GROUP EYE CARE PLAN

ONEIDA NATION

Plan Number: 10-301285

Administered by:

Ameritas Life Insurance Corp.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third- party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your coverage or the termination of our arrangements with the providers, whichever comes first.

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Coverage for each Member and each Covered Dependent will be based on the Member's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Members

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Member, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for coverage by completing the eligibility period, if any; and

c. for whom the coverage has become effective.

CHILD. Child refers to the child of the Member or a child of the Member's spouse , if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. a Member's spouse.

b. each child less than 26 years of age, for whom the Member or the Member's spouse is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while covered as a dependent under b. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Member's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental or physical handicap; and

2. Chiefly dependent upon the Member for support and maintenance.

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Members at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our Network Providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other Provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the Provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is January 1, 2011. The effective date of coverage for a Member is shown in the Planholder's records.

All coverage will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Member.

CONDITIONS FOR COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such coverage on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Member."

If employment is the basis for membership, a member of the Eligible Class for Coverage is any all eligible members working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

N/a are excluded from the Eligible Class for Coverage.

If both spouses are Members and if either of them covers their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for coverage as a dependent.

ELIGIBLE CLASS FOR DEPENDENT COVERAGE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any all eligible members working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

N/a are excluded from the Eligible Class for Dependent Coverage.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Coverage, as explained above, is not a member of the Eligible Class for Dependent Coverage.

When a member of the Eligible Class for Dependent Coverage dies and, if at the date of death, has dependents covered, the Planholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Planholder and the affected dependents, the name of such deceased employee will continue to be listed as a member of the Eligible Class for Dependent Coverage.

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is required to contribute to the payment of coverage fees for his or her dependents.

SECTION 125. This plan is provided as part of the Planholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur after an eligibility period defined by the Planholder is satisfied. The same eligibility period will be applied to all members.

If employment is the basis for membership in the Eligible Class for Members, a Member whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for coverage.

EFFECTIVE DATE. Each Member has the option of being covered and covering his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the coverage fees. The Effective Date for each Member and his or her Dependents, will be the:

1. the date on which the Member qualifies for coverage, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for coverage.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the coverage, or any increase in coverage, is to take effect. If not, the coverage will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the coverage, or any increase in coverage, is to take effect. The coverage will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the **earliest of:**

1. the date on which the Member's coverage terminates;
2. the date on which the Member ceases to be a Member;
3. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
4. the date all Dependent Coverage under the plan is terminated.

The coverage for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the coverages may be continued. Contact your plan administrator for details.

EYE CARE EXPENSE BENEFITS

If a Member has Covered Expenses under this section, we pay benefits as described. The Member may use a Participating Provider or a Non-Participating Provider. The Member has the freedom to choose any provider.

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of:

A. the provider's charge, or

B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Member. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS
A Participating Provider agrees to provide services and supplies to the Member at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES
Covered expenses are the eye care expenses incurred by a Member for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Member must advise the Participating Provider's office that he or she has coverage under this network plan. If the Member receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Member.

EXTENSION OF BENEFITS
We will extend benefits for eye care supplies if this plan terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the plan and must be received within six months after the plan terminates.

EXPENSES INCURRED
An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS
This plan has the following limitations.

a) This plan does not cover more than one Eye Exam in any 12-month period.

b) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.

c) This plan does not cover more than one set of Frames in any 24-month period.

d) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lenses benefit.

e) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if a Member meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.

   a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
   b. Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
   c. Anisometropia of 3D or more.
   d. High Ametropia exceeding -10D or +10D in meridian powers.

f) This plan does not cover Orthoptics or vision training and any associated testing.

g) This plan does not cover Plano Lenses.

h) This plan does not cover non-prescribed Lenses or sunglasses.

i) This plan does not cover two pairs of glasses in lieu of Bifocals.

j) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.

k) This plan does not cover medical or surgical treatment of the eyes or supporting structures.

l) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Member shows it was not possible to submit the proof of loss within this period.

m) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

SERVICE	**PLAN MAXIMUM COVERED EXPENSE**	
	Participating Provider	*Non-Participating Provider*
Eye Exam	Covered In Full	Up to $ 40.00
(All lenses are per pair) Single Vision Lenses	Covered In Full	Up to $ 40.00
Lined Bifocal Lenses	Covered In Full	Up to $ 60.00
Lined Trifocal Lenses	Covered In Full	Up to $ 80.00
Lenticular Lenses	Covered In Full	Up to $ 80.00
Frame	Up to $150.00	Up to $ 45.00
Contact Lenses		
Elective	Up to $150.00	Up to $104.00
Medically Necessary	Covered In Full	Up to $210.00
Contact Lens Standard Fit and Follow-Up	Covered In Full	Up to $ 40.00
Contact Lens Premium Fit and Follow-Up	Up to $ 55.00	Up to $ 40.00

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Member unless otherwise agreed upon through your authorization or Provider contracts.

FACILITY OF PAYMENT. If a Member or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Member, then we may, at our option, pay the benefit up to an amount not to exceed $5,000 to any relative by blood or connection by marriage of the Member who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Member may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the Provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Member sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Planholder to obtain the Plan is a representation and not a warranty. No misrepresentation by the Planholder will be used to deny a claim or to deny the validity of the Plan unless:

1. The Plan would not have been issued if we had known the truth; and

2. We have given the Planholder a copy of a written instrument signed by the Planholder that contains the misrepresentation.

The validity of the Plan will not be contested after it has been in force for one year, except for nonpayment of fees or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Plan is not a substitute for coverage under a worker's compensation or state disability income benefit law and does not relieve the Planholder of any obligation to provide such coverage.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Eye Care Plan
Name, Address of Plan Sponsor:	ONEIDA NATION 909 PACKERLAND DR GREEN BAY, WI 54303
Plan Sponsor Tax ID Number:	39-6081138
Plan Number:	501
Type of Plan:	Group Plan
Name, Address, Phone Number of Plan Administrator	RALINDA NINHAMLAMBERIES ONEIDA NATION 909 PACKERLAND DR GREEN BAY, WI 54303 920-490-3512
Name, Address of Registered Agent For Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Plan Additional Notification of Legal Process Must Be Sent To:	Ameritas Life Insurance Corp. P.O. Box 82595 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Self Funded
Plan Fiscal Year End:	December 31
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Plan

Please refer to the Conditions for Coverage within the Group Plan and Document of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Plan

The Group Plan which provides benefits for this plan may be terminated by the Planholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Planholder fails to pay the required fees. Ameritas Life Insurance Corp. may terminate the Group Plan on any Fee Due Date if the number of persons covered is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Planholder has failed to perform its obligations relating to the Group Plan.

After the first Plan year, Ameritas Life Insurance Corp. may also terminate the Group Plan on any Fee Due Date for any reason by providing a 30-day advance written notice to the Planholder.

The Group Plan may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after the Plan ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means a Covered Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is covered on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which this plan would otherwise end;

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Coverage ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Coverage ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes covered, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or
b. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time

during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Coverage for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Covered Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Coverage for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of

their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Fee Requirements

The Plan continued under this provision will be retroactive to the date the Plan would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required fee not later than 45 days after electing COBRA continuation, and monthly fee on or before the Fee Due Date thereafter. The monthly fee is a percentage of the total fee (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Fee Due Date. The fee may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi**vi. When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

1. The date the Group Plan terminates;

2. 31 days after the date the last period ends for which a required fee payment was made;

3. The last day of the COBRA continuation period

4 The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care Plan and (b) not subject to any preexisting condition limitation in that Plan.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in 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 you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department

of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

EyeMed Vision Care
4000 Luxottica Place
Mason, Ohio 45040-8114
(866) 289-0614 phone
(513) 765-6050 fax

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Plan on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Plan on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate of coverage for such information, call us, or contact your state regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.