STARMOUNT LIFE INSURANCE COMPANY

called "We", "Our", and "Us")

8485 Goodwood Blvd. Baton Rouge, LA 70806-7878

GROUP VISION CARE INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company
8485 Goodwood Blvd.
P.O. Box 98100
Baton Rouge, LA 70806-7878

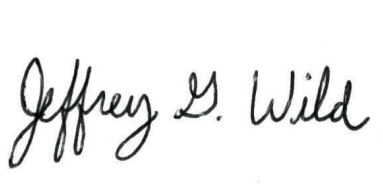
Administrator: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd.
P.O. Box 98100
Baton Rouge, LA 70898-9100

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.



Jeffrey G. Wild, Secretary **Erich Sternberg, President**

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

10-Day Right to Examine this Certificate: It is important to Us that You are satisfied with the coverage provided under this Certificate and that it meets Your insurance goals. If You are not satisfied, You may return it within 10 days after You receive it. We will refund all premiums paid and Your coverage will be void from its effective date.

TABLE OF CONTENTS

PART I. CERTIFICATE SCHEDULE

Policyholder:	**East Baton Rouge Parish Schools**
Policyholder's Address:	**PO Box 2950, Baton Rouge, LA 70821**
Group Policy Number:	EBRPS
Effective Date: **Amended Date:**	**January 1, 2003** **January 1, 2012**
Initial Term:	24 Months
Eligible Classes:	All Full Time Employees Working At Least 30 Hours Per Week
Waiting Period:	One month from the first day of Active Work
Mode of Premium Payment:	MONTHLY
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Rolling Benefit Plan Basis	
Vision Exam:	**Once every 12 Months**
Eyeglass Lenses:	**Once every 12 Months**
Frames:	**Once every 12 Months**
Contact Lenses:	**Once every 12 Months**

CO-PAY (PER INSURED)			
	In-Network Provider: Wal-Mart Vision Centers	Other In-Network Providers:	Out-of-Network Provider:
Vision Exam:	$10.00	$10.00	See Below
Eyeglass Lenses:	$0.00	$15.00	See Below
Frames:	$0.00	$15.00	See Below
Contact Lenses:	$0.00	$15.00	See Below

BENEFITS AND ALLOWANCES [1]			
	In-Network Provider: Wal-Mart Vision Centers	Other In-Network Providers:	Out-of-Network Provider:
Vision Exam:			
By Ophthalmologist	Covered in Full	Covered in Full	$30 Allowance
By Optometrist	Covered in Full	Covered in Full	$30 Allowance
Materials- Eyeglass Lenses [3]:			
Single Vision	Covered in Full	Covered in Full	$25 Allowance
Bifocals	Covered in Full	Covered in Full	$40 Allowance
Progressives	$100 Allowance	$100 Allowance	$40 Allowance
Trifocals	Covered in Full	Covered in Full	$50 Allowance
Lenticular	$80 Allowance	$80 Allowance	$50 Allowance
Materials – Frames[3]:	$94 at Wal-Mart & Sam's Club	$120 retail allowance ($94 at Costco*)	$40 Allowance
Materials – Contact Lenses[2]:			
Non-Elective	$210 Allowance	$210 Allowance	$210 Allowance
Elective	$130 Allowance	$130 Allowance	$130 Allowance

* Special payment and reimbursement terms apply for material purchases at Costco.

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

[2] The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. Contact Lenses consist of (3) components: materials, exams and fittings. Coverage is for materials and the exam, up to the Contact Lenses allowance. Fittings may be covered but only up to the amount of any unused Contact Lenses allowance – after Materials.

[3] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

PART III. DEFINITIONS

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A request for payment of benefits under this Certificate.

Co-Pay – An Insured's share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. If an Out-of-Network Provider is used, the Co-Pay will be deducted from the Out-of-Network Allowance at the time We pay benefits. Co-Pay amounts are listed in the Schedule of Benefits.

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

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

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

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of an In-Network Provider. This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

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

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Waiting Period, if any.

