BlueCross BlueShield of Oklahoma

Voluntary Vision Insurance

Employee Benefit Booklet

CITY OF TULSA

F024608-0001

Option 4 (2 Year Low)

Plan 1 - 12.12.24 $100

01/03/2020

DEARBORN LIFE INSURANCE COMPANY

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

Administrative Office Address: 701 E. 22nd Street, Lombard IL 60148

Having issued Group Policy No. F024608

(herein called the *Policy*)

to

CITY OF TULSA
(herein called the *Policyholder*)

GROUP VISION INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, if *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the *Policy*. *Your* insurance is subject to all the definitions, exclusions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This *Certificate* describes *Your* eligibility for benefits and the terms and provisions of the *Policy*. It replaces and cancels any other *Certificate* previously issued to *You* under the *Policy*.

If the terms and provisions of this Group Insurance *Certificate* (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the issued Oklahoma *Certificate* will govern Oklahoma residents. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy*

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Group Vision Insurance Certificate
with Dependent Vision Benefits
Non-Participating

THIS IS A LIMITED BENEFIT POLICY

THIS IS NOT A WORKERS' COMPENSATION POLICY

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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SCHEDULE OF BENEFITS

POLICYHOLDER: CITY OF TULSA

POLICY NUMBER: F024608

POLICY EFFECTIVE DATE: 01/01/2020

ANNUAL ENROLLMENT PERIOD: October 1 to November 30

ELIGIBILITY:
Option 4

All Active full-time Non-Sworn Employees and Elected Officials electing Option 4 (2 Year Low) of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time Non-Sworn *Employees*, excluding Elected Officials is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Elected Officials do not have a hours worked requirement. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

Eligibility Period:

Current *Employees*: First of the month following 30 Days of continuous, full-time *Active Work*
New *Employees*: First of the month following 30 Days of continuous, full-time *Active Work*

Policyholder Contribution: Voluntary Vision 0% of premium

Coverage For: *Employee, Spouse, and Dependent Child*

Dependent Benefit amounts unless otherwise stated:

Spouse Benefits 100% of the *Employee's* benefit amount
Dependent Child Benefits 100% of the *Employee's* benefit amount
Birth to age 26

Insured Persons have the right to obtain vision care from the *Provider* of his or her choice. However, payment of benefits varies depending on the type of *Provider* chosen. Benefits are payable as shown in the following *Schedule of Benefits*:

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Vision Examination* Insured 12 months	$20 *Co-payment*	up to $45
VISION MATERIALS		
Standard Plastic Lenses Insured 12 months		
Single Vision	$20 *Co-payment*	up to $30
Bifocal	$20 *Co-payment*	up to $50
Trifocal	$20 *Co-payment*	up to $65
Lenticular	$20 *Co-payment*	up to $100
Other Lenses (as developed)	N/A	N/A
Frames	$0 *Co-payment* up to $100 allowance	up to $55

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Insured 24 months		
Contact Lenses (**only one option available per Benefit Frequency**) Insured 12 months		
Conventional	$0 *Co-payment* up to $100 allowance	up to $80
Disposable	$0 *Co-payment* up to $100 allowance	up to $80
Medically Necessary	$0 *Co-payment* Paid In Full	up to $210
Lens Options Insured 12 months		
Standard Polycarbonate	$40 *Co-payment*	N/A
Standard Polycarbonate (For covered Dependent Children under 19 years of age)	$0 *Co-payment*	up to $28
UV Treatment	$0 *Co-payment*	up to $11
Tint, Solid or Gradient	$15 *Co-payment*	N/A
Standard Plastic Scratch Coating	$15 *Co-payment*	N/A
Standard Progressive Lenses (add on to Bifocal)	$85 *Co-payment*	up to $50
Premium Progressive Lenses (add on to Bifocal)	Tier 1 $105 *Co-payment* Tier 2 $115 *Co-payment* Tier 3 $130 *Co-payment* Tier 4 $85 *Co-payment* up to $120 allowance	up to $50
Standard Anti-Reflective Coating	$45 *Co-payment*	N/A
Premium Anti-Reflective Coating	Tier 1 $57 *Co-payment* Tier 2 $68 *Co-payment* Tier 3 80% of charge	N/A
Photochromic Lenses	$75 *Co-payment*	N/A

*Covered *Dependent Children* are eligible for more than one exam within 60 days of the initial exam if prescription has changed by 0.50 diopter sphere/cylinder > 20 degrees axis, or visual acuity improvement by one line on standard chart.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the *Schedule of Benefits*.

