COUNCIL ITEM 13A
DATE 12/10/12

PORT ST. LUCIE CITY COUNCIL
AGENDA ITEM REQUEST

RECEIVED

Meeting Date: December 10, 2012

DEC 01 2012

Public Hearing ____ Ordinance ____ Resolution ____ Motion X

City Manager's Office

Item: #20130006 Approval of Administrative Service Contracts with Vision Care, Inc. (n/k/a CompBenefits Company) for the City's Vision Care Plan: Original effective April 1, 1999, Amendment #1 effective April 1, 2000, Confidentiality and HIPAA Privacy Business Associate Agreement effective February, 2010, Amendment #2, effective January 1, 2013 increasing the Administrative Service fee by 5% from $1.15 to $1.21 per employee per month and provide that dependent children are covered to age 26 or 30 and continue to meet dependent criteria.

1) Recommended Action: Approval of Administrative Service Contracts with Vision Care, Inc. (n/k/a CompBenefits Company) for the City's Vision Care Plan: Original effective April 1, 1999, Amendment #1 effective April 1, 2000, Confidentiality and HIPAA Privacy Business Associate Agreement effective February 17, 2010, Amendment #2, effective January 1, 2013 increasing the Administrative Service fee by 5% from $1.15 to $1.21 per employee per month.

Exhibits:

a) Original Administrative Service Contract, dated May 7, 1999
b) Amendment #1, June 15, 2000
c) Correspondence dated February 19, 2010 from Humana, Inc. to City H.R. enclosing updated Confidentiality and HIPAA Privacy Business Associate Agreement to sign and return.
d) Correspondence dated March 9, 2010 from City Assistant H.R. Director to Humana, Inc. transmitting signed Business Associate Agreement.
e) Confidentially and HIPAA Privacy Business Associate Agreement, effective February 17, 2010.
f) CompBenefits Company Certificate of Benefits
g) Plan Sponsor Certification of HUMANA Group Health Plan Obligations under Health Information Technology for Economics and Clinical Health Act ("HITECH")
h) Department Memo
i) Amendment #2 increasing the Administrative Service Fee by 5% and increases dependent age criteria.

Summary Explanation/Background Information:

On May 11, 1999, the Deputy City Manager executed an agreement for a vision plan with Vision Care, Inc. which included Administration Services at the rate of $1.15 per month per eligible employee; payable monthly in advance. The Agreement was amended in 2000 and was also executed by the Deputy City Manager. Vision Care, Inc. subsequently became CompBenefits Company, a part of the Humana, Inc. family of companies in 2007 and has continued to administer the City's Employee Group Vision Insurance. With the enactment of the American Recovery and Reinvestment Act of 2009 ("ARRA") new obligations imposed resulted in an updated contract, the Confidentiality and HIPAA Privacy Business Associate Agreement, that was sent to the city through H.R. dept. to sign and return. The Agreement was executed by the Director of H.R. and processed.

To date, the Administrative fee has remained constant @ $1.15 per month per eligible employee, payable monthly in advance. Vision Care Inc. (n/k/a CompBenefits Company) has requested an increase to the Administrative fee by 5% from $1.15 to $1.21 per month per employee, payable in advance. The increased monthly administrative fee is guaranteed during the time period of January 1, 2013 through December 31, 2013.

In the interim the Office of Management and Budget is in the process of issuing a new bid for Employee Group Vision Insurance and Administrative Services.

Purchase (X) is ( ) is not a replacement

Purchase (X) was budgeted ( ) was not budgeted.

Expenditure: $ 1.21 per month per employee

Department requests expenditure from the following:

Fund	605	Medical Trust
Cost Center	1900	General Government
Object Code	549365	Vision Insurance
Project	V53210	

Director of OMB concurs with award: _____

City Manager concurs with award: _____

Submitted by: Susan Williams CM for SW

Title: Director of Human Resources

Date Submitted: November 30, 2012

MEMORANDUM

To: Gregory J. Oravec, City Manager

From: David K. Pollard, CGFO, Director of OMB

Date: November 30, 2012

Re: Vision Care Plan

On May 11, 1999, the Deputy City Manager executed an agreement for a vision plan with Vision Care, Inc.; this contract was amended in April of 2000 and that amendment was also executed by the Deputy City Manager. In February of 2010, the Confidentiality and HIPAA Privacy Agreement was executed by the HR Director. It appears that the earlier contract and amendments did not follow the required process of being reviewed and approval by the City Council. The documents also should have been signed by the City Manager. With this being known, staff is requesting proper Council Approval for the existing contract and the latest amendment.

If approved by City Council, the City intends to ratify the original contract and its subsequently executed documents and execute a 2nd Amendment. The 2nd Amendment will clarify the name change of the company from Vision Care, Inc. to CompBenefits Company and to increase the administration fee by 5% per employee per month.

Please place this item on the December 10, 2012 City Council agenda for approval.

Please let me know if you have any questions or concerns.

/DKP

visionCARE℠
Our focus is your care. PLAN

RECEIVED
MAY 17 1999
Ack'd.....

COPY

May 11, 1999

Mr. Victor Granello
Deputy City Manager
City of Port St. Lucie
121 SW Port St. Lucie Blvd.
Port St. Lucie, FL 34984-5009

Dear Mr. Granello:

Enclosed please find a copy of the signed agreement for the above group. We look forward to being of service to you and your group clientele.

Sincerely,

Luis M. Perna
President

LMP/cg
Encl.

cc: Nicholas P. Baccile

1511 NORTH WESTSHORE BOULEVARD • SUITE 1000 • TAMPA, FLORIDA 33607 • P.O.BOX 30349 • TAMPA, FLORIDA 33630-3349
PHONE 813.289.2020 • 800.749.5855 • FAX 813.281.0916

ADMINISTRATIVE SERVICES
BENEFITS ADMIN.
JUN 2 8 2000
RECEIVED

VISIONCARE PLAN

AMENDMENT I

COPY

To the Contract Between

Vision Care, Inc.
d/b/a
VisionCare Plan
(A licensed PLHSO under Chapter 636, F.S.)

and

City of Port St. Lucie
(Hereinafter called Group)

The Contract shall be amended as follows:

Effective April 1, the following eligibility wording shall be added:

Dependent children are covered to the end of the year in which they turn 19 or 25 years of age and continue to meet dependent status.

The undersigned hereby agree to the Amendment as stated above.

Vision Care, Inc.
~~City of Port Lucie~~

By. .....
(Authorized Signature)

Title. President

Date. 6.15.00

City of Port St Lucie
~~Vision Care, Inc.~~

By. Victor L Manello

(Authorized Signature)

Title. Deputy City Mgr

Date. 9-13-99

VisionCare Plan Form FL207199

VISIONCARE PLAN

COPY

ADMINISTRATIVE SERVICE CONTRACT

Vision Care, Inc.
d/b/a
VisionCare Plan
(A licensed PLHSO under Chapter 636, F.S.)

City of Port St. Lucie
(Hereinafter called Group)

Agree as Follows:

VisionCare Plan shall provide a Panel of Doctors to perform services for persons certified as eligible, subject to the terms and conditions of this Contract.

This Contract shall be effective from the first day of April 1999, for an initial term of twenty-four months and continuing thereafter until either party shall give the other sixty (60) days prior written notice of their intention to terminate.

The provisions and conditions set forth on the nine (9) pages shall form a part of this Contract as fully as if recited over the signatures hereto affixed.

In Witness Whereof, the parties have caused this Contract to be executed at Tampa, Florida, this 10th day of May, 1999.

City of Port St. Lucie	Vision Care, Inc.
By. Victor L. Granello	By.
(Authorized Signature)	(Authorized Signature)
Title...Deputy City Manager	Title. President
Date. May 7, 1999	Date. 5-10-99

Please submit without changes
Thanks,
VIC

VisionCare Plan Form FL207199

VISIONCARE PLAN

ELIGIBILITY

Group agrees to furnish VisionCare Plan with current listings of persons who meet the three (3) month waiting period and are eligible for services provided in this Contract or agrees to certify eligibility on the application post cards. To include retirees, spouses & dependents of employees killed in the line of duty, also divorced spouses & dependents by court order. Dependent children include biological children, adopted children, any other child you support who either lives with you in a parent child relationship or who's parents is your child and is covered as a depnedent under this plan.

ADMINISTRATION

A. All funds used by VisionCare Plan in connection with the administration of this Contract shall be furnished by Group. Recognizing that prompt payment is essential to proper execution of this Contract, Group agrees to make available to VisionCare Plan adequate funds for this purpose. An advance deposit in the amount of $3,385.20 shall be provided to VisionCare Plan by Group and replenished each month upon presentation by VisionCare Plan of a statement of benefits paid. This deposit shall be adjusted periodically to provide a realistic sum as required.

B. In consideration of the services of VisionCare Plan, Group agrees to pay VisionCare Plan the sum of $1.15 per month per eligible employee, payable monthly in advance.

C. VisionCare Plan shall process requests for Benefit Forms which shall be forwarded to VisionCare Plan by eligible persons, Group, or by the administrator.

D. Benefit Forms shall be issued by VisionCare Plan in accordance with the latest eligibility information furnished by Group.

E. Any Benefit Form so issued by VisionCare Plan shall constitute a certification to the VisionCare Plan Panel Doctor that payment will be made, and VisionCare Plan shall not be held liable for any Benefit Forms issued in error, provided they were issued in accordance with these provisions.

F. VisionCare Plan shall furnish a billing to group on a monthly basis for doctors' services and ophthalmic materials pursuant to this Contract.

G. In the event of termination of this Contract by either party, Group agrees to provide funds for payment pursuant to Benefit Forms issued prior to the termination date, provided such Benefit Forms are filed with VisionCare Plan within one year after termination of the Contract.

OFFICES NATIONWIDE

VISIONCARE PLAN

BENEFITS

I. DEDUCTIBLE

The following benefits are available to each eligible person from any participating VisionCare Plan Panel Doctor at no cost to eligible person provided eligible person follows the proper procedures by obtaining a VisionCare Plan Benefit Form and presenting it to the doctor in advance.

II. VISION EXAMINATION

Each eligible person shall be entitled to a vision examination once every twelve (12) months as follows:

Vision Analysis - A comprehensive examination of the visual functions, including the prescription of corrective eyewear where indicated.