Eligible Dependent - Means Your:

1. spouse; or
2. natural child, grandchild, step-child, foster child, adopted child or a child during the pendency of adoption who:
   a. is less than 26 years old; or
   b. becomes incapable of self-support because of mental or physical handicap while insured under the Group Policy and prior to reaching the limiting age for dependent children. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child

remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 26; or

d. is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

An Eligible Dependent will also include a child who is placed in Your home following execution of an act of voluntary surrender in Your favor or the favor of Your legal representative effective on the date on which such act of voluntary surrender becomes irrevocable.

If a Dependent is eligible to be an Insured, he is not eligible as a Dependent.

In the event both parents of a Dependent child are Insured under separate Certificates, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

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

He, Him and His – Refers to the male or female gender.

Immediate Family Member – An Insured's parent, step-parent, spouse, child, step-child, brother or sister.

Initial Term - The period following the group's initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period.

In-Network Provider - An Ophthalmologist, Optometrist or Optician who has entered into a agreement with the Administrator to provide Covered Services or Materials at an agreed to cost. When an In-Network Provider is used, the Insured will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory - A list of In-Network Providers and the services they are contracted for in Your area. The list will be updated periodically.

Insured – Means You (the Insured Member) and each Covered Dependent.

Insured Member– Means a person:

1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Waiting Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the section titled "Limitations."

Materials – Means corrective Eyeglass Lenses, Frames and Contact Lenses.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Ophthalmologist- A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optician – A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

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

Plano Lens - A lens that has no refractive power.

Policyholder - The entity stated on the front page of the Policy.

Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

Rolling Benefit Plan – Benefits begin anew 12 months from the date of service.

Vision Exam – An examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

You or Your – The Insured Member.

Waiting Period - The period of time a Member must wait before He is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other spouse's coverage.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder's discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within 31 days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, , birth or adoption, coverage is effective on the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

PART VI. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date He is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. We may require payment of any pro-rata premium for the time the insurance was in effect during the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 6 month period. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

We pay a benefit if an Insured receives Covered Services or Materials at the allowable Frequency while his coverage under this Certificate is in force. An Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

A. In-Network Benefits

When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A provider's status may occasionally change. We recommend that You call the Administrator to verify the provider's participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Note Exception: If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Supplement To Schedule Of Benefits.

Both the Co-Pay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

B. Out-of-Network Benefits

If an Insured chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us. (See the "Notice of Claim" provision.) Any Co-Pay that applies should not be paid to the Out-of-Network Providers, as it will be deducted from Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any Co-Pay.

C. Covered Services or Materials

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

1. To check or improve their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Schedule of Benefits.

PART IX. LIMITATIONS AND EXCLUSIONS

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

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

Coverage for a Late Entrant or Re-Enrollee is limited to the Vision Exam benefit during the first 12 months after such person's effective date of coverage.

Dilation is covered in full under the Vision Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease .

Exclusions

No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses
6. Medical and surgical treatment of the eyes;
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. Any eye examination or corrective eyewear required by an Employer as a condition of employment;

10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;

11. Services for which benefits are paid by Worker's Compensation;

12. Benefits provided under the employee's medical insurance except in the case of Coordination of Benefits;

13. Blended bifocal lenses

14. Groove, Drill or Notch, and Roll and Polish;

15. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;

16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.)

17. Cosmetic items;

18. Faceted lenses

19. High-Index Lenses

20. Laminated Lenses

21. Oversize Lenses – any lens with an eye size of 61mm or greater

22. Photochromic (Transition) lenses

23. Polaroid lenses

24. Polished bevel lenses

25. Polycarbonate lenses

26. Prism lenses

27. Slab-off lenses

28. Tints (except Pink tint #1 and #2

29. Ultra-violet tint or coating

30. Additional cost for contact lenses over the allowance

31. Additional cost for a frame over the allowance

32. Progressive Power Lenses*

*Progressive Power Lens Benefit. If this type of lens is <u>not</u> a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

PART X. CLAIM PROVISIONS

A. In-Network Claims
When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator. (Note the exception under Part VI.A, "In-Network Benefits.)