The *Eligibility Waiting Period* is further defined in the *Schedule of Benefits*.

When does Your Contributory insurance become effective?
You may enroll for coverage during the *Annual Enrollment Period*, unless *You* qualify because of a *Change in Family Status*. *Your Contributory* coverage will become effective on the latest of the following dates if *You* are *Actively at Work* on that date:

1. If *You* enroll for coverage prior to the *Policy Effective Date*, the *Policy Effective Date*; or
2. If *You* enroll for coverage after the *Policy Effective Date* on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*; or
3. If *You* enroll during an *Annual Enrollment Period*, the next *Anniversary Date* following the *Annual Enrollment Period*.

Coverage requested because of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.

Change in Family Status
If *You* experience a *Change in Family Status*, *You* may enroll for coverage, apply for additional coverage, or request changes to *Your* current insurance coverage, provided the change is consistent with the *Change in Family Status*. For *Your* coverage to become effective, *We* must receive a completed *Enrollment Form* within 31 days of the *Change in Family Status*.

Change in Family Status means:
1. *You* get married; or
2. *You* have a *Dependent Child*, or *You* adopt or become the legal guardian of a *Dependent Child*; or
3. *Your Spouse* dies or *You* become divorced; or
4. *Your Dependent Child* becomes emancipated or dies; or
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance; or
6. *You* have a change in employment classification which results in *You* changing from part-time to full time, or full-time to part-time employment.

When does Dependent coverage become effective?

Your Dependent's coverage will become effective on the latest of:

1. The date *Your* coverage becomes effective under the *Policy*, if *You* have enrolled for *Dependent* coverage on or before that date; or
2. The first day of the month following the date *You* enroll for *Dependent* coverage.

When does coverage for a new Spouse become effective?
Coverage for a new *Spouse* starts automatically on *Your* marriage. *Your* new *Spouse* will be a *Covered Person* for 31 days. *Your Spouse* will cease to be a *Covered Person* unless:

1. *You* request, in writing within those 31 days continuation of such *Dependent* coverage; and
2. The required premium is paid. Premium will be charged from the date of marriage.

When does coverage for a newborn Child become effective?
If *You* have not previously elected *Dependent Child* coverage, coverage for a newborn *Child* starts automatically from the moment of birth if a *Child* is born to *You.* The newborn *Child* will be a *Covered Person* for 31 days. The newborn *Child* will cease to be a *Covered Person* after 31 days, unless:

1. *You* request in writing within those 31 days continuation of such *Dependent Child* coverage; and
2. The required premium is paid. Premium will be charged from the date of birth.

If *You* currently have *Dependent Child* coverage, *Your* newborn *Child* will be automatically added to *Your* coverage.

Dependent Child coverage will also be extended to newly adopted, foster or step *Children*, as of the date they become financially dependent on *You* for support, provided they otherwise meet the definition of a *Dependent Child*.

Will the Effective Date of coverage be delayed if Your Dependent is confined to a Hospital?
The *Effective Date* of coverage will be delayed if *Your Dependent*, other than a newborn *Child*, is confined in a *Hospital* on the date coverage would otherwise become effective. In such case, the *Dependent's* coverage will become effective on the first day of the month that follows discharge from the *Hospital*.

What is an Annual Enrollment Period?
Unless otherwise specified, *Annual Enrollment Period* means a period of time during which *Employees* may enroll for coverage or request changes to their benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment Period* will become effective on the next *Policy Anniversary Date*.

If You are not Actively at Work, when does coverage become effective?
If *You* are not *Actively at Work* on the date *Your* coverage would otherwise become effective, and *Your* absence is caused by an *Injury*, *Illness* or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work.*

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

1. not *Hospital Confined*; or
2. disabled due to an *Injury* or *Sickness*.

Eligibility after You Terminate Employment
If *Your* coverage ends due to termination of employment, *You* must meet all the requirements of a new *Employee* if *You* are rehired by the *Policyholder* at a later date.

Exception: If *Your* coverage ends due to termination of employment and *You* return to *Active Work* for the *Policyholder* in an eligible class within 30 days, *We* will not apply a new *Eligibility Waiting Period* as defined in the *Schedule of Benefits*.

What happens if We are replacing a Prior Policy?
Subject to the payment of premiums when due, *We* agree to waive the *Actively at Work* requirement if *You*:

1. were covered by a *Prior Policy* on the day immediately preceding the *Policy Effective Date*; and
2. *You* are on lay-off, non-medical leave of absence, or sabbatical leave; and
3. *You* are covered under an extension of benefits under the *Prior Policy*.