1) An examination for vision analysis shall include the following procedures which shall be recorded on the patient's case record

   a) Patient's history (personal and family medical history, personal and family ocular history, and chief complaint);

   b) Visual acuity (unaided or acuity with present correction);

   c) External Examination;

   d) Pupillary Examination;

   e) Visual Field Testing (Confrontation);

   f) Internal Examination (Direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities);

   g) Biomicroscopy (Binocular or monocular);

   h) Tonometry;

   i) Refraction (with recorded visual acuity);

   j) Extra ocular muscle balance assessment;

   k) Diagnosis and treatment plan,

OFFICES NATIONWIDE

2) If, because of the patient's age or physical limitations, one or more of the procedures specified herein or any part thereof, cannot be performed, the reason for same shall be noted on the patient's case record.

Low Vision - Eligible persons who have a low vision condition diagnosed by a VisionCare Plan Panel Doctor are entitled to low vision services from the doctor as well as ophthalmic materials or other aids prescribed by the doctor subject to the limitations described in "LIMITATIONS." Low Vision is a condition where the usual frame is not adequate to support the larger or thicker lenses needed for correction. Therefore, a special apparatus has to be built to support the lenses on the patient's head.

When a VisionCare Plan Panel Doctor determines the presence of a low vision condition, he shall request advance approval prior to beginning services.

Services and materials covered may include supplemental testing, evaluations, training, low vision prescription services, plus optical and non-optical aids. Non-cosmetic contact lenses for low vision patients are also covered, when appropriate.

Following the initial service, the patient will be entitled to subsequent care consisting of an annual regular VisionCare Plan examination (covered by the regular VisionCare Plan plan) plus additional low vision services and materials as deemed necessary by the doctor and approved by the VisionCare Plan consultant.

III. MATERIALS

A. LENSES AND FRAME - Where the vision examination indicates that new lenses or frame or both are necessary for the proper visual health and welfare of an eligible person, they will be supplied, together with such professional services as are necessary, which shall include, but not be limited to: 1) prescribing and ordering proper lenses, 2) assisting in the selection of a new frame, 3) verifying the accuracy of the finished lenses, 4) proper fitting and adjustment of the spectacles, 5) progress or follow-up work as necessary, 6) subsequent adjustments to frame to maintain comfort and efficiency.

Certain materials such as oversize blanks are cosmetic in nature, and not necessary for the visual welfare of the patient. The extra cost of these must be borne by the patient.

These materials are available to each eligible person on the following basis:

VISIONCARE PLAN

LENSES: available once each twelve (12) months if a prescription change is warranted;

FRAME: available once each twelve (12) months if a replacement is necessary.

VisionCare Plan reserves the right to limit the cost of frames provided by its Panel Doctors under this plan. The limit will be set at a level that will cover the majority of the frames in common use in that geographical area. If the eligible person wishes to select a more expensive frame than that allowed under the program, the cost difference shall be borne by the patient.

B. MEDICALLY NECESSARY CONTACT LENSES - Contact lenses are furnished under the VisionCare Plan plan when the VisionCare Plan doctor secures prior approval from VisionCare Plan for the following conditions: A) following cataract surgery; B) when visual acuity cannot be corrected to 20/70 in the better eye except by their use; C) anisometropia of greater than 350 diopters and aesthenopia or diplopia, with spectacles; D) keratoconus diagnosis where contact lenses is the treatment of choice: E) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

Contact lenses furnished under the above provision are on a paid-in-full basis unless it is determined by the VisionCare Plan consultant that a certain type of lens is not strictly medically necessary but is cosmetic in nature. In this situation the patient will be asked to pay the cost difference above the basic medically necessary lenses.

Contact lenses once furnished under the above provisions of the plan can only be replaced with prior authorization by VisionCare Plan, but in no event more frequently than once in any twelve (12) month period.

C. ELECTIVE CONTACT LENSES - When patients choose contact lenses for reasons other than those mentioned above, VisionCare Plan will make an allowance of $100.00 toward their cost in lieu of all other benefits for that year. Participants will not be entitled to a separate exam and lens allowance, but instead, an all encompassing flat allowance.

LIMITATIONS

EXTRA COST ITEMS:

This plan is designed to cover visual needs rather than cosmetic materials. When the patient selects any of the following extras, VisionCare Plan will pay the basic cost of the allowed lenses and the patient will pay the additional laboratory cost for extras, plus a modest additional fee.

OFFICES NATIONWIDE

VISIONCARE PLAN

1) Oversized lenses
2) Blended and progressive lenses (no-line bifocals)
3) Lens coating
4) Tinted lenses (except pink #1 and pink #2)
5) Photochromic lenses
6) Frames costing more than the plan allowance
7) Faceted lenses
8) Other cosmetic items

LOW VISION CARE PLAN BENEFIT LIMITS:

Prior Authorization - When a Panel Doctor suspects a low vision condition, he shall write up his findings and send it to VisionCare Plan for review by their optometric consultants. If the consultants concur that the patient is eligible, and that the doctor is correct in his initial assessment of the problem, the consultants shall authorize supplementary testing by the doctor. Supplemental testing is paid by the plan with no co-payment required by the patient for this benefit. This benefit is also not subject to the contract deductible(s) as described above. The purpose of the testing is to determine the nature of the problem and to allow the doctor to gather enough facts to propose a treatment plan.

Co-payment - After supplemental testing has been completed, the doctor shall write up his treatment plan and send it to the VisionCare Plan consultants. They will review the plan and, after approval, VisionCare Plan will authorize payment for the approved plan on a co-payment basis in an amount not to exceed a total of $1,000.00 each two years, with the patient paying 25% up to $250.00 and VisionCare Plan paying 75% up to $750.00. The benefits for the completion of the approved treatment plan are not subject to the contract deductible(s) as described above. Thus: both VisionCare Plan and the patient must approve the plan.

NOT COVERED:

There is no benefit for professional services or materials connected with:

1. Medically necessary contact lenses, except with prior authorization.
2. Orthoptics or vision training, subnormal vision aids, aniseikonic lenses, plano (non-prescription) lenses or glasses secured when there is no prescription change.
3. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
4. Medical or surgical treatment of the eyes.
5. Services or materials provided as a result of Workers' Compensation law, or similar legislation, or obtained through or required by any government agency or program whether Federal, State, or any subdivision thereof.

OFFICES NATIONWIDE

6. Any eye examination required by an employer as a condition of employment, or any service or material provided by any other vision care plan, or group benefit plan containing benefits for vision care.

7. If the covered person does not obtain the VisionCare Plan Benefit Form in advance, but visits the Panel Doctor as a private patient, the Panel Doctor is not obligated to accept VisionCare Plan fees as full payment for these services, but may elect to charge his usual and customary fees.

8. Two pair of glasses in lieu of bifocals.

VisionCare Plan may at its discretion waive any of the plan limitations if, in the opinion of our optometric consultants, this is necessary for the patient's visual welfare.

GENERAL PROVISIONS

1. VisionCare Plan acts as a contracting agency hereunder to enable Group and eligible persons to acquire professional vision care on a prepaid basis. Under no circumstances shall VisionCare Plan or Group be liable for the negligence, wrongful acts, or omissions of any doctor, laboratory or other person or organization performing services or supplying materials in connection with this Contract. Group agrees that neither Group nor its representatives or employees shall engage in referring members of Group to any particular doctor, or doctors, whether or not a member of the VisionCare Plan Panel.

2. Each eligible person shall be entitled to obtain the services enumerated herein from any participating Panel Doctor of VisionCare Plan. The names, addresses, and telephone numbers of participating Panel Doctors shall be made available to eligible members of Group when seeking services.

3. VisionCare Plan shall have the right at all reasonable times to inspect such records of Group as VisionCare Plan deems necessary to determine the number and eligibility of eligible persons, and Group agrees to make such records available at such times and on request.

4. All notices provided hereunder shall be deemed as having been properly made upon depositing the same in the United States mail, postage prepaid, and addressing such notices to VisionCare Plan at its main office, or to Group at the address appearing last on the books of VisionCare Plan.

5. Upon receipt by VisionCare Plan of a request for benefits from a member of Group, VisionCare Plan will issue a Benefit Form to such member provided: (A) The request is certified by Group; or (B) The member appears eligible by reason of the latest information available to VisionCare Plan, furnished by the Group. Benefit Forms so issued shall be assigned an expiration date, allowing a reasonable period of time for the eligible person to obtain services. Such Benefit Form, properly used, shall constitute a claim against the plan,

OFFICES NATIONWIDE

irrespective of later loss of eligibility by the member or cancellation of this Contract.

6. Benefit Forms authorizing services will not be issued under this Contract on or after the date of expiration of the Contract.

7. If service for an eligible person hereunder is being rendered as of the termination date of this coverage, such service shall be continued to completion but in no event beyond nine (9) months after the termination date of the Contract. VisionCare Plan reserves the right to reject any and all claims for services or benefits which are filed with it more than ninety (90) days after completion of services.

8. This instrument contains all of the provisions of the Contract between the parties hereto; and no promise or agreement not contained herein shall be binding on the parties unless the same is in writing, signed by the parties hereto and attached to this Contract. Only an Officer or Director of VisionCare Plan has the power to change, modify or waive the provisions of this Contract, and then only in writing. Consent of eligible persons is not required to effect any such change.

9. Neither this Contract, nor any benefits hereunder, including the payment of money, is assignable, except with prior consent of VisionCare Plan.

10. If any provision of this Contract is declared invalid or unenforceable, the remaining provisions hereof shall remain in full force and effect. The failure of either party to protest any default or breach shall not constitute a waiver of such party's rights under this Contract, or such party's rights upon any subsequent default or breach.

11. This Contract shall be governed by and construed under the laws of the State of Florida.

12. This Contract may be amended from time to time by mutual agreement of both Group and VisionCare Plan.

13. Each party represent it has all requisite legal power and authority and has taken all action necessary or appropriate to enter into this contract and that its representative executing this contract is duly empowered to do so.

14. With respect to indemnification, each party shall be liable for its own acts and/or omissions and shall be liable therefor in accordance with applicable law.

