UNITED HEALTHCARE INSURANCE COMPANY

VISION INSURANCE

CERTIFICATE OF COVERAGE

FOR

ACTION EXPEDITING INC

GROUP NUMBER: G/GA5P2662BW VISION PLAN: V0008

EFFECTIVE DATE: June 1, 2015

OFFERED AND UNDERWRITTEN BY

UNITED HEALTHCARE INSURANCE COMPANY

UnitedHealthcare Insurance Company
Group Vision Care PPO Certificate of Coverage

Issued To:	ACTION EXPEDITING INC ("Enrolling Group")
Policy Number:	G/GA5P2662BW
Policy Effective Date:	June 1, 2015

This *Certificate(s) of Coverage ("Certificate")* sets forth your rights and obligations as a Covered Person. It is important that you read your *Certificate* carefully and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide Coverage for Vision Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy will take effect on the date specified in the Policy and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Georgia .

This is a Preferred Provider Policy.

This Certificate describes Network and Non-Network Benefits. If the Copayment for a Benefit shown in the Group Vision Care Table of Benefits is a percentage, the difference between the Copayment for Network and Non-Network Benefits may not exceed 30%.

In the event of an Emergency, seek attention at the nearest appropriate provider. In this case, the Service will be paid as a Network Benefit until the Covered Person can be safely transferred to the care of a Network Provider.

To find a Network Provider, you may call the Spectera Locator Service at 1-800-839-3242. Spectera, Inc. is a Third Party Administrator for UnitedHealthcare Insurance Company. You may also access a listing of Network Providers on the Internet at www.myuhcvision.com. The listing of Network Providers is updated by the Company annually.

Introduction to Your Certificate

You and any of your Enrolled Dependents, are eligible for Coverage under the Policy if the required Premiums have been paid. The Policy is referred to in this *Certificate* as the "Policy".

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a *Certificate,* this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Vision Services rendered after the effective date of the Policy, this *Certificate* replaces and supersedes any *Certificate* which may have been previously issued to you by the Company that pertains to the specific Vision Services Covered by the Policy.

The employer expects to continue the group plan indefinitely. But the employer reserves the right to change or end it at any time. This would change or end the terms of the Policy in effect at that time for active employees.

How To Use This Certificate

This *Certificate* should be read in its entirety. Many of the provisions of this *Certificate* and the attached *Schedule(s) of Covered Vision Services* are interrelated; therefore, reading just one or two provisions may not give you an accurate understanding of your Coverage.

Your *Certificate* and *Schedule(s) of Covered Vision Services* may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this *Certificate* or *Schedule(s) of Covered Vision Services* may have been changed.

Many words used in this *Certificate* and *Schedule(s) of Covered Vision Services* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions.* By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Schedule(s) of Covered Vision Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in *Section 1: Definitions.*

From time to time, the Policy may be amended. When that happens, a new *Certificate, Schedule(s) of Covered Vision Services* or Amendment pages for this *Certificate* or *Schedule(s) of Covered Vision Services* will be provided to you. Your *Certificate* and *Schedule(s) of Covered Vision Services* should be kept in a safe place for your future reference.

However, this *Certificate* may be amended at any time by applicable state or Federal laws, rules and regulations. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede this *Certificate.*

We have sole authority to interpret the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. We may, from time to time, delegate this authority to other persons or entities providing services in regard to the Policy.

Contact Us

Throughout this *Certificate* you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding Vision Services or any required procedure, please contact us at 1-800-638-3120.

Group Vision Care Certificate of Coverage Table of Contents

Section 1: Definitions

This section defines the terms used throughout this *Certificate* and *Schedule(s) of Covered Vision Services* and is not intended to describe Covered or uncovered services.

Amendment - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

Copayment - the charge that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

Coverage or Covered - the entitlement by a Covered Person to reimbursement for expenses incurred for Vision Services Covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Vision Services must be provided: (1.) when the Policy is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in *Section 3: Termination of Coverage* occur; and (3.) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Network Vision Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Person - either the Subscriber or an Enrolled Dependent, while Coverage of such person under the Policy is in effect. References to you and your throughout this *Certificate* are references to a Covered Person.

Dependent - (1.) the Subscriber's legal spouse or (2.) a Dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any Dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section Coverage for a Disabled Dependent Child.*

The Subscriber agrees to reimburse us for any Vision Services provided to the child at a time when the child did not satisfy these conditions.