B. Out-of-Network Claims
In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

C. Notice of Claim
Written notice of claim must be given to Us within 30 days after the loss starts or as soon as reasonably possible. Notice should be sent to Our Administrator at the following address:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
P. O. Box 14389
Baton Rouge, LA 70898-4389

D. Claim Forms
When the Administrator receives notice of Claim that does not contain all necessary information, forms for filing proof of loss will be sent to You along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, You will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss within the time stated in the Proof of Loss provision.

E. Proof Of Loss
Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

F. Payment Of Claims
Benefits will be paid to You unless an Assignment of Benefits has been requested by You or by operation of law. Benefits due and unpaid at Your death will be paid to Your estate. If benefits are payable to Your estate, We can pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

G. Time of Payment of Claims
Benefits payable under this Certificate for any loss incurred will be paid within 30 days following Our receipt of written proof of loss, unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. For extended periods of disability, We will make payment at least every thirty days during any extended period during which You are entitled to such payments. Any balance remaining unpaid at the end of Our liability will be paid within 30 days following our receipt of written proof of loss.

Failure to comply with the requirements of this provision will subject Us to a penalty payable to You of double the amount of the benefits due under the terms of this Certificate during the period of delay, together with attorney's fees to be determined by a court of competent jurisdiction in the parish where You live or have Your domicile, excepting a justice of the peace court.

H. Extension of Benefits
Termination of Your coverage will be without prejudice to any claim for continuous loss that commenced while such coverage was in force; however, the payment of benefits after the termination date will be predicated upon continuing loss for which benefits were payable prior to such termination date and limited to the payment of the maximum benefits payable for such loss.

I. Extension of Time Limitations
If any limitation of the Policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on the Policy is less than that permitted by law of the state, district or territory in which the You reside at the time coverage is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

J. Overpayments
If we pay a benefit and it is later shown that a lesser amount should have been paid, We will be entitled to a refund of the excess. This applies to payments made to You, to a Covered Dependent, or to the provider of the Covered Services or Materials.

PART XI. COORDINATION OF BENEFITS (COB)

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

A. DEFINITIONS RELATED TO COB

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

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for vision services on either a group or individual basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

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

B. BENEFIT COORDINATION

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

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately.
Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

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

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

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

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

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

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

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

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

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

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

D. Right to Receive and Release Needed Information

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. Right to Make Payments To Another Plan

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

F. Right to Recovery

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

PART XII. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

Starmount Life Insurance Company
AlwaysCare Benefits, Inc.
P. O. Box 14389
Baton Rouge, LA 70898-4389

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XIII. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XV: REPLACEMENT OF EXISTING COVERAGE

This provision applies when the Policy replaces coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the Prior Plan. Coverage under this Policy will not be considered as replacement coverage unless the Policyholder's coverage under this Policy takes effect within 60 days after coverage under the Prior Plan ends.

In the absence of this provision, an Insured who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under this Policy because the person is not actively at work or is confined in a hospital.

Each such person will be insured under this Policy if:

(a) the person was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
(b) the prior plan covered more than fifteen (15)people; and
(c) the person is a Member of an Eligible Class under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY**. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

Louisiana Life and Health
Insurance Guaranty Association
P. O. Drawer 44126
Baton Rouge, Louisiana 70804

Louisiana Department of Insurance
P. O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. On the back of this page is a brief summary of the Law's coverage, exclusions and limits. This summary does not cover all provisions of the Law nor does it in any way change any person's right or obligations under the Law or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(over)

EXCLUSIONS FROM COVERAGE

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

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

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by the prospectus:

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

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

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

(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;

(8) any obligation that does not arise under the express written terms of the policy or contract;

(9) any policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Part D coverage.