Coverage will continue for the first to occur of:
1. expiration of the balance of the extension of benefits under the *Prior Policy*; or
2. 12 months; or
3. the date the *Policy* terminates.

Prior Policy means the group vision insurance policy issued to the *Policyholder* immediately prior to the *Effective Date* of this *Policy*.

Changes to Your coverage
A change in *Your* coverage may occur if:

1. *You* enroll for a different benefit amount; or
2. there is a *Policy* change; or
3. *You* enter another class and become eligible for a change in benefits.

If *You* are eligible for additional coverage due to a *Policy* change, the additional coverage will be effective on the date the *Policy* change is effective, as requested by the *Policyholder* and agreed upon by *Us*.

If a change results in additional coverage, for reasons other than a *Policy* change, the change will be effective the first of the month following the later of:

1. The date *You* enroll for the additional coverage; or
2. The date *You* become eligible for the additional coverage, if enrollment is not required.

In order for *Your* additional coverage to begin, *You* must be *Actively at Work*. Additional *Contributory* coverage is subject to *Our* receipt of premium.

If a change results in a decrease in coverage the change will take effect immediately.

Exception: Increases or decreases to *Your* coverage made during the *Annual Enrollment Period* will become effective on the next *Policy Anniversary Date*, provided *You* are *Actively at Work* on that day.

VISION INSURANCE BENEFITS

Benefits are payable for each *Insured Person*, as shown in the *Schedule of Benefits*, for expenses incurred while this insurance is in force.

What are the In-Network Provider Benefits?
The *Insured Person* must pay any *Co-payment* or any cost above the allowance shown in the *Schedule of Benefits* at the time the covered service is provided. Benefits will be paid to the *In-Network Provider* who will file a claim with the Company.

What are the Out-of-Network Provider Benefits?
The *Insured Person* must pay the *Out-of-Network Provider* the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the *Insured Person* for the *Out-of-Network Provider* benefits up to the maximum dollar amount shown in the *Schedule of Benefits*.

How Many Vision Examinations are Available?
An *Insured Person* is eligible for one *Vision Examination* in each *Benefit Frequency*.

What Vision Materials are Available?
If the *Vision Examination* covered by the *Policy* a *Vision Examination* results in an *Insured Person* needing corrective *Vision Materials* for the *Insured Person's* visual health and welfare, those *Vision Materials* prescribed by the *Provider* will be supplied, subject to certain limitations and exclusions of the *Policy*, as follows:

1. Lenses provided one time in each *Benefit Frequency*.
2. Frame(s) provided one time in each *Benefit Frequency*.
3. Contact Lenses provided one time in each *Benefit Frequency* in lieu of lenses, Contact Lenses Fit and Follow-Up benefits apply only for covered Contact Lenses.

LIMITATIONS

Limitations:

1. *Vision Examination* and/or *Vision Materials*. Fees charged by a *Provider* for services other than a covered benefit must be paid in full, by the *Insured Person*, to the *Provider*. Such fees or materials are not covered under the *Policy*.
2. Benefit allowances provide no remaining balance for future use within the same *Benefit Frequency*.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. any *Vision Examination Vision Materials*;
4. any eye or *Vision Examination*, or any corrective eyewear required by a *Policyholder* as a condition of employment; safety eyewear;
5. 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;
6. Plano (non-prescription) lenses and/or contact lenses;
7. non-prescription sunglasses;
8. two pair of glasses in lieu of bifocals;
9. services or materials provided by any other group benefit plan providing vision care;
10. certain name brand *Vision Materials* for which the manufacturer maintains a no-discount practice;
11. services rendered after the date an *Insured Person* ceases to be covered under the *Policy*, except when *Vision Materials* ordered before coverage ended are delivered, and the services rendered to the *Insured Person* are within 31 days from the date of such order; or
12. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next *Benefit Frequency* when *Vision Materials* would next become available.

TERMINATION PROVISIONS

When does Your coverage under the Policy end?
Your coverage terminates on the earliest of the following dates:

1. the date on which the *Policy* is terminated; or

2. the end of the month after the date *You* stop making any required contribution toward payment of premiums; or

3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or

4. the last day of the month on which the *Participating Employer*'s participation under the *Policy* is terminated; or

5. the earliest of:
   a. the date *You* die; or
   b. the end of the month after the date *You* are no longer a *Member* of a class eligible for this insurance; or
   c. the end of the month after the date *You* request termination of coverage under the *Policy;* or
   d. the first of the month following the date *You* reach age 99; or
   e. the end of the month after the date *You* are no longer *Actively at Work* as a result of a *Disability*, layoff, or leave of absence or labor dispute, or military leave or Reserve National Guard.

