless it is contained in a written Client Application. Any change or amendment to this Policy must be mutually agreed upon by both VSP and Client. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Client for distribution to Enrollees do not constitute a part of this Policy.

8.02. Indemnity: VSP agrees to indemnify, defend and hold harmless Client, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Client agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Client, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

8.03. Liability: VSP arranges for the provision of vision care services and materials through agreements with VSP Preferred Providers. VSP Preferred Providers are independent contractors and are responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. Under no circumstances shall VSP or Client be liable to each other for the negligence, wrongful acts or omissions of any doctor, non-VSP owned laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

8.04. Assignment: Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto, except as expressly authorized herein.

8.05. Severability: Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

8.06. Governing Law: This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in conformance with, applicable federal or state statutes or

regulations is hereby amended to conform with the requirements of such statutes or regulation, now or hereafter existing.

8.07. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

8.08. **Equal Opportunity**: VSP is an Equal Opportunity and Affirmative Action employer.

IX.

DEFINITIONS

The key terms in this Policy are defined:

9.01. ADDITIONAL BENEFIT RIDER: The document, attached as Exhibit C to this Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under Exhibit A.

9.02. ADMINISTRATIVE SERVICES PROGRAM: A self-insured vision care plan whereby Client pays VSP for the Plan Benefits in addition to a monthly administrative fee.

9.03 ASSIGNMENT OF BENEFITS: A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

9.04. BENEFIT AUTHORIZATION: A process used to confirm eligibility of an individual named as a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

9.05. CLIENT (Policyholder): An employer which contracts with VSP to provide coverage under this Policy for its Enrollees and their Eligible Dependents.

9.06. CLIENT APPLICATION: The form signed by an authorized representative of the Client to apply for Enrollee coverage under this Policy.

9.07. COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985.

9.08. COMPLAINTS AND GRIEVANCES: Disagreements regarding access to care, quality of care, treatment or service.

9.09. CONFIDENTIAL MATTER: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons acquired by VSP in the course of providing Plan Benefits hereunder.

9.10. COORDINATION OF BENEFITS: A procedure which allows more than one insurance plan to consider a Covered Person's vision care claims for payment or reimbursement.

9.11. COPAYMENTS: Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

9.12. COVERED PERSON: An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under this Policy.

9.13. ELIGIBLE DEPENDENT: Any dependent and/or Civil Union Partner of an Enrollee who meets the criteria for eligibility established by Client.

9.14. ENROLLEE: An employee or member of Client who meets the criteria for eligibility established by Client.

9.15. EVIDENCE OF COVERAGE ("EOC"): A summary of the provisions of this Policy, prepared by VSP and provided to Client for distribution to Enrollees by Client.

9.16. OPEN ACCESS PROVIDER: Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

9.17. PLAN or PLAN BENEFITS: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.

9.18. POLICY PERIOD: The length of time this Policy is in effect, as shown on the front page of this Policy.

9.19. RENEWAL DATE: The date when this Policy shall renew or terminate if proper notice is given.

9.20. RETENTION: VSP's administrative fee deducted from net premiums paid by Client.

9.21. RISK PROGRAM: A fully insured vision care plan whereby VSP will calculate a rate per Enrollee to cover the cost of claims incurred and administrative costs. Under the arrangement, VSP assumes the risk of utilization exceeding the rate per Enrollee over the full Policy Term.

9.22. SCHEDULE OF BENEFITS: The document, attached as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

9.23. SCHEDULE OF PREMIUMS: The document, attached as Exhibit B to this Policy, which defines the payments a Client is obligated to pay to VSP on behalf of a Covered Person to entitle him/her to Plan Benefits.

9.24. STATE OF DELIVERY: The State in which this Policy is being issued, delivered or renewed.

9.25. TERMINATION: Cancellation of the Policy as stated in Article I.

9.26. URGENT CONDITION: A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

9.27. VISION CARE POLICY or POLICY: The Policy issued by VSP to a Client, under which the Client's Enrollees or members, and their Eligible Dependents, are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.

9.28. VSP PREFERRED PROVIDER: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons of VSP.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on July 1st and ending on June 30th.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Civil Union Partner*
- Domestic Partner**
- Any unmarried or unpartnered child or dependent of Enrollee, including natural child from date of birth, a child acquired through a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Unmarried or unpartnered dependent children are covered up to the end of the year in which they turn age 23.

A dependent unmarried or unpartnered child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

*Pursuant to N.J.S.A. 27:1-32
**Pursuant to N.J.S.A. 26:8A-4(b)

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to age 23.

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to $130.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Network Provider shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Network Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Exhibit B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
VSP Choice Plan

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$ 4.66 per month for each eligible Enrollee without dependents
$ 12.87 per month for each eligible Enrollee with eligible dependents

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

Exhibit C

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Policy, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Civil Union Partner*
- Domestic Partner**
- Any unmarried or unpartnered child or dependent of Enrollee, including natural child from date of birth, a child acquired through a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Unmarried or unpartnered dependent children are covered up to the end of the year in which they turn age 23.