Other exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Law, Louisiana Revised Statutes R.D. 22.2081 *et seq*.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more that what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000, no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the association will not pay more than $100,000 in cash surrender values, $500,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

STARMOUNT LIFE INSURANCE COMPANY
PRIVACY NOTICE AND NOTICE OF INSURANCE INFORMATION PRACTICES
2004

This Notice Describes How Medical and Financial Information About You May Be Used and Disclosed. Please Review This Notice Carefully.

Starmount Life Insurance Company and its insurance affiliates are committed to protecting your privacy and the confidentiality of information we collect from you or about you in compliance with Gramm-Leach-Bliley (GLB) law.

We are required by law to maintain the privacy of your protected health and financial information. This notice outlines our duties and practices in this regard.

How We Collect Information: We get most information from you or anyone you have authorized to provide the information. Information is obtained from your application for insurance, from other related forms or through a verification phone call with you. If additional information is needed, we may obtain it from your independent sales agent, physicians, hospitals, or other medical personnel, your employer, other transactions with our company or its affiliates, other insurers, the Medical Information Bureau or consumer reporting agencies.

Information collected may relate to your personal characteristics, employment, health, avocations, finances, as well as transactions with us or our affiliates. The information we collect might include name, address, Social Security number, telephone number, date of birth, medical and family history and dependent information. It may also include type and plan of insurance, other insurance you own, claim data, the amount of insurance premiums, or any other information.

How We Protect Information: Starmount Life Insurance Company and its affiliates maintain physical, electronic and procedural safeguards to protect the information we have obtained about you and to assist us in preventing unauthorized access to that information.

Electronic records are protected by multiple computer software products that use security features such as passwords, encryption, user identification numbers, and personal identification numbers to guard against unauthorized access. Our internal systems contain electronic firewalls and other security measures designed to prevent unauthorized access to our electronic records. We also employ surveillance software to determine if any abnormal activity occurs. Electronic points of entry, as well as databases, servers, e-mail and workstations are generally protected by virus detection/removal software.

We train all employees on our Privacy Policy and the importance of the privacy and confidentiality of all information we collect.

How We Use and Disclose Information: We may disclose any information we collect when we believe it is necessary for us to conduct or service our business or where disclosure is permitted or required by law. For example, information may be disclosed while you are insured, or after your insurance terminates, to:

- Anyone to whom you have authorized us to disclose the information;
- Your independent sales agent;
- Claims adjusters to process your claims;
- Underwriters to accept or reject your request for insurance;
- Investigators and attorneys;
- Consultants, Third-party administrators, PPO Networks, and Health care clearinghouses; Data processing firms and billing firms;
- Our affiliated companies, business associates, other insurance companies and reinsurers;
- Persons or organizations that conduct audits and scientific research, including actuarial or underwriting studies;
- Persons/entities performing general administrative and claim processing activities for us; and
- Insurance regulators, courts or government agencies or others as may be permitted or required by law.

Information may also be shared with our affiliates so that they may offer you other products and services. We may also provide information to others outside Starmount Life Insurance Company with whom we have a joint marketing agreement. For example, we may have a joint marketing agreement with another insurer to enable us to offer you that company's insurance products. Any person or entity with whom we share information must maintain the same high standards of privacy and confidentiality that we require of our own employees and affiliates.

We do not make disclosures of information to any other companies that may want to sell their products or services to you. We will not sell any information to a catalog company. We do not disclose information subject to the Fair Credit Reporting Act.

Other disclosures will be made only with your written authorization, which you may revoke at any time.

Right to Access and Correct Information:
You have a right to inspect and copy your protected health information. You have a right to ask for an accounting of any disclosures of information. We may impose a reasonable fee for this service where permitted. You may ask us to correct or change our records regarding your information. If we agree, we will make the correction/change. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of information. You can contact us by phone at 225-926-2888 or by mail to
E. Sternberg, Starmount Life Insurance Company, P. O. Box 98100, Baton Rouge, LA 70898-9100, or e-mail Erich@StarmountLife.com.

