



It is a pleasure to welcome you as a member of VisionCare Plan. To help you get the most out of your coverage, we have identified the most important things you should remember.

To take full advantage of plan benefits, you must present a Benefit Form to your VisionCare network doctor at the time of your visit. Here's how it works:

1. Before you make an eye appointment you can request a Benefit Form in a number of ways:
  - Calling our Customer Care Department at 1-800-865-3676
  - Contacting us at our Web site, [www.visioncare.com](http://www.visioncare.com)
  - Completing the "Request for VisionCare Plan Benefits Form" below, and faxing it to us toll-free at 800-421-0100.
  
2. VisionCare will send you a personalized Benefit Form valid for 60 days, that outlines your paid-in-full benefits, along with an up-to-date list of VisionCare network doctors for your area. Then schedule your appointment with the doctor of your choice. Please do not make an appointment for vision care services until you obtain an approved Benefit Form.
  
3. Give the Benefit Form to the doctor during your first visit. You'll pay your copayments at that time, as well as any additional expenses for cosmetic items you have chosen.

You have nothing more to do – the doctor provides you with all of the services listed on your Benefit Form, and bills VisionCare directly. Selecting a VisionCare network doctor from the VisionCare list assures direct payment to the doctor and a guarantee of quality and cost control.

Please Print or Type

**BOX**

**1**

<b>REQUEST FOR VISIONCARE PLAN BENEFIT FORM</b>						
<b>Employee's Name</b>						
Mr. _____	_____	_____	_____	_____	_____	_____
Mrs. _____	_____	_____	_____	_____	_____	_____
Miss _____	_____	_____	_____	_____	_____	_____
<b>Home Address</b>						
_____	_____	_____	_____	_____	_____	_____
Street	City	State	Zip	Phone		_____
Employer <b>TRINITY UNIVERSITY</b>				Group Number: <b>VS728</b>		

**2**

<b>LIST ONLY THOSE FAMILY MEMBERS REQUESTING BENEFITS AT THIS TIME</b>					<b>CERTIFIED BY VISIONCARE PLAN</b>	
<input type="checkbox"/> 1. Self	Last Name	First	Middle Initial	Birth Date	VisionCare Plan Use Only	
<input type="checkbox"/> 2. Spouse	_____	_____	_____	/ /	_____	
<input type="checkbox"/> 3. Child	_____	_____	_____	/ /	_____	
<input type="checkbox"/> 4. Child	_____	_____	_____	/ /	_____	
<input type="checkbox"/> 5. Child	_____	_____	_____	/ /	_____	
If child age 19 or over and attending school full-time, give name of school _____						
Do you have another plan that provides vision care? <input type="checkbox"/> No <input type="checkbox"/> Yes VisionCare Plan _____ <input type="checkbox"/> Other _____						
DO NOT WRITE IN THIS SPACE						
AUTHORIZED BY _____						
DATE _____						

**3**

I wish to see a doctor in (City of County) _____ (State) _____ (Zip) _____
Date _____ Employee Signature _____

**COMPBENEFITS INSURANCE COMPANY**

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100 Mansell Court East

Roswell, GA 30076

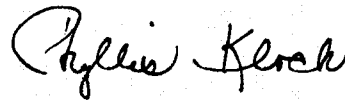
(800) 865-3676

**CERTIFICATE  
OF  
GROUP VISION INSURANCE**

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

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

Signed for CompBenefits Insurance Company



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President

## SECTION I- DEFINITIONS

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

**Dependent-** means any of the following persons:

1. Your spouse;
2. Your unmarried children or grandchildren;
  - a) from birth to age 25 and dependent upon You for support; or
  - b) at least 25 years of age and:
    - i. primarily dependent upon You for support because of mental or physical handicap;
    - ii. was incapacitated and insured under Policy on his 25<sup>th</sup> birthday; and
    - iii. continues to be incapacitated beyond his 25<sup>th</sup> birthday.

A child also includes adopted children, as well as stepchildren or foster children living with the Subscriber in a parent-child relationship.

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

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

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

**Non-VisionCare Plan Network Provider-** means any provider who is NOT under agreement with the VisionCare Plan Network.

**Policy-** means the Policy issued to the Policyholder.

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

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

“You” and “Your” means the Certificateholder.

**VisionCare Plan Network-** means jointly and severally the VisionCare Plan Network Providers under agreement with Us to provide certain vision services to individuals at contracted rates and terms.

**VisionCare Plan Network Provider-** means a provider under agreement with VisionCare Plan Network.

“We”, “Our”, “Us”, and “Plan” means CompBenefits.

## SECTION II-BECOMING INSURED

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

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

**Newborn Child-** A child born to You or Your Dependent spouse is covered from the moment of birth for 30 days. If you choose to insure Your newborn, You must enroll the child within 30 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 30-day period.

**Adopted Child-** A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child

under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.

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

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

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

### **SECTION III-PROCEDURES FOR USING BENEFITS**

**Provider Choice** - The Insured may elect to receive services and Materials from either a VisionCare Plan Network Provider or a Non-VisionCare Plan Network Provider of his or her choice.