CONSUMER ASSISTANCE:

Florida Department of Insurance
Division of Insurance - Consumer Assistance
200 East Gaines Street
Tallahassee, FL 32399-0322
1-800-342-2762

VISIONCARE PLAN

NON-PANEL REIMBURSEMENT

For complete cost and quality control the eligible person should select a doctor from the Participating Doctor List. However, if an eligible person does not wish to secure services as described in the plan from a VisionCare Plan Doctor, he may secure services from a non-participating doctor or dispensing optician and submit the bill to VisionCare Plan for reimbursement in accordance with the following schedule:

PROFESSIONAL SERVICES:

Vision Analysis, up to	$35

MATERIALS:

Single Vision lenses, up to	$30
Bifocal lenses, up to	$50
Trifocal lenses, up to	$60
Lenticular lenses, up to	$100
Frame, up to	$30

CONTACT LENSES:

*Necessary	$180
Elective	$100

*Determination of "Necessary" versus "Elective" contact lenses under the non-panel reimbursement schedule will be consistent with Panel Doctor services.

The above lens allowances are for two lenses.

The amounts shown are maximum, and the actual amount to be paid in reimbursement to the member shall be the lesser of the maximum shown in the schedule for services, the amount charged, or the amount usually charged by the provider of such services to his private patients as determined by VisionCare Plan.

Availability of services under this reimbursement schedule are subject to the same time limits and deductible as those described for Panel services, and are in lieu of obtaining these services from a VisionCare Plan Panel member.

OUT-OF-STATE SERVICES

A. Panel Member services are available throughout the United States.

B. In areas where VisionCare Plan does not have Panel Doctors nearby, the member may obtain service from any licensed practitioner and receive reimbursement under the above schedule.

AMENDMENT 2
TO THE ADMINISTRATIVE SERVICE CONTRACT
BY AND BETWEEN
VISION CARE, INC. (n/k/a COMPBENEFITS COMPANY)
AND
CITY OF PORT ST. LUCIE

Reference is made to the Administrative Service Contract ("Agreement") between Vision Care, Inc. (n/k/a CompBenefits Company) ("VisionCare Plan") and City of Port St. Lucie ("Group") effective April 1, 1999.

The parties do hereby agree to amend the Agreement as follows:

1) Effective January 1, 2013, paragraph B of the Administration section is hereby deleted in its entirety and replaced with the following:

   A. In consideration of the services of VisionCare Plan, Group agrees to pay VisionCare Plan the sum of $1.21 per month per eligible employee ("Monthly Administration Fee"), payable monthly in advance. The Monthly Administration Fee is guaranteed during the time period January 1, 2013 through December 31, 2013.

In all other respects, the terms and conditions of the Agreement shall remain unchanged.

The effective date shall be January 1, 2013.

IN WITNESS WHEREOF, the parties agree to the foregoing provisions by placing their duly authorized signatures below.

Vision Care, Inc. **(n/k/a CompBenefits Company)**	**City of Port St. Lucie**
By:_____	**By:**_____
Name:_____	**Name: Gregory J. Oravec**
Title:_____	**Title: City Manager**
Date: _____	**Date:** _____

Humana Inc.
Privacy Office
500 West Main Street
P. O. Box 1438
Louisville, KY 40201-1438
Humana.com

ADMINISTRATIVE SERVICES
BENEFITS ADMIN.
FEB 25 2010
RECEIVED

HUMANA.
Guidance when you need it most

February 19, 2010

City of Port St. Lucie
Attn: Claudia McCaskill/Tracy Skiner
121 SW Port Saint Lucie Blvd
Port Saint Lucie, FL 34984

Dear Claudia McCaskill/Tracy Skiner:

CompBenefits Corporation became a part of the Humana, Inc. family of companies in October 2007. We would like to extend our appreciation for your continued partnership as we work together to provide health benefits to your members. During these challenging times, the importance of our partnership cannot be underestimated, and we thank you for your efforts to keep our relationship strong as we work together to achieve our objectives. As you know, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is designed to protect the privacy and provide for the security of Members' Protected Health Information ("PHI"). Our records indicate that we are currently providing third party administration services on your behalf involving the creation, use and/or disclosure of your Members' PHI.

The new Health Information Technology for Economics and Clinical Health Act ("HITECH"), which was part of the American Recovery and Reinvestment Act of 2009 ("ARRA") directly imposes new obligations on Business Associates by law.

Enclosed is an updated Business Associate agreement reflecting all of the HIPAA changes made by the HITECH provisions of the ARRA that must be signed by an authorized person within your organization and returned to the address below. Please sign both original documents; mail one original document to the address shown below and keep the other original for your records.

Mailing address:
Humana Privacy Office
Attn: Gregory Gish
PO Box 1438
Louisville, KY 40201-1438

I appreciate your time and attention to this matter as we both work to ensure we maintain the security and confidentiality of your members' information.

If you have any questions, please call Gregory Gish at 1-800-664-4140, extension 1625. Thank you in advance for your prompt attention to this very important request.

Sincerely,

Jim Theiss
Chief Privacy Official, Humana Inc.
Enclosure

CITY OF PORT ST. LUCIE

Human Resources

A CITY FOR ALL AGES

March 9, 2010

Humana Privacy Office
Attn: Gregory Gish
P. O. Box 1438
Louisville, KY 40201-1438

Dear Mr. Gish:

Attached is the signed Business Associate agreement that has been signed by the Director of Human Resources for the City of Port St Lucie.

Please note in your records that any future administrative correspondence such as this document should be addressed to my attention here at the City.

Thank you for your assistance in this matter.

Sincerely,

Sharon E. Pack

SHARON E. PACK
Assistant Director, H.R.

Enclosure

121 S.W. Port St. Lucie Boulevard • Port St. Lucie, FL 34984-5099 • 772/344-4335
TDD# 772/873-6339 Job Line 772/807-4473

CONFIDENTIALITY and HIPAA PRIVACY
BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is entered into by and among **City of Port St. Lucie ("Client"),** who maintains a self-insured dental and/or vision plan that is a signatory to this Agreement, the **City of Port St. Lucie ("Plan"),** and **CompBenefits Insurance Company** ("**Business Associate**"), who is a provider of administrative services with respect to the Plan under a separate agreement referred to as the "ASO Agreement".

This HIPAA Business Associate and Confidentiality Agreement (hereinafter the "**Agreement**) is effective the seventeenth day of February, 2010.

In consideration of the mutual promises below and the exchange of Information described herein, the parties agree as follows:

In connection with providing administrative services with respect to the Plan under the ASO Agreement, Business Associate receives certain information relating to individuals with respect to whom benefits may be or become payable under the provisions of the Plan ("Information"), some of which may constitute Private Health Information (defined below). In this regard:

1. Definitions. The following terms shall have the meaning set forth below:
   (a) ARRA. "ARRA" means the American Recovery and Reinvestment Act of 2009

   (b) C. F. R. "C.F. R." means the Code of Federal Regulations.

   (c) Designated Record Set. "Designated Record Set" has the meaning assigned to such term in 45 C. F. R. 160.501.

   (d) Discovery. "Discovery" shall mean the first day on which a Security Breach is known to Business Associate (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of Business Associate), or should reasonably have been known to Business Associate, to have occurred.

   (e) Electronic Health Record. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized health care clinicians and staff.

   (f) Electronic Protected Health Information. "Electronic Protected Health Information" means information that comes within paragraphs 1 (i) or 1 (ii) of the definition of "Protected Health Information", as defined in 45 C. F. R. 160.103.

   (g) Individual. "Individual" shall have the same meaning as the term "individual" in 45 C. F. R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C. F. R. 164.502 (g).

   (h) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C. F. R. 160.103, limited to the information created or received by Business Associate from or on behalf of The Plan.

   (i) Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45
   C. F. R. 164.501.

(j) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

(k) Security Breach. "Security Breach" means the unauthorized acquisition, access, use or disclosure of Protected Health Information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. Security Breach does not include:

(i) any unintentional acquisition, access, or use of Protected Health Information by an employee or individual acting under the authority of Business Associate if:

(a) such acquisition, access or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with Business Associate; and

(b) such information is not further acquired, accessed, used or disclosed by any person; or

(ii) any inadvertent disclosure from an individual who is otherwise authorized to access Protected Health Information at a facility operated by Business Associate to another similarly situated individual at the same facility; and

(iii) any such information received as a result of such disclosure is not further acquired, accessed, used or disclosed without authorization by any person.

(l) Security Breach Compliance Date. "Security Breach Compliance Date" means the date that is thirty (30) days after the Secretary publishes interim final regulations to carry out the provisions of Section 13402 of Subtitle D (Privacy) of ARRA..

(m) Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 C. F. R. 164.304.

(n) Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C. F. R., Parts 160-162.

(o) Unsecured Protected Health Information. "Unsecured Protected Health Information" means Protected Health Information that is not secured through the use of a technology or methodology specified by guidance issued by the Secretary from time to time.

b. The Parties acknowledge that Business Associate is a service provider with respect to the Plan under the ASO Agreement. This Agreement pertains to Private Health Information and Protected Health Information in the possession or control of Business Associate in connection with services provided under the ASO Agreement, and in that respect complements or amends any provisions respecting confidentiality of Private Health Information expressed in the ASO Agreement. However, unless this Agreement specifically describes an administrative service and obligates Business Associate to provide it, nothing in this Agreement shall operate to modify or enlarge the scope of administrative services to be provided by Business Associate, which are otherwise described in the ASO Agreement.