A dependent unmarried or unpartnered child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

*Pursuant to N.J.S.A. 27:1-32
**Pursuant to N.J.S.A. 26:8A-4(b)

PROGRAM DESCRIPTION

The Diabetic Eyecare Program ("DEP") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- "floating" spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema
- age-related macular degeneration
- glaucoma

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Network Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDER

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, "straight ahead" central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

A Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to $ 100.00 after a $20.00 Copayment.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Non-Member Providers.
2. Services from a Non-Member Provider are in lieu of services from a Member Doctor.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Non-Member Providers to adhere to VSPs quality standards.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1- 800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-370-4526.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY: 711

To access language services at no cost to you, call 1- 800-370-4526.

Para acceder a los servicios de idiomas sin costo, llame al 1- 800-370-4526. (Spanish)

如欲使用免費語言服務，請致電 1- 800-370-4526。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1- 800-370-4526. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1- 800-370-4526. (Tagalog)

T'áá ni nízaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó koji' hóíne' 1- 800-370-4526. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1- 800-370-4526 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1- 800-370-4526. (Albanian)

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للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1- 800-370-4526. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1- 800-370-4526 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1- 800-370-4526 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1- 800-370-4526। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1- 800-370-4526. (Bisayan-Visayan)

သင့်အတွက်အခမဲ့ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1- 800-370-4526
ဆို့. ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1- 800-370-4526. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1- 800-370-4526. (Chamorro)

ᎦᏙᎧᏗ ᏚᎾᏂᏍᎧᏗ ᎤᏩᏫᏯᏁᏗ Ꮭ ᎠᎴᎧᏗ ᏗGEGWᏁᏗ ᎯᎩ, ᏫᏨᏍᏏᎳᏓᏏ 1- 800-370-4526. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1- 800-370-4526. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1- 800-370-4526. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1- 800-370-4526. (Dutch)

Pou jwenn sèvis lang gratis, rele 1- 800-370-4526. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας,

τηλεφωνήστε στον αριθμό 1- 800-370-4526. (Greek)

તમારે કોઇ જાતના ખર્ચ વગિ ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1- 800-370-4526. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1- 800-370-4526. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लएि बनिा कसिी कीमत के भाषा सेवाओं का उपयोग करने के लएि, 1- 800-370-4526 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1- 800-370-4526. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1- 800-370-4526. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1- 800-370-4526. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1- 800-370-4526. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1- 800-370-4526 (Italian)

言語サービスを無料でご利用いただくには、1- 800-370-4526 までお電話ください。(Japanese)

လာတ်ကမၤန့်ကျိဉ်အတ်မဟာအတ်ဝဲးတ်မာတမဉ်လာတအိဉ်ဒီးအပူၤလာကဘဉ်ဟုဉ်ဆီးအဂီၢ်ဘဉ်နုဉ် ကိး 1- 800-370-4526 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1- 800-370-4526 번으로 전화해 주십시오. (Korean)

M dyi wuḍu-dù kà kò ḍò bě dyi móuń nì Pídyi ní, nìí, ḍá nɔ̀bà nìà kɛ: 1- 800-370-4526. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1- 800-370-4526. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຽຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບ ີ 1- 800-370-4526. (Laotian)

कोणत्याही शुल्काशविाय भाषा सेवा प्राप्त करण्यासाठी, 1- 800-370-4526 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1- 800-370-4526. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1- 800-370-4526. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1- 800-370-4526។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1- 800-370-4526 मा टेलफिोन गर्नुहोस् I (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1- 800-370-4526. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1- 800-370-4526. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1- 800-370-4526. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1- 800-370-4526تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1- 800-370-4526 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1- 800-370-4526. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1- 800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1- 800-370-4526. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1- 800-370-4526. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1- 800-370-4526. (Samoan)

Za besplatne prevodilačke usluge pozovite 1- 800-370-4526. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1- 800-370-4526. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1- 800-370-4526. (Swahili)

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(Syriac-Assyrian) 1- 800-370-4526

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1- 800-370-4526 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1- 800-370-4526 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1- 800-370-4526. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1- 800-370-4526. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1- 800-370-4526 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1- 800-370-4526. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1- 800-370-4526 پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1- 800-370-4526. (Vietnamese)

צו צוטריט שפראך באדינונגען אין קיין פריַז צו איר, רופן 1- 800-370-4526. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1- 800-370-4526. (Yoruba)

Aetna Life Insurance Company

aetna™

New Jersey Life And Health Insurance Guaranty Association Act

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

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

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

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

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

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

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

State of New Jersey
Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

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

Proprietary

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

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

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

Exclusions from Coverage
However, persons owning such policies are not protected by this association if:

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

The Association also does not provide coverage for:

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

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

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

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

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

Proprietary

Aetna Life Insurance Company

Group health insurance policy

The group health insurance policy ("group policy") is by and between

Aetna Life Insurance Company
(**Aetna**, we, us, or our)
and
Monroe Township Board of Education
(**Policyholder**, you, or your)

Group policy number:	GP-152709
Date of issue:	July 30, 2020
Effective date:	July 1, 2020
Renewal date:	July 1

This group policy takes effect on the **effective date** if we have received your signed group application and the initial premium. It remains in force until terminated.