The term Dependent also includes a child for whom vision care Coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.

Eligible Person - an employee or member of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

Enrolled Dependent - a Dependent who is properly enrolled for Coverage under the Policy.

Enrolling Group - the employer or other defined or otherwise legally constituted group (Association, Union, etc.) to whom the Policy is issued.

Experimental, Investigational or Unproven Services - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding Coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. territories.

Initial Eligibility Period - the initial period of time, determined by us and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Network - the collective group of Vision Providers who are subject to a participation agreement in effect with us, directly or through another entity, to provide Vision Services to you. The participation status of providers will change from time to time. The participation status of the provider may change based on the location where Vision Services were provided.

Network Benefits - benefits available for Covered Vision Services when provided by a Vision Provider who is a Network Vision Provider.

Non-Network - a Vision Provider who is not a participant in the Network.

Non-Network Benefits - Coverage available for Vision Services obtained from Non-Network Vision Providers.

Physician - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Plan Year - a period of time beginning with the month and day of the Policy Effective Date of any year and terminating exactly one year later. If the month and day of the Policy Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between us and the Enrolling Group.

Premium - the periodic fee required to maintain Coverage of Covered Persons in accordance with the terms of the Policy.

Rider - any attached description of Vision Services Covered under the Policy. Vision Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

Subscriber - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group. A Subscriber must reside within the United States or U.S. territories.

Vision Provider - any optometrist, ophthalmologist, or other person who may lawfully provide services to Covered Persons participating in our vision plans.

Vision Service - any Covered benefit listed in *Section 7: Covered Vision Services.*

Section 2: Eligibility and Effective Date of Coverage

Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period by completing information provided by the Enrolling Group. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Effective Date of Coverage

In no event is there Coverage for Vision Services rendered or delivered before the Policy Effective Date of Coverage.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day after any applicable waiting period required by the Enrolling Group is completed.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and us. Coverage is effective only if we receive any required Premium and properly completed enrollment information within 31 calendar days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. In the case of adoption, Coverage will take effect on the earlier of the date of placement for adoption or the date of legal adoption. Coverage is effective only if we receive any required Premium and are notified of the event within 31 calendar days.

Change in Family Status

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, death, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In the case of adoption, Coverage will take effect on the earlier of the date of placement for adoption or the date of legal adoption. In such cases you must submit the required contribution of coverage and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption.

Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

A. the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period; and

B. Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if we receive any required Premium and properly completed enrollment information within 31 calendar days of the date coverage

under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption.

Section 3: Termination of Coverage

Conditions for Termination of a Covered Person's Coverage Under the Policy

We may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy.

Your Coverage, including Coverage for Vision Services rendered after the date of termination for vision conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber, Enrolled Dependent or active member of the Policyholder.

C. The date in which the Dependent child attains the limiting age.

D. The date we receive written notice from either the Subscriber or the Enrolling Group instructing us to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

E. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, we will provide written notice of termination to the Subscriber.

F. The date specified by us that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided us with false material information, including, but not limited to, false material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. We have the right to rescind Coverage back to the Policy Effective Date.

G. The date specified by us that all Coverage will terminate because the Subscriber permitted the use of his or her proof of Coverage by any unauthorized person or used another person's proof of Coverage.

H. The date specified by us that Coverage will terminate due to material violation of the terms of the Policy.

I. The date specified by us that your Coverage will terminate because you failed to pay a required Premium.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the Coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless Coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 calendar days of the date Coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of Coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 calendar days of our request as described above, Coverage for that child will end.

Payment and Reimbursement Upon Termination

Termination of Coverage will not affect any request for reimbursement for Vision Services rendered prior to the Policy Effective Date of termination. Your request for reimbursement must be furnished as required in *Section 4: Reimbursement.*

Section 4: Reimbursement

Reimbursement for Services

The Covered Person will be responsible for any claims paid by us when Coverage was provided in error, except where that error was made by us. We will reimburse you for Vision Services subject to the terms, conditions, exclusions and limitations of the Policy and as described below.

Payment of Claims

When obtaining Vision Services from a Network Vision Provider, you will be required to pay a Copayment and any charges not Covered by the Policy to your Vision Provider. When obtaining Services from a Network Vision Provider, you will not be required to submit a claim form.

When obtaining Vision Services from a Non-Network Vision Provider, you will be required to pay all billed charges to your Vision Provider. You may then obtain reimbursement from us for the Covered portion of Vision Services.