Termination will not affect an eligible claim for a covered Loss which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the *Disability* began, if all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
Leave of Absence	Until the end of the twelfth month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the *Policyholder's* Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
Labor Dispute	Until the end of the twenty fourth month following the sixth month in which the sabbatical began, if all premiums are paid when due.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.
Reserve National Guard	If *You* are a member of an organized United States Reserve Corps or National Guard Unit, coverage will continue while *You* are: 1. In attendance at annual field training, cruise or other active duty training period of less than 60 days (except while attending a service school lasting beyond 60 days, in which case coverage will extend for the duration of the school); or 2. on the way to or from such training; or 3. participating in an authorized periodic inactive duty training, assembly or other inactive duty training authorized by unit orders; or 4. participating as a member of *Your* unit in an authorized parade, exhibition or ceremony.

For the purposes of this provision, *Disability* means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation.*

Will coverage be continued if You are eligible for leave under FMLA?
In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 and its amendments (FMLA), or any applicable state family and medical leave law provided the *Policyholder* continues to pay *Your* required premium, *Your* coverage will continue for a period of up to the later of:

1. the leave period permitted by the federal FMLA; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:
1. After the birth of a *Child*; or
2. After the legal adoption of a *Child*; or
3. After the placement of a foster *Child* in *Your* home; or
4. To a *Spouse*, *Child* or parent due to their serious *Illness*; or
5. For *Your* serious health condition; or
6. For any event later added by amendment to the Act.

During *Your* FMLA period:
1. The *Policyholder* must remit the premium required by the *Policy*; and
2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder*.

When does Dependent coverage end?
Dependent coverage will end on the earliest of:
1. the last day of the month *You* are no longer an *Employee* (except in the case of *Disability*, layoff, or leave of absence or sabbatical, or military leave or Reserve National Guard as set forth above); or
2. the date on which the *Policy* is terminated; or
3. the last day of the month *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the last day of the month on which the *Participating Employer*'s participation under the *Policy* is terminated; or
6. the last day of the month *You*:
    a. are no longer a member of a class eligible for this insurance; or
    b. request termination of coverage under the *Policy*; or
    c. reach age 99; or
    d. are retired or pensioned; or
7. the date a *Dependent Child* or *Spouse* no longer meets the *Policy* definition of *Dependent*; or
8. the first of the month following 90 days after the date of *Your* death. Premium will not be payable during this period.

Coverage will continue past the age limit for *Dependent Children* who are primarily dependent on *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to *Us* on request.

GENERAL PROVISIONS

Entire Contract; Changes
The Entire Contract consists of:
1. The Group Insurance *Policy*;
2. The *Application*;
3. This *Certificate*;
4. The *Enrollment Forms* of the persons *Insured*, including any individual statements; and
5. Any riders; endorsements; or amendments to the *Policy* or the *Certificate*.

Coverage under the *Policy* can be amended by mutual consent of the *Policyholder* and *Us*. No change in the *Policy* is valid unless approved in writing by one of *Our* officers. No agent has the right to change the *Policy* or to waive any of its provisions.

Statements on the Application
All statements made in any signed *Application*, or other written and signed statement, are considered representations and not warranties (absolute guarantees). No representation by:
1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in the signed *Application* or other written and signed statement; or
2. any *Employee* in enrolling for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the Application for Insurance or other written and signed statement, if applicable, has been signed by the *Employee* and has been given to the *Employee*.

Legal Actions
Unless otherwise provided by federal law, no legal action brought to recover on the *Policy* of any kind may be filed against *Us*:
1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error
Clerical error or omission by *Us* to the *Policyholder* will not:
1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy*; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:
1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

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. No statement *You* made relating to *Your* insurability under the *Policy* will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force for two years during *Your* lifetime, and in no event unless the statement is contained in a written instrument signed by *You* and a copy is given to *You* or to *Your* beneficiary.

Premium Provisions
Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Contributory* coverage. The *Policyholder* agrees to and is responsible for remitting such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a *Policy* month will begin on the next premium due date. Premium charges for insurance terminating during a *Policy* month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have become effective or terminated.