Term of the group policy:	The initial term shall be the 12 consecutive month period beginning on the **effective date**. Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.
Premium due dates:	The **effective date** and the first day of each succeeding calendar month.

Signed at **Aetna's** Home Office 151 Farmington Avenue Hartford, Connecticut 06156.

This policy is non-participating.

This policy is governed by applicable federal law and the laws of New Jersey.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Proprietary

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Proprietary

The group policy

The group policy consists of several documents taken together. These documents are:

- Your group application
- This group policy
- The booklet-certificate(s)
- The schedule of benefits
- Any riders and amendments to the group policy, the booklet-certificate, and the schedule of benefits as stated below

A booklet-certificate consists of a booklet-certificate and any schedule of benefits, amendment or rider form which may be issued to support or amend the booklet-certificate.

All policy attachments and booklet-certificate documents that are part of the complete policy are on file with the **policyholder** and us.

If you want to discuss your coverage

If you have questions about your coverage under the group policy, or if you wish to discuss it, contact your agent. If you did not use an agent to purchase your coverage, or if you have additional questions, you may contact us at:

Aetna
151 Farmington Avenue
Hartford, Connecticut 06156
1-800-872-3862

Please have your group policy number available when you contact us. It is on the front page of this group policy.

Proprietary

Glossary

You will see some words in bold type in the group policy. The bold type means we have defined those words. The definitions are in this section and in the *Glossary* section of the booklet-certificate.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the booklet-certificate.
- The person has enrolled for coverage and paid any required premium contribution.
- The person's coverage has not ended.

Dates:

Effective date

Date we first cover you under the group policy.

Final rates and fees schedule effective date

Date stated on the *Final rates and fees schedule*.

Premium due date

The **effective date** and the first day of each succeeding calendar month.

Renewal date

Date that is 12 months after the **effective date** and each 12 months after that.

Termination date

The date coverage ends according to the *Termination* section.

Policyholder

Monroe Township Board Of Education and entities associated with it for purpose of coverage under this group policy.

Premium

Premium – rates and amount due

The premium rates are stated in the final rates and fees schedule. We will provide you with a new final rates and fees schedule if and when the premium rates change. Any new schedule will state its effective date.

We charge premium based on the premium rates in effect on the **premium due date**.

The premium due on any **premium due date** is the sum of the premium charges for the coverage we provide. When we calculate premium due, we will use our records to determine who is a **covered person**.

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – changes in rates

We may change the premium rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We identify these factors in our rate quote to you.
- There is a change in federal and state laws or regulations, or there is a judicial decision, that materially affects the cost of providing coverage.

We may change the premium rates as of a **premium due date** during any subsequent term.

We will provide 60 days prior written notice to you of any change in premium rates.

Premium – experience credit

We may declare an experience credit at the end a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer
- By application of the amount to premium due in the current or succeeding plan year, or
- By any other manner that we and you agree to

We can require you to share an experience credit with your employees in a manner reasonably acceptable to us, as a condition of our giving the credit. If the sum of employee contributions for coverage exceeds the sum of premium paid less any experience credits, we will require you to apply at least the excess experience credit for the sole benefit of employees.

Premium – reduction due to performance guarantees

We may agree with you in writing to meet specific levels of service when we administer the group policy. We may also agree to reduce our premium if we failed to meet the guaranteed levels of service. The reduction is an agreed-upon percent of premium due during the period we fail to meet the performance guarantees. We will apply any credit at the end of the plan year, to either prior premium paid or to future premium due.

Proprietary

Premium – when due

Premium is due on the **premium due date**.

You have a payment grace period of 31 days immediately following the **premium due date**. The group policy will remain in force during the grace period. If we have not received all premiums due by the end of the grace period, this group policy will automatically terminate at the end of the grace period.

Premium – how billed and paid

We may bill you electronically. You shall pay premium due by electronic fund transfer. Payment occurs when the transfer is honored by a bank.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Premium – overdue amounts

You shall pay us interest on the total premium amount that is overdue. Overdue premium includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit to you premium payments if any of the following are true:

- We billed you based on eligibility information you provided us
- The eligibility information included a person who was not eligible for coverage
- You request that we retroactively drop the person from coverage, and
- The person did not pay the required premium contribution for the period.

Our credit of premium is limited to 2 month's credit for a person whose loss of eligibility occurred more than 60 days before the date you notified us. We may reduce the credits by the amount of any benefit payments we may have made on behalf of such persons before you notified us that the person was not eligible for coverage.