Starmount Life Insurance Company
AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Starmount Life Insurance Company, Inc. and AlwaysCare Benefits, Inc. (a Starmount Life Insurance company). (collectively "Starmount") are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How Starmount May Use or Disclose Your Health Information

1. **Payment Functions.** Starmount may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** Starmount may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, Starmount may use and disclose your health information. Starmount may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, Starmount may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** Starmount may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** Starmount may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** Starmount may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker's Compensation.** Starmount may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. **Disclosures to Plan Sponsors.** Starmount may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When Starmount May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Starmount will not use or disclose your health information without written authorization from you. If you do authorize Starmount to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. Starmount is not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. Starmount is not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, Starmount may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that Starmount amend your health information. Starmount is not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. Starmount will provide one list per 12 month period free of charge; Starmount may charge you for additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Starmount's Obligations Under This Notice

Starmount is required by law to:

1. Maintain the privacy of your health information.

2. Provide you with a notice of its legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Notify you if Starmount is unable to agree to a requested restriction on how your information is used or disclosed.

5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

Starmount reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that Starmount maintains. Revised Notices will be distributed to you by mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Starmount Life Insurance Company.
P. O. Box 98100
Baton Rouge, LA 70898-9100

You may also file a complaint with the Secretary of the Department of Health and Human Services. Starmount will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: April 14, 2003.

AlwaysCare Benefits, Inc. (a Starmount Life Insurance Company)

FIRST NOTICE OF COBRA

VERY IMPORTANT NOTICE

A Federal law, usually called COBRA, requires that most employers sponsoring group dental and vision plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this notice carefully.

You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of employment (for reasons other than gross misconduct on your part), or because your employer files for reorganization under Chapter XI of the Bankruptcy Law while you are retired.

If you are the spouse of an employee covered by this employer, you have the right to choose continuation coverage for yourself if you lose your group health coverage for any of the following five reasons:

(1) The death of your spouse;

(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

(3) Divorce or legal separation from your spouse;

(4) Your spouse becomes entitled to Medicare; or

(5) Your spouse's employer files for reorganization under Chapter XI of the Bankruptcy Law while your spouse is retired.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

(1) The death of a parent;

(2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;

(3) Parents' divorce or legal separation;

(4) A parent becomes entitled to Medicare;

(5) The dependent ceases to be a "dependent child" under the Group Health Plan; or

(6) The parent's employer files for reorganization under Chapter XI of the Bankruptcy Law while the parent is retired.

Under COBRA, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the happening of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage. The employer has the responsibility to notify AlwaysCare Benefits, Inc., of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the employer is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the events described above, to inform the employer that you want continuation coverage.

If you do not choose continuation coverage, your group dental and vision insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost your group health coverage because of a termination of employment or reduction of hours. In that case, the required continuation coverage period is 18 months. If, during that 18-month period, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to his or her own continuation coverage, (for example, the former employee dies, is divorced or legally separated, or be entitled to Medicare, or a dependent ceases to be a "dependent child" under the dental and vision plan the continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

If you are entitled to 18 months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours, were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the employer within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

However, the new law also provides that your continuation coverage may be cut short for any of the following four reasons:

(1) The employer no longer provides group dental and/or vision coverage to any of its employees;

(2) The premium for your continuation coverage is not paid in a timely fashion;

(3) You become covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or

(4) You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you may have to pay all or part of the premium for your continuation coverage. You will have an initial grace period of 45 days starting with the date you choose continuation coverage to pay any premiums; and after that initial 45 day grace period, you will have a grace period of at least 30 days to pay any subsequent premiums. COBRA also says that, at the end of the 18 month, 29 month or 3 year continuation coverage period, you must be allowed to enroll in any individual conversion health plan which may be provided under the plan.

If you have any questions about COBRA, please contact the Employer. Also, if you have changed marital status, if a dependent ceases to be a "dependent child" under the plan, or if you or your spouse have a changed address, please notify the Employer.