Misstatement of Age
If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:
1. the effective date or termination date of insurance; and
2. the amount of insurance; and

3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that *You* should have been paid if the true age had been known.

Conformity with State Statutes and Regulations
If any provision of the *Policy* conflicts with the statutes and regulations of the state in which *You* reside, it is automatically changed to meet the minimum requirements of the statute.

Assignment
Benefits under the *Policy* may not be assigned.

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim
We must receive written notice of claim within 30 days of receiving services, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to any authorized agent of *Ours*.

Claim Forms
Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof* only if *We* receive written *Proof*, which describes the occurrence, extent and nature of the loss for which claim is made.

Proof of Loss
We must receive written *Proof* within 90 days of the date *You* receive services or supplies. If it is not possible to give *Us* written *Proof* within 90 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof* must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid if it can be shown that:
1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof* was given as soon as was reasonably possible.

We will give *You* written response to *Your* 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, *We* notify *You* in writing that an extension is necessary due to matters beyond *Our* control, identify those matters and gives the date by which *We* expect to render a decision. If the extension is due to *Your* failure to submit information necessary to decide *Your* claim, the time for decision shall be tolled from the date on which *We* send *You* notice of the extension until the date *We* receive *Your* response to *Our* request. This period will be no longer than 45 days after *We* have requested the information. At that time *We* will decide *Your* claim based on the information *We* have at that time.

Who will receive Your Insurance Benefits?
In-Network Provider benefits are payable to *You* or to *Your Provider*. *Out-of-Network Provider* benefits are payable to *You*. Any benefits payable on, or after, *Your* death, will be payable to *Your* Estate.

Do I have the Right to Appeal a Claim Denial?
If *Your* claim is denied, in whole or in part, *You* will receive a written notice giving the following:
- the reason or reasons for the denial;
- the *Policy* provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that *You* have to follow to have the claim reviewed;
- a statement that *You* have the right to bring a civil action under section 502(a) of ERISA after *You* appeal *Our* decision and after *You* receive a written denial on appeal; 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 *You* upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request.

If the claim has been denied, in whole or in part, *You* can appeal the denial to *Us* for a full and fair review. *You* have at least 180 days to appeal from the claim denial.

You 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 *Your* claim; and
c. submit written comments, documents, records and other information relating to *Your* claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after *We* receive *Your* appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, *We* notify *You* 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 *Your* claim is extended due to *Your* failure to submit information necessary to decide *Your* claim on appeal, the time for *Your* decision shall be tolled from the date on which the notification of the extension is sent to *You* until the date *We* receive *Your* response to the request.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that *You* are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *Your* claim for benefits;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision 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 decision and that a copy will be provided free of charge to *You* upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request; and
- the following statement: "*You* and *Your* plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact *Your* local U.S. Department of Labor Office and *Your* State insurance regulatory agency."

GENERAL DEFINITIONS

Actively at Work or ***Active Work*** means that *You* must:
1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the *Schedule of Benefits* and either:
   a. work at the *Policyholder*'s usual place of business; or
   b. work at a location to which the *Policyholder*'s business requires *You* to travel; and
3. not be a temporary or seasonal *Employee*; and.
4. be paid regular earnings by the *Policyholder*.

Anniversary Date means the annual month and day that corresponds with the *Policy Effective Date*.

Annual Enrollment Period means the annual timeframe defined in the *Schedule of Benefits* when *Employees* can make benefit changes.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the *Insured Person's Effective Date* or last date services were provided to the *Insured Person*. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Certificate means this *Vision Insurance Certificate*.

Child(ren) means:
1. *Your* natural or step *Child* under the age stated in the *Schedule of Benefits*; or
2. a *Child* under the age stated in the *Schedule of Benefits* placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the *Child*. Eligibility will continue unless the *Child* is removed from placement ; or
3. a *Child* of *Your Child* who is *Your* dependent for federal income tax purposes at the time application for coverage of the *Child* of *Your Child* is made.

Co-payment means the designated amount, if any, shown in the *Schedule of Benefits* each *Insured Person* must pay to a *Provider* before benefits are payable for a covered *Vision Examination* and or *Vision Materials* per *Benefit Frequency*.

Computer Display means a personal computer monitor, personal laptop or mainframe terminal. It does not include any handheld electronic devices.

Contributory means *You* pay all or a portion of the premium for this insurance coverage.

Covered Person means an *Employee* or *Eligible Dependent* covered under the *Policy*.