2. With respect to Private Health Information, generally, the following provisions apply.

a. The Parties acknowledge that in the course of performing their respective duties under the ASO Agreement, they may acquire or obtain access to or knowledge of Private Health

Information. This information is at all times the property of the Plan or the Client, depending upon its nature and source, and not the Business Associate, even if it is received by the Business Associate. Information of this nature that is received by the Business Associate will be deemed to be information received on behalf of the Plan. However, information that is produced incidentally through application of the computer systems employed by the Business Associate in the course of providing services under the ASO Agreement will not be considered property of the Plan or the Client or any Covered Person, if it is not specific to the Plan or not material to Plan administration.

b. The Parties agree to cooperate in order to safeguard Private Health Information to ensure that the information remains confidential and is not improperly disclosed. The Parties will make sure that individuals under their direct control, respectively, who perform functions that may bring those individuals into contact with Private Health Information are made familiar with the confidentiality obligations set forth in this Agreement, appropriately trained in privacy policies directed at safeguarding against improper disclosure, and abide by those requirements as minimum safeguards against improper disclosure. The Parties acknowledge with respect to Private Health Information that disclosure is improper if it is not allowed by law or made for any purpose other than Plan administration or benefits delivery. Disclosure to individuals who perform Plan-related functions under the auspices of the Plan Administrator or health care provider may be proper, if the disclosure is allowed by law and made for Plan purposes. Furthermore, the Client further represents and warrants that security controls, restrictive processes, and other appropriate safeguards have been put in place between the employer of a Covered Person and the Plan to protect Private Health Information from improper disclosure.

c. Business Associate will afford access to Private Health Information or other personal information received by it to the Plan or the Client, as permitted under this Agreement and by law. Business Associate will afford access to this information to other persons only as reasonably directed in writing by the Plan or the Client, with due regard for confidentiality, and Business Associate shall have no further obligation with respect to that information. Except as provided in this Agreement, Business Associate will disclose Private Health Information to a third party only if authorized by an ancillary agreement respecting confidentiality. Business Associate is directed to afford access to Private Health Information to the persons listed in Attachment A, under circumstances where disclosure is appropriate and necessary:

d. In connection with performing its obligations under this Agreement, it may become necessary for Business Associate to disclose to the Plan or the Client, their designees or third parties under contract with either of them ("Recipients", for purposes of this section) trade secret and/or proprietary information of Business Associate or its affiliates (referred to in this section collectively as "CompBenefits"). The Client and the Plan agree to safeguard and ensure the confidentiality of such trade secret and/or proprietary information, which shall include information relating to (i) the business of CompBenefits, its affiliates, their clients and representatives, (ii) third parties under contract with CompBenefits, (iii) service provider arrangements or contracts, (iv) service provider network arrangements or contracts, and (v) documentation relating to the computer systems utilized by CompBenefits.

(1) Access to the trade secret and/or proprietary information described above will be permitted for Recipients only; it may be used by Recipients only in a manner necessary to accomplish the purposes described above with respect to Private Health Information and other personal information; and it may not be disclosed to any third parties, including their employees that do not have a need to know,

without authorization by CompBenefits (except as may be required by order of a court or regulatory agency of competent jurisdiction). Access to such records or information does not constitute a transfer of ownership, permission to appropriate, or license to use the same for any purpose not contemplated under this Agreement.

(2) The Client and the Plan understand and agree that the Client (or its designee) must recognize and abide by restrictions upon disclosure of information and/or systems that are imposed by contracts between CompBenefits and third parties (provided CompBenefits first notifies the Client or the Plan or their designees in writing of such restrictions) or by law, regulation, or order of a court or regulatory agency.

e. Upon termination of this Agreement, records containing Private Health Information in the possession of the Plan Manager will be either delivered to the Plan Administrator or destroyed when the Plan Manager's records retention obligations have been fulfilled. If such delivery or destruction is not feasible, the protections of this Agreement will continue to apply to those records and further uses and disclosures of the Private Health Information or other personal information shall be limited to those purposes that make the return or destruction of the information infeasible.

f. The Client, the Plan and Business Associate agree that they will require other persons or entities that receive Private Health Information and/or trade secret or proprietary information in connection with and as permitted by this Agreement to agree in writing to observe the protections described herein as minimum safeguards against improper disclosure of such information.

3. With respect to Protected Health Information, specifically, the following provisions apply:

a. Business Associate, the Plan and the Client, intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this Agreement in compliance with HIPAA and the regulations promulgated thereunder by the U.S. Department of Health and Human Services, including, but not limited to, Title 45, Section 164.504(e) of the Code of Federal Regulations ("CFR"), as the same may be amended from time to time and other applicable state and federal laws, rules and regulations.

b. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that further amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI.

c. Obligation of Business Associate.

(1) Permitted Uses and Disclosures. Business Associate may create, use and/or disclose PHI of Covered Persons pursuant to the ASO Agreement or this Agreement provided that such use and/or disclosure would not violate the Privacy and Security Rules if done by Plan or the minimum necessary policies and procedures of the Plan, for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the PHI will remain confidential and used or further disclosed only as required by Law or for the

purpose for which the PHI was disclosed to the person, and the person notifies the Business Associate of any instances of which the person is aware in which the confidentiality of the PHI has been breached.

(2) Specific Use and Disclosure Provisions

(1) Except as otherwise prohibited by this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(2) Except as otherwise prohibited by this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached in accordance with the Security Breach and Security Incident notifications requirements of this Agreement.

(3) Except as otherwise prohibited by this Agreement, Business Associate may use Protected Health Information to provide data aggregation services to The Plan as permitted by 42 C.F.R. 164.504(e)(2)(i)(B).

(4) Business Associate may use Protected Health Information to report violation of law to appropriate Federal and State authorities, consistent with 164.502 (j)(1).

(3) Data Aggregation Services. For purposes of this Section, "Data Aggregation" means, with respect to PHI pertaining to Covered Persons in the possession of Business Associate by virtue of the ASO Agreement, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a Business Associate of another Covered Entity, as that term is defined under HIPAA to permit data analyses that relate to the operations of the respective Covered Entities.

(4) Safeguards. Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as specifically provided for by the ASO Agreement or this Agreement. Such safeguards shall at a minimum include: (i) a comprehensive written information privacy and security policy; and (ii) a program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of his/her/its activities; and (iii) appropriate confidentiality agreements with all employees, subcontractors, independent contractors and any entity to which Business Associate has delegated or sub-delegated his/her/its rights, duties, activities and/or obligations under the ASO Agreement or this Agreement which contain terms and conditions that are the same or similar to those contained in this Agreement.

(5) Reporting of Disclosures and Mitigation. Business Associate shall provide written notice within five (5) calendar days to Plan of any use or disclosure of PHI other than as specifically provided for by the ASO Agreement or this Agreement. Such notice shall be provided in the manner set out in this Agreement. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is

known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

(6) Contractors. It is understood and agreed that Business Associate shall maintain written confidentiality agreements with contractors, including without limitation subcontractors and independent contractors, as necessary to perform the services required under the ASO Agreement, in a form consistent with, the terms and conditions established in this Agreement. Business Associate shall ensure that any agents, including subcontractors, to whom it provides Covered Person's PHI received from, created by, or received by Business Associate on behalf of the Plan agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI.

(7) Availability of Information. Business Associate shall prepare, maintain and retain records relating to the use and disclosure of PHI in such form and for such time periods as required by applicable state and federal laws, rules and regulations, and in accordance with such standards. The Plan may obtain, copy and have access, upon reasonable request, to any administrative or financial record of Business Associate related to the use and disclosure of PHI. Copies of such records shall be provided to the Plan by Business Associate upon reasonable request of the Plan, which includes the scope of the request, at no additional cost to the Plan.

(A) Business Associate shall make PHI available to Plan as reasonably required to fulfill Plan's obligations to amend such PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526 and Business Associate shall, as directed by Plan, incorporate any amendments to PHI into copies of such PHI maintained by Business Associate.

(B) If so directed by the Plan, Business Associate will provide access to PHI by Covered Persons, provide copies of PHI to Covered Persons, and provide an accounting to Covered Persons or to the Plan, as directed by the Plan, of disclosures by Business Associate for purposes other than Plan operation or benefits delivery that are improper disclosures under HIPAA and the HIPAA Privacy Regulations, but only with respect to PHI in Business Associate's possession and under its control at the time of such disclosure.

(C) However, Business Associate will not be responsible for determining the rights of Covered Persons to acquire access to PHI concerning them (whether or not such information is at any time in the possession of the Plan Manager).

(8) Amendment of PHI. Business Associate shall make PHI available to the Plan as reasonably required to fulfill the Plan's obligations to amend such PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526, and Business Associate shall, as directed by the Plan, incorporate any amendments to PHI into copies of such PHI maintained by Business Associate. However, Business Associate will not be responsible for determining the rights of Covered Persons to modify PHI concerning them (whether or not such information is at any time in the possession of the Plan Manager).

(9) Internal Practices. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, created by, or received by Business Associate on behalf of the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining Business Associate's compliance with HIPAA and the HIPAA Regulations.

(10) Notification of Breach. During the term of the ASO Agreement, Business Associate agrees to report to The Plan any Security Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than ten (10) calendar days after Discovery of a Security Breach. Such notice shall include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed In connection with such Security Breach. In addition, Business Associate shall provide any additional information reasonably requested by The Plan for purposes of investigating the Security Breach. Business Associate's notification of a Security Breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA and related guidance issued by the Secretary from time to time.

Breach notifications must be reported to the Plan by one of the following method:

By Mail:[Plan's Privacy Officer]
[Addr 1]
[Addr 2]
[City, State, Zip]

(11) With respect to Electronic Protected Health Information, Business Associate shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of The Plan. Business Associate acknowledges that, effective the later of the Effective Date of this Agreement or February 17, 2010, (i) the foregoing safeguard, policies and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to Plan, and (ii) Business Associate shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguard, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

(12) With respect to Electronic Protected Health Information, Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

(13) Business Associate shall report to Plan any Security Incident of which it becomes aware.

d. Obligations of the Plan / Client.

(1) The Plan or the Client will use appropriate safeguards to maintain the confidentiality, privacy and security of PHI in transmitting same to Business Associate pursuant to the Arrangement and this Agreement.

(2) The Plan or the Client shall notify Business Associate of any limitation(s) in CompBenefits's notice of privacy practices that The Plan or the Client produces in accordance with 45 C.F.R. 164.520 (as well as any changes to that notice), to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

(3) The Plan or the Client shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Business Associate's use or disclosure of Protected Health Information.

(4) The Plan or the Client shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that The Plan or the Client has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

e. Audits, Inspection and Enforcement. From time to time upon reasonable notice, or upon a reasonable determination by the Plan or the Client that Business Associate has breached this Agreement with respect to PHI, the Plan or the Client may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any term of this Agreement and shall certify the same to the Plan in writing. Waiver, whether expressed or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party, shall not at any time be deemed a waiver of a party's right to elect such remedy (ies) at any subsequent time if a condition of default continues or recurs.

To the extent that the Plan or the Client determines that such examination is necessary to comply with the Plan's legal obligations pursuant to HIPAA relating to certification of its security practices, the Plan or the Client or the Plan's authorized agents or contractors, may, at the expense of either of them, examine Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Plan the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations or this Agreement.

