Northwest Mississippi Community College

Your Vision Plan

Policy No. 914829 011

Underwritten by Starmount Life Insurance Company

7/5/2022

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

Group Vision Insurance Certificate of Coverage

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

Policyholder: Northwest Mississippi Community College

Policy Number: 914829 011

Policy Effective Date: August 1, 2022

Policy Anniversary: August 1

Governing Jurisdiction: Mississippi

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

All references to provisions, sections, and defined terms found within this Certificate have been capitalized. If you have any questions about the terms and provisions of this Certificate, please contact your Employer or us at (888) 400-9304 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

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

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Mississippi Department of Insurance at (573) 751-4126.

Table of Contents

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

Eligible Group(s)

All Employees in Active Employment in the United States working a minimum of 37.5 hours per week.

Paying for Coverage

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

Schedule of Benefits

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

Group Vision Insurance Schedule of Benefits

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

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

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

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

IN-NETWORK PROVIDER		
Covered Services and Materials	**Co-Pay**	**Benefit after Co-Pay**
Eye Exam		
By Ophthalmologist or Optometrist	$15	Covered in Full
Materials - Eyeglass Lenses[1]		
Single Vision Eyeglass Lenses	$25	Covered in Full
Bifocal Eyeglass Lenses	$25	Covered in Full
Trifocal Eyeglass Lenses	$25	Covered in Full
Progressive Eyeglass Lenses	$25	$70 Allowance
Lenticular Eyeglass Lenses	$25	Covered in Full
Materials - Frames[1]		
Eyeglass Frames	$25	$120 Allowance*
Materials - Contact Lenses[2]		
Contact Lenses - Elective	$25	$120 Allowance*
Contact Lenses - Non-Elective	$25	Covered in Full

OUT-OF-NETWORK PROVIDERS	
Covered Services and Materials	**Benefit**
Eye Exam	
By Ophthalmologist or Optometrist	$35 Allowance
Materials - Eyeglass Lenses	
Single Vision Eyeglass Lenses	$25 Allowance
Bifocal Eyeglass Lenses	$40 Allowance
Trifocal Eyeglass Lenses	$50 Allowance
Progressive Eyeglass Lenses	$40 Allowance
Lenticular Eyeglass Lenses	$50 Allowance
Materials - Frames	
Eyeglass Frames	$50 Allowance
Materials - Contact Lenses[2]	
Contact Lenses - Elective	$100 Allowance
Contact Lenses - Non-Elective	$210 Allowance

[1] If you purchase Eyeglass Lenses and Frames in the same benefit period from an In-Network Provider, only one Co-pay will apply.
[2] Contact Lenses consists of materials and the fitting up to the Contact Lenses allowance. Fittings may be covered but only up to the amount of any unused Contact Lenses allowance, after Materials.
*- Allowances are less any applicable Co-Pay

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

SUPPLEMENTAL BENEFITS	
OUT-OF-NETWORK PROVIDERS	
Covered Services and Materials	**Benefit**
Polycarbonate upgrade for Children < 19	Not Covered

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

Vision Benefits

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

Eye Exams

Benefit Description

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

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

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

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

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

Covered Materials

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

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

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

In-Network Benefits

When you enroll for coverage, a Provider Directory will be made available to you. The Provider Directory is made up of In-Network Providers who are available to you. You may select any of the In-Network Providers and change providers at any time without notice. A provider's status may occasionally change. You may contact us to verify a provider's participation status in the network, by calling customer service at (888) 400-9304 or online at www.AlwaysAssist.com.

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

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

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

Out-of-Network Benefits

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

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

Exclusions

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

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

We will also not pay any claims incurred after:

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

Limitations

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

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

Dilation is covered in full under the Vision Exam Benefit only if done for one of the following conditions:

- central vision loss;
- photopsia;
- floaters;
- high myopia;
- diabetes; or
- history of ocular surgery, ocular trauma, or ocular disease.

Coordination of Benefits

This provision applies when an Insured has vision coverage under more than one Vision Plan, as defined below. The benefits payable between the Vision Plans will be coordinated.

Definitions

Allowable Expense: An expense that is considered a covered charge, at least in part, by one or more of the Vision Plans. When a Vision Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Coordination of Benefits: Taking other Vision Plans into account when we pay benefits.