Your request that we retroactively drop coverage is your representation that the person did not pay the required premium contribution for the period.

We will retroactively cover eligible persons whom you did not include in the eligibility information you provided us. We will cover them retroactively no more than 60 days before the date you both notify us and pay all applicable past premium.

Premium – waiver

Payment of premiums

We may waive up to one month's billed premium payments during any group policy term.

The premium waiver will not apply for those employees if after that month's premium has been billed, employees are added or removed from the plan coverage. For that month of coverage, additional premium will be due or credited.

Repayment of the waived premium

We may require you to pay back the premium waived if the group policy is terminated within 12 months of your original **effective date**. We will give you 60 days prior written notice if you must repay the waived premium.

Proprietary

Fees for special services

Special services

You may request that we provide special services beyond the routine administration of this group policy. We will charge you a fee for each special service we provide.

The special services are:

- Our billing you for amounts due in a non-electronic medium.
- Our accepting payment of amounts due from you other than by electronic fund transfer. If you pay us by check, the check does not constitute payment until it is honored by a bank.
- Our handling your check returned to us due to insufficient funds. We may return the check to you without a second attempt to cash it.
- Reinstatement of the group policy according to the *Termination* section.
- Any other special service you request and we agree to provide.

Special services – fees

The special service fees are stated in the final rates and fees schedule. We may change any fee on 60 days advance notice to you. We will provide you with a new final rates and fees schedule if and when the amount of any fee changes. The new schedule will state its effective date.

Payment for third party technology provider

We will pay a third party technology provider you choose to provide services related to the administration for this group policy. The fee we pay them will be an agreed upon amount between us and you. If we stop payment to the third party technology provider, we will give you 30-60 days advance notice.

Fees – when due

Fees are due on the **premium due date** immediately following our invoicing you.

Fees – how billed and paid

We may bill you electronically. You shall pay fees by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees – overdue amounts

You shall pay us interest on the total amount of fees that is overdue. Overdue fees include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

Some of our other responsibilities

We will prepare the booklet-certificate and schedule of benefits that are part of the group policy, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form.

We will provide the coverage stated in the booklet-certificate and schedule of benefits that are part of the group policy. We will administer the coverage as required by the group policy and applicable federal and state laws.

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers'** claims and otherwise help us administer the group policy. For a copy of our Notice of Privacy Practices, call the toll-free Member Services number on your member ID card or log on to www.aetna.com.

Our duties in this section survive termination of the group policy.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – certain Patient Protection and Affordable Care Act (ACA) requirements

You shall distribute two documents required by the federal ACA:

- Summary of benefits and coverage (SBC)
- Notices of material modifications

You shall distribute them to your employees and their dependents, in accordance with the federal delivery, timing, and trigger requirements.

You shall certify to us on an annual basis and upon our request, that you have distributed them and will distribute them consistent with the ACA. You shall give us your certification within 30 calendar days of our request.

You shall give us information or proof upon our request, that you have distributed them and will distribute them consistent with the ACA. The information or proof must be in a form we will accept. You shall give us the information or proof within 30 calendar days of our request.

Your duties and our rights in this ACA provision survive termination of the group policy.

Distribution – booklet-certificate and schedule of benefits

You will distribute as required by applicable federal and state laws, the booklet-certificate and schedule of benefits that we provide you.

Information – access

You shall make payroll and other records directly related to a person's coverage under this group policy available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the group policy.

Information – eligibility

You shall send us eligibility information we request to administer the group policy. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means, as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us, you represent that it is correct. You acknowledge that we can and will rely on the information.

Proprietary

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the group policy have been resolved.
- Send us information you sent us before, upon request.

We will not start covering a person under the group policy until you send us the information to enroll that person. Subject to applicable federal and state laws and the group policy, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ceases, or
- A dependent loses eligibility under the group policy

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud, or
- Making an intentional misrepresentation of material fact

to get coverage or to get a benefit under the group policy.

Your duties and our rights in this Information – eligibility provision survive termination of the group policy.

90 day waiting period limitation

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the ACA. It applies both to you and to us.

You will give us **effective dates** for your employees and their dependents that take into account all state and federal waiting period requirements. You acknowledge that we will rely on this information. You will inform us immediately if this information changes.

We will use this effective date information to enroll eligible employees and their dependents into the group plan.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the booklet-certificate and applicable federal and state laws. Your notification will include:

- A description of plans available
- Premium rates
- Application forms

You will give the notification within 15 calendar days to a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the group policy.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the group policy. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The group policy and all coverage end as of the last day of the grace period if you have not paid us all premiums and fees due as of the beginning of the grace period. The grace period is described in the *Premium* section.

Termination by you

You may end coverage under this group policy if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the group policy. You can send us a termination notice during a period for which you have paid premium, but your **termination date** must be after that period.