Dependent or Eligible Dependent means:
1. *Your* lawful *Spouse*; and/or
2. *Your Child*(ren) who are not in active military service; and are within the age limits set forth in the *Schedule of Benefits*.

Employee or Eligible Employee means an *Actively at Work*, full-time *Employee* working in the United States of America as shown in the *Schedule of Benefits* whose principal employment is with the *Policyholder* and who is reported on the *Policyholder*'s records for Social Security and withholding tax purposes.

Enrollment Form means a form acceptable to *Us* that *You* complete to enroll for coverage under the *Policy*.

Hospital means either of the following:
1. A licensed facility which
   a. maintains on the premises everything necessary for major surgical treatment, and
   b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed *Physicians*; and
   c. provides 24-hour service by registered graduate nurses.

2. A free-standing surgical facility which maintains on the premises everything necessary for major surgical treatment available to the *Hospital* on a prearranged basis.

The term *Hospital* does not include an institution which is primarily a place for rest or convalescence, a place for the aged, a nursing home, a place for the treatment of alcohol or drug abuse or any facility primarily affording custodial, educational, or rehabilitative care.

Hospital Confinement or Confinement means the assignment to a bed as an inpatient in a *Hospital* on the advice of a *Physician* or confinement in an observation unit within a *Hospital* for a period of no less than 20 continuous hours on the advice of a *Physician*.

In-Network Provider means a *Provider* who has signed a *Preferred Provider Agreement* with the *PPO*.

Insured(s) means an *Employee* or *Dependent* covered under the *Policy*.

Insured Person(s) means the *Insured*. *Insured Person* will also include the *Insured's Dependents*, if shown on the Insured's identification card, if enrolled.

Male Pronoun whenever used includes the female.

Material and Substantial Duties means duties that are normally required for the performance of *Your Regular Occupation* which cannot be reasonably omitted or modified.

Medically Necessary Contact Lenses means:
1. Keratoconus where the *Insured Person* is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an *Insured Person* can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a *Provider*, located within the *PPO Service Area*, who has not signed a *Preferred Provider Agreement* with the *PPO*.

Policy means the contract between the *Policyholder* and *Us* including the *Application*, this *Certificate* and any amendments, riders or endorsements.

Policy Effective Date or ***Effective Date*** means the date stated on *the Schedule of Benefits.*

Policyholder means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*. If the *Policyholder* is an association the term *Participating Employer* shall be substituted for *Policyholder*.

PPO Service Area means the geographical area where the *PPO* is located.

Preferred Provider Agreement means an agreement between the *PPO* and a *Provider* that contains the rates and reimbursement methods for services and supplies provided by such *Provider*.

Preferred Provider Organization ("PPO") means a network of *Providers* and retail chain stores within the *PPO Service Area* that has signed a *Preferred Provider Agreement.*

Proof means evidence satisfactory to *Us* that the *Covered Person* has received services or supplies listed in the *Schedule of Benefits*.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Regular Occupation means the occupation that *You* are routinely performing when *Your* insurance terminates due to *Disability*. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for *Your Policyholder* or at *Your* specific location.

Schedule of Benefits means the schedule which is a part of this *Certificate*.

Spouse means lawful *Spouse*.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means those materials shown in the *Schedule of Benefits*.

Voluntary means coverage for which *You* pay 100% of the premium.

We, Our and ***Us*** means Dearborn Life Insurance Company.

You, Your and ***Yours*** means the *Employee* to whom this *Certificate* is issued and whose insurance is in force under the terms of the *Policy*.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer's group health **plan** (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to You and Your family, and
- What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the Certificate or Certificate of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

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

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason other than Your gross misconduct.

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

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage ***may*** last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.** In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.

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

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma 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 insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma 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 cash surrender or 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
  - $300,000 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, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

"Health benefit plan" is defined in 36 O.S. §2024(7) 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 or 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 Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan paticipants shall be entitled to:

1. Receive Information about Your Plan and Benefits

   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

   In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

3. Enforce Your Rights

   If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

   Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

   If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions

   If You have any questions about Your Plan, You should contact the Plan Administrator. If You have questions about this statement or about rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

ERISA INFORMATION STATEMENT

The benefits described in Your certificate are insured by an Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Oklahoma (“We” or "Insurer"), pursuant to an "Employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1) established by Your employer, or where applicable, employee organization (the “Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate 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 Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to You pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE:

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Blue Cross and Blue Shield of Oklahoma
701 E. 22nd Street
Lombard, IL. 60148
1-888-381-9727

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148