4. Termination.

a. Material Breach. Notwithstanding anything to the contrary in the ASO Agreement or this Agreement, a breach by Business Associate of any provision of this Agreement respecting PHI, as reasonably determined by the Client and the Plan, shall constitute a material breach of the ASO Agreement providing grounds for immediate termination of the ASO Agreement.

b. Reasonable Steps to Cure Breach. Business Associate shall take reasonable steps to alleviate any potential, alleged or actual violations of permitted disclosures of PHI. If Business Associate's efforts are unsuccessful, Client may: (i) terminate the ASO Agreement immediately or (ii) if termination of the ASO Agreement is not feasible, report Business Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Judicial or Administrative Proceedings. Either party may terminate the ASO Agreement, effective immediately, if: (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

d. Effect of Termination. Upon termination of the ASO Agreement for any reason, Business Associate shall return or destroy all Covered Person PHI or PHI created or received by Business Associate with respect to the Plan that Business Associate still maintains in any form, and shall retain no copies of such PHI or, if return or destruction is not feasible, it shall continue to extend the protections of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. The Plan or the Client shall have the final determination on whether the Business Associate may destroy documents as opposed to returning the originals.

5. Indemnification. The Plan, the Client, and Business Associate will indemnify, hold harmless, and defend each other from and against any and all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in connection with: (i) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of a party under this Agreement respecting PHI; and (ii) any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the party's performance under this Agreement.

6. Disclaimer. Business Associate makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA or the HIPAA Regulations will be adequate or satisfactory for the Plan's or the Client's own purposes or that any information in the Plan's or the Client's possession or control, or transmitted or received by the Plan or the Client, is or will be secure from unauthorized use or disclosure. The Plan or the Client, respectively, is solely responsible for all decisions made by it regarding the safeguarding of PHI.

7. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under the ASO Agreement, available, at no cost to either the Plan or the Client, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Plan or the Client, or the Client's directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy attributable to Business Associate, except where Business Associate or its contractor, employee or agent is a named adverse party.

8. No Third Party Beneficiaries. The parties have not created and do not intend to create by this Agreement any third party rights under this Agreement, including but not limited to Covered Persons. There are no third party beneficiaries to this Agreement.

9. Receipt of PHI. Business Associate's receipt of Covered Person's PHI pursuant to the transactions contemplated by the ASO Agreement shall be deemed to occur beginning on the execution date below, and Business Associate's obligations under this Agreement shall commence with respect to such PHI upon such receipt.

10. Interpretation. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations. In the event of any irreconcilable conflict between this Agreement and the ASO Agreement as to the subject matter referenced herein, this Agreement shall control.

11. Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, the safeguarding of Electronic Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, both parties agree to negotiate in good faith any necessary amendment of this Agreement. Such amendment shall not be effective until both parties have agreed in writing to its terms.

12. Survival. The respective rights and obligations of Business Associate under Sections 4(d) of this Agreement shall survive the termination of this Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement.

Business Associate:

CompBenefits Insurance Company

By:

Print Name: J Gregory Catron
Title: VP Assistant General Counsel

Date: 02/15/2010

Address for Notice:

COPY TO:

COPY TO:
CompBenefits Insurance Company.
Privacy Office
P.O. Box 1438
Louisville, KY 40202-1438

Client:

By: _____

Print Name: _____
Title: _____

Date: _____

Address for Notice:

COPY TO:

Plan:

City of Port St. Lucie

By:

Print Name: JAMARA J. WILLIAMSON
Title: DIRECTOR, H.R.

Date: MARCH 2, 2010

Address for Notice:

COPY TO:

Attachment A

Persons Authorized to Receive PHI on behalf of the Plan"

Individual's name	Individual's name
Title	Title
Company Name	Company Name
address	address
city / state / zip	city / state / zip
Telephone No.	Telephone No.
FAX No.	FAX No.
E-Mail Address	E-Mail Address

Individual's name	Individual's name
Title	Title
Company Name	Company Name
address	address
city / state / zip	city / state / zip
Telephone No.	Telephone No.
FAX No.	FAX No.
E-Mail Address	E-Mail Address

Add additional Names as Necessary

HUMANA®
CompBenefits

CompBenefits Company

A Prepaid Limited Health Service Organization
Licensed Under Chapter 636, Florida Statutes

Certificate of Benefits

This certificate outlines the features of the Group Vision Contract issued to your Group by CompBenefits Company. Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Contract. If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 865-3676.

Gerald L. Ganoni
President

DEFINITIONS

Copayment- the amount paid by Member for services rendered or materials purchased.

Contract- means the written agreement between CompBenefits Company and the Group.

Contribution- a periodic payment due to CompBenefits Company by or on behalf of Member to receive benefits as provided by the Certificate.

Dependent– means any of the following persons: your spouse; your children; from birth to age 26 and dependent upon you for support; 26 years of age but under 26 years of age, if the child meets all of the following: the child is dependent upon you for support; and the child is living in your household, or the child is a full-time or part-time student. A child also includes adopted children, as well as stepchildren or foster children living with the Subscriber in a parent-child relationship.

Group- means the aggregate of individuals eligible to be covered under the Plan as established by the terms of the Contract.

Member- means the Subscriber and covered Dependents of a Subscriber.

Plan, We, Us or Our- means CompBenefits Company

Schedule of Benefits – means the listing of benefits showing what is paid.

Subscriber- an individual in good standing for whom the necessary contributions and Copayments have been made and to whom a Certificate evidencing coverage has been issued.

VisionCare Plan Network Provider- a licensed optometrist or ophthalmologist under agreement with CompBenefits Company to provide vision services to Plan Members.

LIMITATIONS

The Plan is designed to cover visual needs rather than cosmetic choices. Covered Materials that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits. The Member is responsible for the following extra items selected, unless otherwise listed as a covered benefit in the Schedule of Benefits. These items include but are not limited to:

* Coated or laminated lenses.
* Blended or progressive multifocal lenses.
* Tinted or photochromic lenses, sunglasses, prescription and plano.
* A frame that costs more than the Plan allowance.
* Groove, drill or notch, and roll and polish.

EXCLUSIONS

The Plan does not pay benefits for services or materials connected with:

* Orthoptics or vision training and any associated supplemental testing;
* Subnormal vision aids, non-prescription or aniseikonic lenses;
* Contact lenses, except as covered in the Schedule of Benefits;
* Hi Index, aspheric and non-aspheric styles;
* Oversized 61 and above lens or lenses;
* Experimental or non-conventional treatment or device;
* Medical or surgical treatment of the eyes;
* Charges incurred after coverage ends;
* Cosmetic items, unless specifically covered in the Schedule of Benefits;
* Any injury or illness covered paid any Workers Compensation or similar law;
* Two pairs of glasses in lieu of bifocals, trifocals or progressives;
* Services or materials from a provider that is not a VisionCare Plan Network Provider; or

* Any services and/or materials required by an employer as a condition of employment.

USING YOUR PLAN

The Member may choose between either the Vision Pass or the Vision Pass w/ ID Card each time prior to services being received.

Vision Pass: You may obtain a Vision Pass before scheduling an appointment. Vision Pass forms may be requested by (i) calling the Plan's Member Services Department at 1-800-865-3676; (ii) connecting to Our Web site at www.compbenefits.com; (iii) faxing toll free at 1-800-421-0100 or (iv) mailing Us at P.O. Box 30349, Tampa, FL 33630-3349.

A Vision Pass Form, valid for sixty (60) days along with a list of VisionCare Plan Network Providers in your area, will be sent to you. Members' use of benefits under another vision plan will affect determination of benefits under this Plan. Members must choose a VisionCare Plan Network Provider from the list and schedule an appointment. Please identify yourself as a VisionCare Plan Member and have your group name and policy number available.

Present the original Vision Pass to the VisionCare Plan Network Provider you selected at the time of your first scheduled appointment. The VisionCare Plan Network Provider will provide the covered service and bill the Plan directly. You will pay your Copayment and any extra costs for services and materials not covered by the Plan.

Vision Pass w/ ID Card: Before scheduling an appointment, the Member must choose a VisionCare Plan Network Provider from the list of the network providers in the Member's area. The Member must call to schedule an appointment and give the VisionCare Plan Network Provider his/her name, the patient's name, ID number, and the Group name and number. After scheduling the appointment, the VisionCare Plan Network Provider's office verifies the Member's eligibility and benefits before performing the exam. When the exam is completed, the VisionCare Plan Network Provider has the Member sign a claim form. The VisionCare Plan Network Provider submits the form directly to the Plan for payment. The Member is responsible for the Copayment and the costs of services and materials not covered by the Plan.

Using a Non-VisionCare Plan Network Provider: When an Insured elects to obtain services or purchase Materials from a Non-VisionCare Plan Network Provider, payment of benefits are based upon the VisionCare Plan Network allowance. The allowances are shown in the Schedule of Benefits. The Insured may pay the Non-VisionCare Plan Network Provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. The Insured is responsible for the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered by the Policy.

PROBLEM-SOLVING

Informal Grievances

Any Member who has a suggestion for improving services or wishes to register a complaint for any matter arising out of the Certificate or for covered services rendered or materials received, may submit an informal oral grievance to the Plan. Assistance with the Plan's grievance procedures, including informal oral grievances, may be obtained by contacting the Member Services Department at the address and phone number shown below. Informal oral grievances will be responded to as soon as possible. The Member has the right to file a formal written grievance with the Plan and to grieve directly to the State of Florida Department of Insurance.

Submission of Formal Grievances

Any Member who has a suggestion for improving services or wishes to register a complaint for any matter arising out of the Certificate, or for covered services or materials received, may submit a formal written grievance to the Plan. The written grievance must be identified as such and submitted to the Plan's Grievance Coordinator within one (1) year from the date of the occurrence of the events upon the grievance is based. The grievance must contain the Member's name, address, phone number, ID number, signature, date, and the action requested. Assistance with the Plan's grievance procedures may be obtained by contacting the Member Services Department at the address and phone number shown below.

Response to Formal Grievances

The Grievance Coordinator will investigate the grievance, gather all of the relevant facts review the case with the appropriate parties and respond in writing to the Member and the VisionCare Plan Network Provider, if appropriate, within ten (10) days of completion of the review. If the grievance involves an eyecare related matter or claim, the Plan's Medical Director shall be involved in the resolution. If it involves denial of benefits or services, the written decision shall state the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days, however, if the grievance involves collection of information from outside the Plan's service area, an additional thirty (30) days will be allowed for processing.

Appeal of Decision

If the Member is not satisfied with the formal grievance decision, the Member may request reconsideration by the Grievance Committee and may also request a personal appearance before the Committee. A request for reconsideration must be made within sixty (60) days after receipt of the written decision. In addition, at any time a Member always has the right to grieve directly to the State of Florida Department of Insurance.