Termination by us

We may end the group policy and all coverage it provides:

- Immediately upon notice to you:
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
  - If you are a member of an association and your membership in the association ceases

- Upon 90 days written notice to you:
  - If you breach a provision of the group policy and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you fail to meet our contribution or participation requirements applicable to this group policy
  - If you do not certify your compliance with our policies and procedures upon request
  - If you change your eligibility or participation requirements without our consent

- Upon 180 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we cease to offer the product line provided by this group policy.

- Upon 180 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we act as required by applicable federal and state laws for uniform termination of coverage.

We may rescind the group policy and all coverage it provides for fraud or intentional misrepresentation of material fact upon 30 days advance written notice. The notice will state the effective date of rescission.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the group policy. You must reply:

- Within two weeks of your receipt of the request
- Within 15 days prior to the **renewal date**

whichever is later.

Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will not continue coverage on and after the **renewal date** and:

- You owe us any unpaid premium
- We owe you a refund if you overpaid premium

Effective time of termination

The group policy and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You and we continue to be responsible following termination for the duties we each incur prior to the termination of the group policy. One of your duties includes payment of premium due for coverage through any grace period up to the day of termination. You and we also continue to be responsible for your and our duties that the group policy states are to occur following termination.

You and we have the rights and duties following termination of the group policy, as stated specifically in the group policy.

You shall notify **covered persons** of the termination of the group policy. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the group policy.

Reinstatement

You may request that we reinstate the group policy and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the group policy as of the **termination date** upon payment of all amounts due and you giving us reasonable assurances that you can and will fulfill all of your obligations under the group policy.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to receive the money back.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 30 days advance written notice of any rescission of coverage.
- The **covered person** has the right to an **Aetna** appeal as explained in the *When you disagree – claim determination procedures/complaints and appeals* section of the certificate.
- The **covered person** has the right to a third party review conducted by an independent utilization review organization.

Responsibility for conduct

Employees and agents

We are responsible to you for what our employees and other agents do.

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our **network** are what the law calls our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this group policy.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your negligence, breach of the group policy, breach of applicable federal and state laws, willful misconduct, criminal conduct, fraud, or your breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this group policy or your role as employer or Plan Sponsor, as defined by ERISA.

These indemnification obligations end with the group policy, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Indemnification – federal law requirements

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the group policy
- Breach of federal and state laws that apply or
- Willful misconduct

and your act or failure to act was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this *Responsibility for conduct* section survive termination of the group policy.

General provisions

General provisions – content and interpretation of the group policy

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the group policy. Federal and state laws means statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the group policy if possible so it complies with applicable federal and state laws.

If the group policy omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the group policy as though the right or duty is stated correctly in the group policy.

If any provision of the group policy is invalid or illegal, you and we shall implement the group policy as though the provision is not in the group policy.

Changes to the group policy

The group policy may be amended by a written form to which you and we both consent.

We may change or end some or all coverage under this group policy by written notice, if we act as required by applicable federal and state laws for uniform modification of coverage and uniform termination of coverage.

We may amend the group policy by written notice. We must give you 60 days advance written notice. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage or
- Will not increase benefits or coverage with a concurrent increase in premium during the current group policy term, other than increased benefits or coverage required by law.

Written consent or payment of the applicable premium on the effective date of any amendment is your consent to any amendment requiring your consent.

Changes to the group policy do not require the consent of any employee or of any other person. All agreements made by us are signed by an authorized executive officer of **Aetna**. Only an authorized officer of **Aetna** may change or waive any of the policy terms or make any agreement binding us.

The group policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. You will not have to give written agreement of a change in the group policy if:

- You asked for the change and we have agreed to it.
- The change is needed to correct an error in the group policy, including any booklet-certificate issued to anyone.
- The change is needed so that the group policy will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this group policy; or the Federal Government.
- We initiated the change and it is not resulting in either a reduction or elimination in benefits or coverage or an increase in premium.

You will have to give written agreement of a change in the group policy:

- That reduces or eliminates benefits or coverage, or
- That increases benefits or coverage with a concurrent increase in premium during the policy term, except if the increased benefits or coverage is required by law.

  Payment of the applicable premium after notice of the proposed changes will be deemed to constitute your written agreement of those changes on behalf of all persons covered under this group policy.

Entire group policy

The group policy replaces and supersedes:

- All other prior group policies of accident and health coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this accident and health coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the group policy.

We may fail to implement or fail to insist upon compliance with a provision of the group policy at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the group policy

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the group policy.

Assignment and delegation

You shall not assign any right or delegate any duty under the group policy unless we approve it in writing in advance.

We may delegate some of our functions under the group policy to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations

We have complete authority to review all denied claims for benefits under this group policy. In exercising this fiduciary responsibility, we have discretionary authority:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the group policy. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A provider's billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the group policy, any booklet-certificate, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee makes an honest mistake of fact, we may make a fair change in premium. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the group policy based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Proprietary

Financial Sanctions Exclusions

If coverage provided by this Policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Incontestability

We will not use a statement you make to void this group policy after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

The group policy requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery or
- By e-mail, facsimile or other electronic means, effective upon sending.