Vision Plan: All Vision Plans, including this Vision Plan, that provides vision benefits or services on a group basis. "Vison Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

"Vision Plan" includes:

- group and blanket insurance;
- self-insured plans;
- prepaid plans;
- government plans;
- plans required or provided by statute (except Medicaid); and
- no fault insurance (when allowed by law).

Primary Vision Plan: The Vision Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Vision Plans.

Benefit Coordination

Benefits will be adjusted so that the total payment under all Vision Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Vision Plan are reduced due to COB, each benefit will be reduced proportionately.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

The Order of Benefit Determination

1. When this is the Primary Vision Plan, we will pay benefits as if there were no other Vision Plans.
2. When a person is covered by a Vision Plan without a COB provision, the Vision Plan without the provision will be the Primary Vision Plan.
3. When a person is covered by more than one Vision Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent.** A Vision Plan that covers a person other than as a dependent will pay before a Vision Plan that covers that person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Vision Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Vision Plan that has covered the dependent child for the longer period will pay first. If the other Vision Plan uses gender to determine which Vision Plan pays first, we will also use that basis.

   c. **Dependent Child/Separated or Divorced Parents.** If two or more Vision Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

i. The Vision Plan of the parent who has responsibility for providing insurance as determined by a court order;

ii. The Vision Plan of the parent with custody of the child;

iii. The Vision Plan of the spouse of the parent with custody; and

iv. The Vision Plan of the parent without custody of the child.

d. **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

e. **Active/Inactive Employee.** The Vision Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary over the Vision Plan which covers that person as a laid off or retired employee. If the other Vision Plan does not have this rule, and as a result, the Vision Plans do not agree on the order of benefits, this rule is ignored.

f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Vision Plan that has covered the person for the longer period of time will pay first.

Right to Receive and Release Needed Information
We may release to or obtain from, any other insurance company, organization, or person information necessary for COB. This will not require the consent of or notice to an Insured. The Insured is required to give us information necessary for COB.

Right to Make Payments to Another Vision Plan
COB may result in payments made by another Vision Plan that should have been made by us. We have the right to pay another Vision Plan all amounts it paid which would otherwise have been paid by us. Amounts paid will be treated as benefits paid under this Vision Plan. We will be discharged from liability to the extent of such payments.

Right to Recovery
COB may result in overpayments by us. We have the right to recover any excess amounts paid from any person, insurance company, or other organization to whom, or for whom, payments were made.

Waiting Period

First of the month following the first day of continuous Active Employment.

Coverage Eligibility Date

For you

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

For your Spouse

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

For your Children

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

Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

Enrolling for Coverage

Initial Enrollment

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

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

Coverage Effective Date for Changes in Coverage

Changes in Coverage Requested by You

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

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

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

Coverage Effective Date if you are not in Active Employment

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

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

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

Continuation of your Coverage During Extended Absences

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

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

Family and Medical Leave of Absence

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

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

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

We will not apply a new Waiting Period.

Leave of Absence due to Military Service

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

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

Injury or Sickness

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

End of Coverage

For You

Your coverage under this Certificate ends on the earliest of:

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

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

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

For your Spouse

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

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

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

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

For your Children

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

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

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

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

Filing a Claim

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

In-Network Claims

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

Out-of-Network Claims

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

Step 1 - Starting a Claim

Notice of a claim may be provided in Writing or by contacting us directly at (888) 400-9304. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

Step 2 - Claim Forms

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

When you or your authorized representative receive the claim form, you or your authorized representative must fill out your own section of the claim form and provide the Insured's provider with the applicable section of the claim form. If applicable, the Insured's provider should complete their section of the form and send it directly to us.

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

Completed claim forms may be sent to us by mail, e-mail, or fax:

Mailing Address: Starmount Life Insurance Company, P.O. Box 14389 Baton Rouge, LA 70898-4389.

Fax: 855-400-9307

E-mail: VisionClaims@Unum.com

Step 3 - Proof of Loss

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

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

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

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

Claim Procedures

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a

claim decision and issue payment for a Payable Claim within 30 days. Benefits will be paid in accordance with the Payment of Benefits provision.

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

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

Payment of Benefits

We will pay all benefits due for any loss, other than loss for benefits that provide for periodic payment, within 25 days after receipt of due Written Proof of such Loss in the form of a clean claim where claims are submitted electronically, and within 35 days after receipt of due Written Proof of such Loss in the form of a clean claim where claims are submitted in paper format. Benefits are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim containing necessary medical information and other information essential for Us to administer the claim.

A "clean claim" means a claim received by Us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or You in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to Us, do not change the clean claim status.