#### **Benefit Form Method**

Prior to obtaining vision care, an Insured must request a Benefit Form. Benefit Forms may be obtained by: (i) calling the Member Services department at 1-800-865-3676; (ii) contacting Our Web site at [www.visioncare.com](http://www.visioncare.com); or (iii) by completing the form entitled "Request for Vision Care" supplied by Us and faxing it toll free to 1-800-421-0100 or mailing it to Us at P.O. Box 30349, Tampa, FL 33630-3349. Upon determination that the Insured is eligible, a Benefit Form will be sent to the Insured together with a list of VisionCare Plan Network Providers for the Insured's area. **CAUTION: Do not make an appointment for services until the Benefit Form is received.**

The Insured then selects a provider from the list of VisionCare Plan Network Providers delivered with the Benefit Form and makes an appointment for services directly with the provider's office. It is important to give the VisionCare Plan Network Provider the Benefit Form at the time of the first visit. If the Insured does not obtain the Benefit Form in advance, but visits the VisionCare Plan Network provider as a private patient, the provider is not obligated to accept Our fees as full payment for services and may elect to charge the Insured his usual and customary fees. **CAUTION: Services must begin prior to the expiration date noted on the Benefit Form.**

Upon completion of the initial examination, the VisionCare Plan Network Provider will require that the Insured sign the Benefit Form. At this time, the Insured is required to pay the VisionCare Plan Network Provider the Copayment, if any, and the costs and fees associated with services or materials NOT covered by the Policy. The VisionCare Plan Network Provider will process the Benefit Form and submit it to Us.

In the event the Insured receives a prescription for corrective eyewear from the examining VisionCare Plan Network Provider, he may obtain Materials from that provider or another VisionCare Plan Network Provider.

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

## **SECTION IV-LIMITATIONS AND EXCLUSIONS**

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

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

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

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

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

**Exclusions-** We will not cover:

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

## **SECTION V-COORDINATION WITH OTHER BENEFITS**

### **1. APPLICABILITY.**

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

### **2. DEFINITIONS.**

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

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

"This Plan" means this Policy.

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

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

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

### 3. ORDER OF BENEFIT DETERMINATION RULES.

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

- (a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
  - (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.
- (b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.
- (d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

#### 4. EFFECT ON THE BENEFITS OF THIS PLAN.

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

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

#### 5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

#### 6. FACILITY OF PAYMENT.

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

#### 7. ERRORS RELATED TO YOUR COVERAGE.

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

### **SECTION VI-PREMIUMS**

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

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

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

**Reinstatement** - If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by CompBenefits or by any agent authorized by CompBenefits to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has

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

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

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

## **SECTION VII-CLAIMS**

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

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

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

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

**Legal Action** - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

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

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

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

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

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

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

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

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

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

## **SECTION IX-GENERAL PROVISIONS**

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

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

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

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

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

### **SCHEDULE OF BENEFITS**

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

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

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

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

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

**Contact lenses when elective** - We will cover the combined cost of an annual vision exam, contact lens evaluation exam, fitting costs and contact lenses up to a maximum of **\$105.00**. Payment will be **IN LIEU OF ALL OTHER BENEFITS**. Replacement will not be more often than once in any **12 month** period. The Copayment is waived.

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

1. Vision Examination **\$10**
2. Materials **\$15**

**Allowance** – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule after deduction of the applicable Co-payment.

Vision Examination	\$35
Single Vision Lens	\$25
Bifocal Lens	\$40
Trifocal Lens	\$60
Lenticular Lens	\$100
Contact Lenses when elective	\$105
Contact Lenses when necessary	\$210
Frame	\$40

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

**WHEN SERVICES ARE OBTAINED FROM A NON-VISIONCARE PLAN NETWORK PROVIDER, PAYMENT OF BENEFITS ARE BASED UPON THE VISIONCARE PLAN ALLOWANCE AFTER DEDUCTION OF THE CO-PAYMENT LISTED ABOVE.**

## DOMESTIC PARTNER RIDER

The Certificate issued by Company to the Policyholder is hereby amended, effective upon receipt of this Rider, as follows:

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Rider are in conflict with the terms and conditions of the Certificate, the terms of this Rider shall govern.

### Domestic Partners

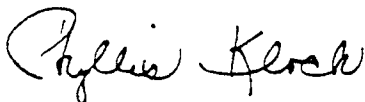
A domestic partner of the certificateholder is an Eligible Dependent if:

- 1) the domestic partner has lived with the certificateholder at the same regular residence and been each other's sole domestic partner continuously for a minimum of twelve ( 12) months and intends to continue such indefinitely;
- 2) is not legally married to anyone else;
- 3) is 18 years of age or older;
- 4) is not related to the certificateholder; and
- 5) is financially interdependent with certificateholder.

The domestic partner has to be the same sex as the certificateholder.

It is agreed and acknowledged that this Rider shall be effective upon receipt by certificateholder.

Signed for CompBenefits Insurance Company



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President