Notice sent to us by mail and commercial carrier shall be sent to:
Aetna
151 Farmington Avenue
Hartford, Connecticut 06156
1-800-872-3862

Notice sent to you by mail and commercial carrier shall be sent to:
Monroe Township Board Of Education
Attention: Michael Gorski, Bus Admin/Board Secretary
423 Buckelew Ave
Monroe Township, NJ 08831

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, rules, and interpretations of the group policy and the booklet-certificate in order to promote orderly and efficient administration. You and all **covered person**s are

bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the group policy.

Third parties rights

This group policy does not give any rights or impose any duties on third parties except as specifically stated.

Proprietary

Final rates and fees schedule

The current premium rates for all of the coverages provided under the policy are on record with us and the **policyholder**.

Proprietary

BENEFIT PLAN

Prepared Exclusively For
Monroe Township Board of Education

Basic Vision

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™



Vision Plan

Booklet-Certificate

Prepared exclusively for:

Policyholder:	Monroe Township Board of Education
Group policy number:	GP-152709-A
Booklet-certificate	1
Group policy effective date:	July 1, 2020
Plan issue date:	May 28, 2021
Plan revision effective date	July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible vision services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** (**Aetna**) and your **policyholder**. Ask the **policyholder** if you have any questions about the **group policy**.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

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Glossary 29

Schedule of benefits Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical vision language that is familiar to **vision providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

1. **Eligible vision services**
   So what are **eligible vision services**? They are vision care services that meet these three requirements:
   - They appear in the *Eligible vision services under your plan* section.
   - They are not listed in the *What your plan doesn't cover –eligible vision service exclusions* section.
   - They are not beyond any limits in the schedule of benefits.

2. **Providers**
   You may choose any **vision provider** for the care you need.

   For more information about the role of your **vision provider**, see the *Who provides the care* section.

3. **Paying for eligible vision services– sharing the expense**
   Generally your plan and you will share the expense of your **eligible vision services** when you meet the general requirements for paying.

   But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section and see the schedule of benefits.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetna.com.
- Register for our secure Internet access to reliable vision information, tools and resources

Online tools will make it easier for you to make informed decisions about your vision care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna** Member Services
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

Your **policyholder** decides and tells us who is eligible for vision care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At any time
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for vision benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your "dependents".)

- Your spouse, including a civil union partner as defined by New Jersey state law. We also mean civil union or civil union partner when we refer to:
  - Husband/wife (spouse)
  - Family/immediate family
  - Dependent
  - Next of kin
- We mean civil union when we refer to:
  - Marriage
  - Widow/widower/widowed
- Your domestic partner established in New Jersey prior to February 19, 2007 as evidenced by a copy of an Affidavit of Domestic Partnership filed with the local registrar and marked as "filed".
- A domestic partnership providing all of the rights and benefits of marriage valid in another state will be valid for this benefit plan.
- Your dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order
    - Grandchildren in your legal custody

Important note:
You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your **policyholder** when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month
    - If we received your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
  - Ask your **policyholder** when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 60 days from the moment of birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days from the moment of birth.
  - You must still enroll the child within 60 days from the moment of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 60 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A foster child - A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.
- A step child – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage, Declaration of Domestic Partnership or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You become a citizen, national or lawfully present in the United States.
- You did not enroll in this plan before because:
  - You were covered by another group vision plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- A court orders you cover a current spouse, domestic partner or a child on your vision plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.

Eligible vision services under your plan

Eligible vision services include services provided by an ophthalmologist or optometrist.

You may get vision services and supplies from any **vision providers**. Refer to your schedule of benefits for more information.

You may use **vision providers** of your choice for **eligible vision services** and supplies under this plan.

Vision care services and supplies

Eligible vision services and supplies include those prescribed for the first time and those required because of a change in **prescription**. These include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are identified by a **vision provider**
- Aphakic lenses prescribed after cataract surgery
- Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses

What your plan doesn't cover –eligible vision service exclusions

We already told you about the many vision care services and supplies that are eligible for coverage under your plan in the *Eligible vision services under your plan* section. In that section we also told you that some vision care services and supplies have exclusions. For example, **cosmetic** surgery is never covered. This is an exclusion.

In this section we tell you about the exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exclusions

The following are not **eligible vision services** under your plan except as described in the *Eligible vision services under your plan* section of this booklet-certificate, or by a rider or amendment included with this certificate:

Cornea transplants

- Cornea (corneal graft with amniotic membrane)

Cosmetic services and plastic surgery

- Any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Examinations

Any vision examinations needed:

- During your stay in a hospital or other facility for medical care
- For the purpose of the fitting of contact lenses
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision)

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care services and supplies

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by a **policyholder** as a condition of employment, and safety eyewear
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Services rendered after the date a member ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured member are within 31 days from the date of such order

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible vision services**. This section tells you about **vision providers**.