Contact Information

CompBenefits Company
P.O. Box 30349
Tampa, FL 33630-3349
Att: Member Services Department
or call, toll free at (800) 865-3676

Florida Department of Insurance
Consumer Assistance
200 East Gaines Street
Tallahassee, FL 32399-032
or call toll free Consumer Hotline at (800) 342-2762

CONVERSION

A Member whose coverage was terminated may receive a converted contract if he was continuously covered under the Plan for at least three (3) consecutive months immediately prior to termination. The converted contract will provide coverage and benefits similar to the Contract previously in effect. A Member is not entitled to a converted contract if termination occurred for any of the following reasons:

* Failure to pay contributions.
* Replacement by similar coverage within thirty-one (31) days.
* Material misrepresentation or fraud in applying for any benefit under the Contract.
* Disenrollment for cause.
* Willful and knowing misuse of the Certificate.
* Willful and knowing furnishing to the Plan incorrect information for the purpose of fraudulently obtaining coverage or benefits.
* The Subscriber has left the Plan's geographic area with the intent to relocate or establish a new residence outside the Plan's geographic area.

Subject to the conditions set forth above, the conversion privilege shall also be available to:

* The surviving spouse and/or children, if any, at the death of the Subscriber, with respect to the spouse and such children whose coverages under Plan contract terminate by reason of such death.
* To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.
* To the spouse of the Subscriber upon termination of coverage of the spouse, while the Subscriber remains covered under a group contract, by reason of ceasing to be a qualified family member under the group contract.
* To a child solely with respect to himself or herself, upon termination of coverage by reason of ceasing to be a qualified family member under a group contract.

DURATION OF AGREEMENT

Except under the following conditions, this Certificate shall remain in force for a period of not less than twelve (12) months. Except for nonpayment of Contributions or termination of eligibility, the Plan may cancel this Certificate with forty-five (45) days written notice for the following reasons:

- When a Member commits any action of fraud or material misrepresentation in applying for or presenting any claim for benefits involving the Plan.

- When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation seriously impairs the ability of a VisionCare Plan Network Provider, to provide services to the Member and/or to other Members.

- When a Member misuses the documents provided as evidence of benefits available pursuant to the Contract or this Certificate.

- When a Member furnishes to the Plan incorrect or incomplete information for the purposes of fraudulently obtaining services.

- When a VisionCare Plan Network Provider is not available within the immediate geographical area of the Subscriber.

- When reasonable efforts by the Plan to establish and maintain a satisfactory patient relationship are unsuccessful or when the Member has indicated unreasonable refusal to accept necessary treatment. When a Member refuses to accept treatment from two (2) VisionCare Plan Network Providers, proof of unreasonable refusal shall be presumed conclusively.

- Prior to cancellation, the Plan shall make every effort to resolve the problem through its grievance procedure and to determine that the Member's behavior is not due to use of the vision care services provided or mental illness.

Coverage for a Member will end on the earlier of:

* On the date the Group tells Us that the Member ceases to be eligible for coverage.
* The last day of the month in which a Dependent of Subscriber is no longer a Dependent as defined.
* Subject to the grace period provision, the last day of the month for which a premium has been paid.
* The date coverage ends for any class or group to which Subscriber belongs.
* The date the Contract ends.

EXTENSION OF BENEFITS

Cancellation of this Certificate by the Plan is without prejudice to any continuous loss which commenced while this Certificate was in force. VisionCare Plan Network Providers shall complete all procedures undertaken upon the Member, until the specific treatment or procedure is completed or for ninety (90) days, whichever occurs first.

CONTINUATION OF COVERAGE

Unless cancellation of this Certificate is made for reasons specified in the Section entitled "Duration of Agreement", Members for whom appropriate Contributions and Copayments are paid will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

At the attainment of the applicable age, coverage as a Dependent shall be extended if the individual is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is

furnished to the Plan within thirty-one (31) days of the Dependent's attainment of the limiting age and subsequently as may be required by the Plan but not more frequently than once every two years.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for employers size 20+ requires that certain employers maintaining group medical plans offer employees and their Dependents the opportunity to continue their coverage when such coverage ends under certain conditions. More information about COBRA continuation can be obtained from your employer.

EFFECTIVE DATE OF COVERAGE

If you qualify under the rules of your group medical insurance and have selected to receive vision care benefits under this Plan, you will be covered on the later of:

- The first of the month following the date first eligible for coverage.
- The date CompBenefits Company accepts your enrollment if you are not enrolled within 30 days of becoming eligible.

Dependents will be covered on the later of:

- The date you first acquire a new Dependent.
- The date the Plan accepts a new Dependent's enrollment if the Dependent is not enrolled within 30 days of becoming eligible.

Newborn Child- A child born to you or your Dependent spouse is covered from the moment of birth for 30 days. If you elect to cover your newborn under this Plan, you must enroll the child within 60 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 30 day period.

Adopted Child- A child placed with you for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants you conservatorship of the child; or 3) the date the child is placed with you for adoption; and additional premium, if any, is paid.

COORDINATION WITH OTHER BENEFITS

APPLICABILITY

This Coordination With Other Benefits provision applies to This Plan when you or your covered Dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in the Section entitled Effect on the Benefits of this Plan.

DEFINITIONS

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, visual care specifically related to a vision exam, lenses and frames. This also includes 1) group or

group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Certificate.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits or the amount CompBenefits Company is obligated to pay the Vision Care Plan Network Provider for the service or material pursuant to the terms of the parties written agreement.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents": (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

This section applies when this Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these rules. The Plan has the right to decide which facts are needed. CompBenefits Company may get needed facts from, or give them to, any other organization or person. CompBenefits Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits Company any facts deemed necessary to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by CompBenefits Company are more than should have paid under this provision, CompBenefits Company may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

CONTRIBUTIONS AND COPAYMENTS

Payments- It is agreed that in order for Member to be eligible for and entitled to receive benefits provided by this Certificate, The Plan must receive all Contributions in advance. The VisionCare Plan Network Provider must receive all Copayments for services rendered or materials obtained under the terms of the Plan.

Grace Period- The Contract under which this Certificate is issued has a thirty (30) day grace period. This provision means that if any required Contribution is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the Contract and this Certificate will stay in force. If full payment is not received within the thirty (30) day grace period, coverage will be terminated effective the first day of the grace period. Subscriber will be liable for the cost of all services and materials received during the grace period.

Reinstatement – Subscribers whose coverage is terminated for non-payment of Contributions prior to the expiration of thirty (30) day grace period only may have their coverage reinstated if a request for reinstatement is submitted by the Group for consideration by the Plan. The Plan may or may not agree to such request.

CHANGES IN CONTRIBUTIONS AND BENEFITS

Contract Changes- The Plan may increase Copayments or delete, amend, or limit any benefits under the Contract upon not less than 90 days prior written notice to the Group prior to renewal of the Contract. It is the responsibility of the Group to notify all Members of any such changes to the Contract.

Premium Changes- Contributions charged by CompBenefits Company for coverage under the Plan may be changed upon not less than 90 days advance written notice to the Group. It is the responsibility of the Group to notify all Members of such change in Contributions.

GENERAL PROVISIONS

Incontestability – In the absence of fraud, all statements made by the Subscriber are considered representations and not warranties during the first two years of coverage. The Plan may avoid providing coverage at any time if Subscriber makes a fraudulent statement in a written application.

Conformity with Florida Law- This Certificate shall be interpreted in accordance with the laws of the State of Florida and any action or claim, including arbitration, shall be brought within the State of Florida. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over CompBenefits Company shall have the effect of amending this Certificate to conform with the minimum requirements thereof. In the event any portion of this Certificate is held to be void, it shall not affect any other provisions.

Notice of Independent Contractor Relationship – The Plan assumes responsibility of fulfilling the terms of this Certificate. VisionCare Plan Network Providers are independent contractors, and the Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a VisionCare Plan Network Provider for any damage which result from any defective or dangerous condition in or about any facility which services are rendered or materials are provided hereunder.

Worker's Compensation Act – The coverage under the Contract is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

SCHEDULE OF BENEFITS

The following vision services and materials are only covered when provided by a VisionCare Plan Network Provider. The Member is responsible for payment of the applicable Copayment, if any.

Vision Examinations - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities: 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once in any **12 month** period.

Materials - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses - We will pay for one pair of prescription lenses once in any **12 month** period.

Frames - We will pay for a new frame once in any **12 month** period. The VisionCare Plan Network Provider will show the Insured the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the amount the Plan covers, the Insured is responsible for the difference in cost.

Contact lenses when necessary – We will pay for one pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month** period and only if prior authorization is obtained from the Plan.

Contact lenses when elective - Benefits include: (1) The cost of an annual vision examination, subject to the Copayment; and (2) the cost of contact lenses, any fitting cost and follow-up visit up to a maximum of **$100.00**, not subject to the Copayment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any **12 month** period.

Co-Payment - An Insured's Co-payment is:

1. Vision Examination **$0**
2. Materials **$0**

COMPBENEFITS INSURANCE COMPANY

100 Mansell Court East **Roswell, GA 30076** **(800) 865-3676**

CERTIFICATE

OF

GROUP VISION INSURANCE

This Certificate outlines the features of the Group Vision Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 865-3676.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

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SECTION I - DEFINITIONS

Copayment- means the amount an Insured is required to pay when a covered service is rendered or covered Materials are purchased.

Dependent- means any of the following persons:

1. Your spouse;
2. Your child;
   a) from birth to age 26 and dependent upon You for support; or
   b) 26 years of age but under 26 years of age, if dependent upon You for support and a full-time or part-time student or residing in your household; or
   c) at least 26 years of age and:
      i. primarily dependent upon You for support because of mental or physical handicap;
      ii. was incapacitated and insured under Policy on his 19th birthday; and
      iii. continues to be incapacitated beyond his 19th birthday.

A child also includes adopted children, as well as stepchildren, children placed in court-ordered custody, including foster children, living with You in a parent-child relationship.

Group- means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

Insured- means You and Your Dependent(s) covered under the Policy.

Materials- means lenses, frame and contact lenses covered under the Policy.

Policy- means the Policy issued to the Policyholder.

Policyholder – means the Group to whom the Policy has been issued.

Schedule of Benefits - means the listing of benefits showing what is paid.