A clean claim does not include any of the following:
• a duplicate claim, which means an original claim and its duplicate when the duplicate is filed within
  30 days of the original claim;
• claims which are submitted fraudulently or that are based upon material misrepresentations;
• claims that require information essential for Us to administer the claim; or
• claims submitted by a provider more than 30 days after the date of service. If the provider does not submit the claim on Your behalf, then a claim is not clean when submitted more than 30 days after the date of billing by the provider to You.

Not later than 25 days after the date We actually receive an electronic claim, We will pay the appropriate benefit in full, or any portion of the claim that is clean, and notify You of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date We actually receive a paper claim, We will pay the appropriate benefit in full, or any portion of the claim that is clean, and notify You of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us will be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that We will either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due to You. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to Your last known address in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to You.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, We must pay You interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the

benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due is less than $1.00, such amount will be credited to Your account. The provisions of this paragraph shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

In the event We fail to pay benefits when due, You may bring action to recover such benefits, any interest which may accrue, and any other damages allowable by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You shall be entitled to recover damages in an amount up to three times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

This amendment is part of your policy. All other terms, conditions, limitations and provisions of your coverage remain unchanged.

Payments to a Minor or Incompetent Insured

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

Overpayment of Claims

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

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

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

Underpayment of Claims

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

Grievance Procedures

Complaints and Grievances
You shall report any complaints and/or grievances to us at (888) 400-9304. Complaints and grievances may be submitted to us verbally or in Writing. You may submit Written comments or supporting documentation concerning your complaint or grievance to assist in our review. We will address the complaint or grievance within 30 days after receipt or, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 days after our receipt of the complaint or grievance.

Claim Denial
If we deny all or any part of your claim, you can access the claim status detail on www.AlwaysAssist.com, you have the right to receive a Written notice of denial setting forth:
- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review; and

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

- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary.

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

The request must be made within 60 days following your receipt of the Written notification of adverse benefits determination and should contain sufficient information to identify the person for whom the claim was denied, including:
- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the provider of services; and
- the claim number.

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

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

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

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

Legal Actions

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

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:
- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

When Days Begin and End

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

Certificate of Coverage Contents

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

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

Your Certificate of Coverage

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

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

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

Cancellation or Modification to the Policy and this Certificate of Coverage

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

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

Representation in Applications

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

Assignment

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

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

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

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

Contestability

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

Misstatement of Age

If an Insured's age is misstated, we will:

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

Fraud

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

necessary to support fraud detection, investigation, and prosecution.

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

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

Agency

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

Communicating with you or your Employer

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

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

Active Employment

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

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

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

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

Temporary and seasonal workers are excluded from coverage.

Allowance

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

Certificate of Coverage or Certificate

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

Children

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

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

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

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

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

Co-Pay

The amount an Insured must pay to a provider before benefits are payable for Covered Services or Materials. The Co-Pay is paid directly to the provider at the time services are

rendered. Co-Pay amounts are listed in the Schedule of Benefits.

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

Contact Lenses, Non-Elective Contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

- Aphakia (after cataract surgery). A pair of prescription single vision or multifocal Eyeglass Lenses and an eye frame can be provided in addition to Non-Elective Contact Lenses for this condition.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Keratoconus.

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

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

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

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

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

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

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

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

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

Insured Any person who has coverage under this Certificate.

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

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

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

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

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

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

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

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

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

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

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

Policy Year August 1, 2022 to August 1, 2023 and each following August 1 to August 1.

Plano Lens A lens that has no refractive power.

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

Policyholder The entity to which the Policy is issued.

Provider Directory A list of In-Network Providers for your plan. You can verify if a provider is an In-Network Provider by calling customer service at (888) 400-9304 or online at www.AlwaysAssist.com.

Qualifying Life Event An event including, but not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

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

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

Spouse The person who is your partner through lawful marriage, civil union, registered domestic partnership, unregistered domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be insured as both a Spouse and an Employee.

Starmount Life Insurance Company	Referred to as "Starmount" and "we," "us," or "our."
Writing or **Written**	A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law.

Privacy Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

unum.com MK-1883 (06-2020)

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in net cash surrender and net cash withdrawal values

- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. §83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy of contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract.There are also various residency requirements and other limitations under Mississippi law.

Benefits provided by long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates benefits.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org or contact:

Mississippi Life and Health Insurance Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201

(8/1/2022)

601-981-0755 601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.