Vision providers

When you need vision supplies, you can go to any **vision provider** to provide **eligible vision services** and supplies to you.

You may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible vision services** that you paid directly to a **vision provider**.

We will tell you what we have paid for **eligible vision services** and supplies. It will tell you if you owe any amounts or if any services or supplies are not covered. You can receive this from us by e-mail or through the mail.

What the plan pays and what you pay

Who pays for your **eligible vision services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains your vision supply maximums listed in your schedule of benefits

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible vision service**.

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of any maximum

Where your schedule of benefits fits in

How your vision supply maximum works

The maximum is the most your plan will pay for **eligible vision services** incurred by a covered person per 24 consecutive month period. You are responsible for any amounts above the maximum.

Important note:
See the schedule of benefits for maximums that apply.

When you disagree - claim determination procedures/complaints and appeals

In the previous section, we explained how you and we share responsibility for paying for your **eligible vision services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **vision provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **vision provider** or to you as appropriate.

Notice	Requirement	Deadline
Submit a claim	• You should notify us in writing within 20 days or as soon as reasonably possible and request a claim form from the **policyholder**. • We will send the claim form to you within 15 calendar days of your request. If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proof of loss. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof within 90 days. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any vision documentation you received from your **vision provider**.
Proof of loss (claim) When you have received a service from an eligible **vision provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us.	• You must send us notice and proof within 90 days.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Time of payment of claims

Upon satisfactory notice of claim, we will pay your claim promptly and within 30 calendar days after we receive your claim electronically or within 30 calendar days after we receive your claim by other means, if:

- The **vision provider** is eligible at the date of service
- You were covered on the date you received the vision care service
- The service or supply is covered under this policy
- The claim is submitted with all of the information requested by **Aetna** on the claim form or in the other instructions that were distributed in advance to you or the **vision provider** in accordance with New Jersey laws
- **Aetna** has no reason to believe the claim was submitted fraudulently

If all or a portion of the claim is not paid within 30 calendar days after we receive your claim electronically or within 30 calendar days after we receive your claim by other means because:

- The claim submission is incomplete due to missing information
- The diagnosis coding, procedure coding or any other required claim information is incorrect
- **Aetna** disputes the amount claimed
- There is strong evidence of fraud by the **vision provider** and **Aetna** has initiated an investigation into the suspected fraud

Aetna will notify the **vision provider**, by electronic means and you and **vision provider** in writing within 30 calendar days of receiving an electronic claim or within 30 days of receiving a claim submitted by other means, if:

- The claim is incomplete with a statement as to what information is missing and necessary to process the claim
- The claim contains incorrect information with a statement as to what information must be corrected in order to process the claim
- **Aetna** disputes the amount claimed in whole or in part with a statement as to the basis of that dispute
- **Aetna** finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with **Aetna's** fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety

If all or a portion of an electronically submitted claim cannot be processed because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, **Aetna** will electronically notify the **vision provider** within 7 days of the status and request any information required to process the claim.

Aetna will acknowledge receipt of a claim submitted by electronic means from a **vision provider** no later than 2 working days following receipt of the transmission of the claim and no later than 15 working days following receipt of a claim received by written notice. The acknowledgement will include the date **Aetna** received the claim and will go to the entity from which **Aetna** received the claim.

If **Aetna** has reason to believe that a claim has been submitted fraudulently, it will investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

Payment of an eligible claim pursuant to the paragraphs above will be deemed to be overdue if not remitted to you or covered dependent by **Aetna** on or before the 30th calendar day following receipt by **Aetna** of a claim submitted by electronic means and on or before the 30th calendar day following receipt of a claim submitted by other than electronic means.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to the paragraphs above, the claims payment shall be overdue if not remitted to you or covered dependent by **Aetna** on or before the 30th calendar day for claims submitted by electronic means and the 30th calendar day for claims submitted by other than electronic means, following receipt by **Aetna** of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim by **Aetna** and you or covered dependent and the **vision provider** are not notified within the time frames provided for in those paragraphs, the claim will be deemed to be overdue.

Any overdue payment will bear simple interest at the rate of 12% per annum. **Aetna** will pay the interest to the **vision provider** at the time the overdue payment is made. The amount of interest paid to a **vision provider** for an overdue claim will be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the **premium**.

Payment of claims
All benefits are payable to you. However, we have the right to pay any vision benefits to a **vision provider**. This will be done unless you have told us otherwise by the time you file the claim.

Any unpaid balance will be paid within 30 days of receipt by us of the due written proof. When a claim is paid, any **premium** due and unpaid may be deducted from the claim payment.

When a **vision provider** provides care to you or a covered dependent, they will submit the claim for you.