"**You**" and "**Your**" means the Certificateholder.

"**We**", "**Our**", "**Us**", and "**Plan**" means CompBenefits.

SECTION II - BECOMING INSURED

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. The first of the month following the date first eligible for coverage;
2. The date We accept Your enrollment, if You are not enrolled within 30 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent's enrollment, if he is not enrolled within 30 days of becoming eligible.

Newborn Child- A child born to You or a covered Dependent is covered from the moment of birth for 30 days. If timely notice is given, Plan may not charge an additional premium for coverage of the newborn child for duration of the notice period. If timely notice is not given, Plan may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, Plan may not deny coverage for a child due to the failure of the Plan to timely notify the Plan of the birth the child.

Adopted Children, Foster Children- Benefits applicable to Your Dependent children also apply to an adopted child, court-ordered child or foster child placed in compliance with chapter 63, from the moment of placement in Your residence. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by You prior to the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in Your residence in compliance with chapter 63.

You must notify Us of the birth or placement of the adopted child not less than 30 days after the birth or placement in Your residence of a child adopted by You. If timely notice is given, We may not charge an additional premium for coverage of the child for the duration of the notice period. If timely notice is not given, We may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, We may not deny coverage for the child due to Your failure to timely notify Us of the birth or placement of the child.

Your Coverage Ends- Coverage for You and/or Your Dependent will end at 12:01 a.m. on the earlier of:

1. On the date the Policyholder tells Us that You and/or Your Dependent cease to be eligible for coverage;
2. The last day of the month in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which a premium has been paid; or
4. The date coverage ends for any class or Group to which You belong; or
5. The date the Policy ends.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

SECTION III - PROCEDURES FOR USING BENEFITS

The Insured may receive covered services and Materials from a licensed Optometrist or Ophthalmologist of his choice. The Insured may pay the provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. We will reimburse covered services and Materials only up to the allowance, as shown in the Schedule of Benefits, after deduction of the applicable Copayment. The Insured is responsible for the Copayment, the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered by the Policy. Determination of benefits under this Plan will be affected if a covered service or Material was provided under another vision plan.

SECTION IV-LIMITATIONS AND EXCLUSIONS

Limitations - In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;
   unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions - We will not cover:

1. Orthoptic or vision training and any associated supplemental testing;
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an Employer as a condition of employment;
5. Any injury or illness paid under any Workers' Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy.
8. Experimental or non-conventional treatment or device;
9. Contact lenses, except as specifically covered by the Policy;
10. Hi Index, aspheric and non-aspheric styles
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

SECTION V-COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, vision care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management

trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Policy.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
   (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.(d)If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

7. ERRORS RELATED TO YOUR COVERAGE.

The Plan has the right to correct benefit payments made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payment if any underpayments have been made.

SECTION VI-PREMIUMS

Premium Payments - All premiums are payable in advance for coverage under the Policy on the first day of each calendar month in accordance with the premium rate schedules of CompBenefits in effect for each premium due date.

Grace Periods - A grace period of 31 days is allowed for payment of each premium due after the first premium, during such grace period the Policy shall continue in force, unless the Group has given the Plan written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will charge a pro-rata premium for the time coverage under the Policy remained in force for any Group during such grace period.

Change in Premiums - Premiums are payable to CompBenefits or Our authorized agent. Premiums may be increased for a Policy period on the anniversary date of the Policy. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 90 days prior to the anniversary of the Policy period.

Reinstatement - If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by CompBenefits or by any agent authorized by CompBenefits to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due

to such sickness as may begin more than ten (10) days after such date. In all other respects, the Policyholder and CompBenefits shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Termination - This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage by this form of Policy or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. You will receive at least one hundred-eighty (180) days advance notice prior to such discontinuance. Unless otherwise permitted under state law, except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination.

This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the expiration date of the grace period.

SECTION VII-CLAIMS

Notice of Claim - Written notice of claim must be given to Us within 60-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 30349, Tampa, FL 33630-3349, or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

Claim Forms - You can get the forms You need for claiming benefits by calling Us at (800) 865-3676 or writing Us at P.O. Box 30349, Tampa, FL 33630-3349. If the forms are not sent to You before the expiration of 15 days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Time of Payment of Claims - Indemnities payable under this Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Proof of Loss – Written proof of loss must be furnished to Us at P.O. Box 30349, Tampa, FL 33630-3349 in the case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90-days after the termination period for which We are liable and, in the case of claim for any other loss, within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Legal Action - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

SECTION VIII- NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA) FOR GROUPS SIZE 20 OR MORE

If Your insurance terminates in accordance with the other terms of this Policy, it will be reinstated as of the date of termination if You elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under this Policy, and if such insurance is terminating due to any of the following Qualifying Events:

1. Termination of Your employment (for reasons other than gross misconduct);
2. Reduction of work hours including lay-off;
3. Death of the Certficateholder;
4. Divorce or legal separation;
5. A child ceases to be a dependent as defined in this Policy;
6. The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

The maximum continuation of coverage period with respect to a reason described above is: (1) 18 months with respect to 1 or 2 above. However, if You are disabled as determined under Title II or XVI of the Social Security Act at the time of the Qualifying Event or any time during the first 60 days of continuation coverage, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months; (2) 36 months with respect to 3, 4 or 5 above; (3) With respect to 6 above, lifetime coverage for You, whereas Your Dependents will be covered until the earlier of: (a) Your death; or (b) death of the Dependent. If, while insurance is being continued, further qualifying events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days.

It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: (1) the date of Qualifying Event; (2) the date of the loss of coverage; or (3) The date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: (1) The end of the maximum continuation of coverage period; (2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; (3) Your becoming covered under another group vision care plan as employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group vision plan; (4) Discontinuance of this vision care benefit provision; or (5) The date Your employer ceases to provide any group vision plan.

SECTION IX-GENERAL PROVISIONS

Representations and Warranties - All statements made by any Insured or the Group are deemed representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You, or in the event of Your death or incapacity, Your beneficiary or personal representative.

Worker's Compensation Act - The coverage under the Policy is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

Conformity with State Statutes - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Limit on Certain Defenses - After the Policy has been in force for a period of two (2) years during the lifetime of the Insured, excluding any period during which the Insured is disabled, it shall become incontestable as to the statements contained in the application.

SCHEDULE OF BENEFITS

Vision Examinations - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities: 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once in any **12 month** period.

Materials - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses - One pair of prescription lenses once in any **12 month** period.

Frames - One new frame once in any **12 month** period.

Contact lenses when necessary – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month** period and only if prior authorization is obtained from the Plan.

Contact lenses when elective - Benefits include: (1) The cost of an annual vision examination, subject to the Copayment; and (2) the cost of contact lenses, any fitting cost and follow-up visit up to a maximum of **$100.00**, not subject to the Copayment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any **12 month** period.

Co-Payment - An Insured's Co-payment is:

1. Vision Examination **$0**
2. Materials **$0**

Allowance – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule.

Vision Examination	$35
Single Vision Lens	$30
Bifocal Lens	$50
Trifocal Lens	$60
Lenticular Lens	$100
Contact Lenses when elective	$100
Contact Lenses when necessary	$180
Frame	$35

WHEN COVERED SERVICES ARE OBTAINED FROM A VISIONCARE PLAN NETWORK PROVIDER, THE INSURED IS ONLY RESPONSIBLE FOR THE CO-PAYMENT AMOUNT LISTED ABOVE.

WHEN SERVICES ARE OBTAINED FROM A NON-VISIONCARE PLAN NETWORK PROVIDER, PAYMENT OF BENEFITS ARE BASED UPON THE VISIONCARE PLAN ALLOWANCE.

Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Medical Child Support Orders**
- **Continuation of Coverage for Full-time Students During Medical Leave of Absence**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) ~Your Rights under ERISA**

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA should consult their benefit plan documents for the applicable claims and appeals procedures.

DISCRETIONARY AUTHORITY

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

1. Interpret plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

CLAIMS PROCEDURES
Definitions

Adverse determination: means a decision to deny benefits for a pre-service claim or a post-service claim under a group health and/or dental plan.

Claimant: A covered person (or authorized representative) who files a claim.

Concurrent-care Decision: A decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan: an employee welfare benefit plan to the extent the plan provides dental care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer: the offering company listed on the face page of your Certificate of Insurance or Certificate of Coverage and referred to in this document as "Humana."

Post-service Claim: Any claim for a benefit under a group health plan that is not a Pre-service Claim.

Pre-service Claim: A request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care Claim (expedited review): A claim for covered services to which the application of the time periods for making non-urgent care determinations:

could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an Urgent-care Claim. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a "Urgent-care Claim" will be treated as a "claim involving urgent care."

Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense.
- Name and address of the provider
- Diagnosis
- Procedure or nature of the treatment
- Place of service
- Date of service
- Billed amount

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Procedural Defects

If a Pre-service Claim submission is not made in accordance with the plan's requirements, Humana will notify the Claimant of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an Urgent-care Claim). If a Post-service Claim is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

- In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

After a determination on a claim is made, Humana will notify the Claimant within a reasonable time, as follows:

Pre-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the Claimant of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the necessary information.

Urgent-care Claims (expedited review)

Humana will determine whether a particular claim is an Urgent-care Claim. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a Claimant to clarify the medical urgency and circumstances supporting the Urgent-care Claim for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the Urgent-care Claim.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information - but not less than 48 hours.

Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or

- The end of the period afforded the Claimant to provide the specified additional information.

Concurrent-care Decisions

Humana will notify a Claimant of a Concurrent-care Decision involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination.

Humana will decide Urgent-care Claims involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a Claimant of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an Urgent-care Claim, the notice will provide a description of the plan's expedited review procedures.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A Claimant, on appeal, may request an expedited appeal of an adverse Urgent-care Claim decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

On appeal, a Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent-care Claims	As soon as possible but no later than 72 hours after Humana receives the appeal request.
Pre-service Claims	Within a reasonable period but no later than 30 days after Humana receives the appeal request.
Post-service Claims	Within a reasonable period but no later than 60 days after Humana receives the appeal request
Concurrent-care Decisions	Within the time periods specified above depending on the type of claim involved.

Appeals Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination.*
- Reference to the specific plan provision upon which the determination is based.
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.

- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under section 502(a) of ERISA.

- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the Claimant, will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination.

- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.

- Demonstrates compliance with the administrative processes and safeguards required in making the determination.

- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee's child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the group health plan; and (e) is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act section 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

CONTINUATION OF COVERAGE FOR FULL-TIME STUDENTS DURING MEDICAL LEAVE OF ABSENCE

A dependent child who is in regular full-time attendance at an accredited secondary school, college or university, or licensed technical school continues to be eligible for coverage for until the earlier of the following if the dependent child takes a medically necessary leave of absence:

- Up to one year after the first day of the medically necessary leave of absence; or
- The date coverage would otherwise terminate under the plan.

We may require written certification from the dependent child's health care practitioner that the dependent child has a serious bodily injury or sickness requiring a medically necessary leave of absence.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health and/or dental 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. 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.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's benefit plan document or contact the Plan Administrator.

What is 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. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorce or legally separation from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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 within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group heath and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gob/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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 the Plan Administrator.

IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

OPTION 1 - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

Category 1 Medicare eligibles are:

- Covered employees in active service who are age 65 or older who choose Option 1;
- Age 65 or older covered spouses; and
- Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

Category 2 Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

- Retired employees and their spouses; or
- Covered dependents of a covered employee, other than his or her spouse.

Calculation and Payment of Benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution,

coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

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

Continuation of Benefits
Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility
An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of Coverage
Of elected, continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months beginning the first day of absence from employment due to service in the uniformed services; or

2. The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other Information
Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information About the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called 'fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue Group Health Plan Coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims Determinations

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

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with Questions

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits 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 N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

Treatment: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.

PLAN SPONSOR CERTIFICATION
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH SELF-INSURED PLANS

City of Port St. Lucie plan sponsor ("plan") hereby certifies the following amendments have been made to the plan documents of the group health plan pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996. City of Port St. Lucie plan has made the following amendments to its plan documents:

- Plan shall not use or disclose member information other than as permitted or required by the plan documents or as required by law;
- Plan ensures that any agents, including a subcontractor, to whom it provides member information received from the group health plan agrees to the same restrictions and conditions that apply to the plan sponsor;
- Plan shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- Plan shall report to the group health plan when it becomes aware of any use or disclosure of the information that is inconsistent with the purpose for which the uses or disclosures were provided to the plan;
- Plan shall make available the designated record set of protected health information to members for the purposes of inspection pursuant to HIPAA requirements
- Plan shall make available protected health information for amendment and incorporate any amendments to protected health information;
- Plan shall make available the information required to provide an accounting of disclosures;
- Plan shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary of Health and Human Services for purposes of determining compliance by the group health plan with this subpart;
- Plan shall return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. [except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible]; and
- Provide for adequate separation between the group health plan and the plan sponsor. The plan documents were amended to:
  - Describe those employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information, provided that any employee or person

who receives protected health information pertaining to the group health plan in the ordinary course of business must be included in such description;

- Restrict the access to and use by such employees and other persons described in paragraph to the plan administration functions that the plan sponsor performs for the group health plan; and

- Provide an effective mechanism for resolving any issues of noncompliance by persons with the plan document provisions required by this paragraph.

This certification is effective as of 17th of Feb., 2010.

Plan Sponsor: City of Port St. Lucie
Authorized Signee: Tamara Gustafson
Title: Director, H.R.
Date: March 2, 2010

HUMANA.
Guidance when you need it most

Group Health Plan Obligations under HITECH
For ASO and SPAA (HSA, FSA and PCA) Products

Humana would like to extend our appreciation for your continued partnership as we work together to provide and administer benefits to your employees. Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is designed to protect the privacy and provide for the security of individuals' Protected Health Information ("PHI").

Health Information Technology for Economics and Clinical Health Act ("HITECH"), which was part of the American Recovery and Reinvestment Act of 2009 ("ARRA") directly imposes new obligations on Covered Entities and Business Associates.

Employers sponsoring plans that are employer funded (ASO medical, ASO dental, FSA, PCA and HSA) must verify that their business associates will satisfy their new obligations under HITECH. These obligations include but are not limited to the following:

- Effective February 17, 2010, HIPAA privacy and security standards that apply to health plans will also apply directly to Business Associates. Business Associates will be subject to the administrative, physical, and technical security requirements of HIPAA, must implement appropriate policies and procedures, and must document their security activities.
- HITECH establishes new security breach notice requirements. Effective September 23, 2009 the HITECH Act requires a health plan that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information and discovers a breach of the information to notify each individual whose health information has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of the breach. Business Associates will also be required to give notice of such a data breach to the health plan and will need to identify each individual whose unsecured protected health information was illegally accessed, acquired, or disclosed.
- Business Associates can now incur civil and criminal penalties for violating these procedures and/or the terms of Business Associate agreement.
- The Department of Health and Human Services (HHS) is now required to perform periodic audits to ensure that covered entities, such as health plans, and Business Associates are complying with HIPAA.

In anticipation of these requirements, Humana has enclosed an updated Business Associate agreement reflecting all of the HIPAA changes made by the HITECH provisions of the ARRA. Please read through the provisions carefully and if acceptable, sign and mail to the address shown below and keep the other original for your records.

Mailing address:
Humana Privacy Office
PO Box 1438
Louisville, KY 40201-1438

For additional information, please contact your local Sales Representative.

HUMANA.
Guidance when you need it most

FAQ for Covered Entities (ASO groups and SPAA products)

What is HITECH?

On February 17, 2009, Congress enacted the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act of 2009.

How does HITECH apply to me as a covered entity?

The Act includes several new provisions including, but not limited to:

- Requirement to notify impacted individuals and the Department of Health and Human Services (HHS) of breaches of protected health information (PHI). Specifically, the new regulations establish guidelines for determining when a breach of unsecured PHI occurs; dictates who must notify of such a breach and to whom notification must be made; and establishes the timeframe and contents of such notification. The Rule became effective on September 23, 2009.
- New regulations regarding business partners and enforcement of penalties
- Restrictions on the sale and marketing of PHI

As a covered entity, what types of measures should I have in place and by when?

Affected entities should review HIPAA compliance efforts with these new obligations in mind. For example, entities should ensure that policies are in place requiring workforce members to immediately report any potential privacy violations or security incidents so that they can effectively and promptly evaluate the incident to determine whether notification obligations are triggered. Entities should also establish policies and conduct training to communicate what notification will be required and should maintain accurate records to prepare required reports to HHS. Affected entities must remain aware of potential changes to these requirements in the future, and be prepared to revise policies and procedures accordingly.

What Are the Notification Requirements?

In situations in which a covered entity or business associate has a reasonable belief that the breach involved an individual's PHI, the entity must provide written notice to each affected individual. Such notice must be provided without "unreasonable delay," but in no case later than sixty days after discovery of the breach. To the extent possible, the notice should include the following information: 1) a brief description of what happened; 2) the types of

information that were involved in the breach; 3) steps that affected individuals should take to protect themselves from potential harm; 4) a description of what the entity is doing to investigate the incident, mitigate harm, and protect against further breaches; and 5) contact procedures by which affected individuals may learn additional information.

What do I need to do if I am aware of an incident or breach?

HITECH establishes new security breach notice requirements. Effective September 23, 2009 the HITECH Act requires a health plan that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information and discovers a breach of the information to notify each individual whose health information has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of the breach. Business Associates will also be required to give notice of such a data breach to the covered entity and will need to identify each individual whose unsecured protected health information was illegally accessed, acquired, or disclosed.

When Must an Entity Report Breaches to the Department of Health and Human Services (HHS)?

Covered entities and business associates must track and report all breaches to HHS. Breaches involving the PHI of more than 500 individuals (in *any* state or jurisdiction) must be reported "immediately." All other breaches must be recorded and annually reported no later than sixty days after the end of each calendar year.

What happens if I do not comply with the new legal requirements?

Covered entities as well as Business Associates can now directly incur civil and criminal penalties for non-compliance with these requirements and/or the terms of Business Associate agreements. Under HITECH the fine can range from $100 per violation to $50,000 per violation with a maximum fine amount of $1.5 million for willful misconduct. Additionally, HITECH gives State Attorneys General the ability to enforce HIPAA violations with injunctions and civil damages.

What resources can I use to find out more about HITECH?

We recommend you contact an attorney or seek legal advice about your responsibility under HITECH. Also, www.cms.hhs.gov and www.hhs.gov/ocr/hipaa are resources you can reference in the internet.

AMENDMENT #2
TO THE ADMINISTRATIVE SERVICE CONTRACT
BY AND BETWEEN
VISION CARE, INC. (n/k/a COMPBENEFITS COMPANY)
AND
CITY OF PORT ST. LUCIE

Reference is made to the Administrative Service Contract ("Agreement") between Vision Care, Inc. (n/k/a CompBenefits Company) ("VisionCare Plan") and City of Port St. Lucie ("Group") effective April 1, 1999.

The parties do hereby agree to amend the Agreement as follows:

1) Effective January 1, 2013, paragraph B of the Administration section is hereby deleted in its entirety and replaced with the following:

"In consideration of the services of VisionCare Plan, Group agrees to pay VisionCare Plan the sum of $1.21 per month per eligible employee ("Monthly Administration Fee"), payable monthly in advance. The Monthly Administration Fee is guaranteed during the time period January 1, 2013 through December 31, 2013."

2) Dependent children are covered until the end of the year in which they reach twenty-six (26) or thirty (30) years of age and continue to meet dependent status.

3)

Notices:

C/O Humana Inc.
Connie Oropesa
Account Executive
3401 SW 160th Avenue
Miramar, FL 33027
Telephone: (305) 626-5241
Fax: (305) 370-6398
E-mail: coropesa3@humana.com

City of Port St. Lucie
Cheryl Shanaberger, CPPO
Deputy Director
Office of Management and Budget
121S.W. Port St. Lucie Blvd.
Port St. Lucie, FL 34984
Telephone: (772) 871-5223
Fax: (772) 871-7337

3) Dependent children are covered to the end of the year in which they turn 26 or 30 years of age and continue to meet dependent criteria.

In all other respects, the terms and conditions of the Agreement shall remain unchanged.

The effective date shall be January 1, 2013.

IN WITNESS WHEREOF the parties agree to the foregoing provisions by placing their duly authorized signatures below.

Vision Care, Inc.
(n/k/a CompBenefits Company)
By: _____
Name: _____
Title: _____
Date: _____

City of Port St. Lucie

By: _____
Name: Gregory J. Oravec
Title: City Manager
Date: _____

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