Provider reimbursement
No assignment or transfer by you of any of your interest under this policy or by a covered dependent is valid unless **Aetna** consents to it.

When you or your covered dependent submit a claim and assign the right to receive reimbursement for eligible expenses to a **vision provider**, we are required to pay benefits in line with the assignment of benefits by remitting payment directly to the **vision provider**, or in the alternative, to the **vision provider** and you or your covered dependent as a joint payee, with signature lines for each of you.

Any payment made solely to you or your covered dependent rather than the **vision provider** under these circumstance will be considered unpaid, and unless remitted to the **vision provider** within the time frames established by New Jersey Law, will be considered overdue and subject to an interest charge as provided in that act.

Adverse benefit determinations

Sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us calling the toll-free number on your ID card.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call Member Services at the number shown on your ID card. You need to include:

- Your name
- The **policyholder**'s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **vision provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **vision provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

We will issue a decision within 10 business days after receiving the request for an appeal:

Exhaustion of appeal process

You may contact the New Jersey Department of Banking and Insurance or Office of Insurance Claims Ombudsman to file a complaint based on questions you may have about the benefits described in this booklet-certificate such as:

- Procedures that are covered or not covered
- Frequency limits
- Timely payment of **premiums**
- Eligibility

You are not required to complete the one level of appeal with us before contacting the New Jersey Department of Banking and Insurance or the Office of Insurance Claims Ombudsman.

New Jersey Department of Banking and Insurance
Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
(Outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431
Email: ombudsman@dobi.state.nj.us

In most situations you must complete the appeal process with us before you pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- The **group policy** ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required **premium** contribution
- We end your coverage
- You become covered under another vision plan offered by your **policyholder**

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue, until stopped by the **policyholder**, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by your **policyholder** but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of	If **premium** payments are made for you, you

absence that is not a medical leave of absence	may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 18 months from the start of the absence.

It is your **policyholder**'s responsibility to let us know when your employment ends. The limits above may be extended only if we and your **policyholder** agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- The **group policy** ends
- You do not pay the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For domestic partnerships, you should provide the **policyholder** a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 60 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to the **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?
COBRA gives some people the right to keep their vision coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to **policyholders** of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree vision coverage and your former **policyholder** files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and when.

Policyholder/Group vision plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – **policyholder**	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree vision coverage and your former **policyholder** files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – **policyholder** or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – **policyholder or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – **policyholder** or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the **policyholder** if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the **policyholder** if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the **policyholder** if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the **policyholder** if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. The **policyholder** has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the **policyholder** within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

To request an extension of coverage, just call the toll-free Member Services.

How can you extend coverage for vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled, your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction.
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**.

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of physical disability or intellectual disability and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:

- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the *When will coverage end for any dependents* section

How can I extend coverage for a dependent after I die?

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 60 days after your death
- Payment is made for the coverage

Your dependent's coverage will end on the earliest date:

- The end of the 36th month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another vision benefits plan
- Any required contributions stop or
- The date your spouse remarries

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable authority.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **vision providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments or riders too. Under certain circumstances, we or your **policyholder** or the law may change your plan. Only we may waive a requirement of your plan. No other person – including your **policyholder** or **vision provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your **policyholder** any unearned **premium** contribution.

Financial sanctions exclusions:

If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible vision services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill until you complete the appeal process. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians** and **vision providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or your **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:

- Loss of coverage, starting at some time in the past.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 60 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.

Some other money issues

Assignment of benefits

When you see a **vision provider** they will bill us directly. You may send us a claim, at your option, We may choose to pay you or to pay the **vision provider** directly.

Recovery of overpayments

We sometimes pay too much for **eligible vision services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **vision provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Premium contribution

This plan requires the **policyholder** to make **premium** contribution payments. If payments are made through a payroll deduction with the **policyholder**, the **policyholder** will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contribution payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your vision information

We will protect your vision information. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call Member Services. When you accept coverage under this policy, you agree to let your **vision providers** share your information with us. We will need information about your physical and mental condition and care.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Calendar Year
A period of 12 months that begins on January 1st and ends on December 31st.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible vision services that meet the requirements for coverage under the terms of this plan.

Effective date of coverage
The date you and your dependent's coverage begin under this booklet-certificate as noted in our records.

Eligible vision services
The vision care services and supplies listed in the *Eligible vision services under your plan* section and not listed or limited in the *What your plan doesn't cover –eligible vision service exclusions* section or in the schedule of benefits.

Group policy
The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policyholder
An employer or organization who agrees to remit the **premiums** for coverage under the **group policy** payable to **Aetna**. The **policyholder** shall act only as an agent of **Aetna** members in the employer group, and shall not be the agent of **Aetna** for any purpose.

Premium
The amount you or your **policyholder** are required to pay to **Aetna** for your coverage.

Prescription
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Vision provider
Any individual legally licensed to provide vision services or supplies.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.