Filing Claims for Reimbursement

You are responsible for submitting a request in writing for reimbursement to our office. Requests for reimbursement should be submitted within 90 calendar days after the date of service. Unless you are legally incapacitated, failure to provide this information to us within 365 calendar days from the date of service will cancel or reduce Coverage for the Vision Service.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof of loss that you submit to us must include all of the following information:

- Your name and address; and
- Patient's name and age; and
- Your identification number; and
- The name and address of the provider(s) of the services(s); and
- Itemized bill which includes a description of each charge; and
- A statement indicating that you are or you are not enrolled for coverage under any other health or vision insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s); and
- Any other information requested by the Company.

If you would like to use a claim form, you may access a form on the Internet at www.myuhcvision.com or call us at 1-800-638-3120 and a claim form will be provided to you. If you do not receive the forms before the expiration of 10 working days after giving us notice, you will 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 written proof of loss.

Reimbursements are payable within 15 working days after the Company receives acceptable proof of loss. Reimbursements made after 15 working days from the date the Company received acceptable proof of loss will include interest in the amount of 18 percent per annum on the amount due.

Proof of Loss. Written proof of loss should be given to us within 90 calendar days after the date of the loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 365 calendar days after the date of service.

Obtaining Services

To find a Network Vision Provider, you may access a listing of Network Vision Providers on the Internet at www.myuhcvision.com. You may also call the UnitedHealthcare Provider Locator Service at 1-800-839-3242. The listing of Network Providers is updated by the Company annually.

You also may obtain Services from a Non-Network Vision Provider. However, the amount of Coverage may be reduced.

Foreign Services

Foreign Services will be treated as Non-Network Benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. We make no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published on the date the Vision Services were rendered.

Section 5: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact Customer Service at 1-800-638-3120. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer Service at 1-800-638-3120. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

How to Request an Appeal

If you disagree with either a claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Vision Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the claim denial.

You also have the option to direct your appeal to the:

Georgia State Insurance Department

Consumer Services Division

Room 716 W, 2 MLK Dr.

Atlanta, GA 30334

Telephone (404) 656-2070.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Vision Provider with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, vision experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent vision claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge.

Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of claims as identified above, the appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending Vision Service is necessary or appropriate. That decision is between you and your Vision Provider.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Section 6: General Legal Provisions

Entire Policy

The Policy issued to the Enrolling Group, including the *Certificate(s), Schedule(s) of Covered Vision Services,* the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the Policy, be deemed representations and not warranties. No such statements shall be used in defense to a claim under the policy, unless contained in a written application.

Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Enrolling Group will be used to void the Policy after it has been in force for a period of 2 years.

Amendments and Alterations

Amendments to the Policy, except those subject to the Change in Premium Rates provision of the Policy, are effective upon 31 calendar days prior written notice to the Enrolling Group. Riders are effective on the date specified by us. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Relationship Between Parties

The relationships between us and Network Vision Providers and relationships between us and Enrolling Groups are solely contractual relationships between independent contractors. Network Vision Providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of Network Vision Providers or Enrolling Groups.

The relationship between a Network Vision Provider and any Covered Person is that of Vision Provider and patient. The Network Vision Provider is solely responsible for the services provided to any Covered Person. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company) and for the timely payment of the Policy Charge.

The relationship between the Enrolling Group and Covered Persons is that of employer and employee, Dependent or other Coverage classification as defined in the Policy.

Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proof that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it, we may delay or deny payment of your Coverage.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning vision care services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your vision records or billing statements, we recommend that you contact your Vision Provider. Vision Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request vision forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Vision Services, we may reasonably require that a Network Vision Provider, acceptable to us, examine you at our expense, when and as often as it may reasonably require during the pendency of a claim under the Policy. We also have the right and opportunity to make an autopsy in case of death, if an autopsy is not prohibited by law.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits or Coverage.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of applicable state or federal statutes or regulations is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services,* or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services.*

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* to the greatest extent legally permissible.

Refund of Overpayments

If we pay benefits for expenses incurred on account of you, that you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment we made exceeded the benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, then you agree to help us get the refund when requested.

If you, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits for you that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Section 7: Covered Vision Services

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides including:

A. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;

B. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);

C. Cover test at 20 feet and 16 inches (checks eye alignment);

D. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;

E. Pupil responses (neurological integrity);

F. External exam;

G. Refraction (when applicable) - to determine power of corrective lenses for distance and near vision;

H. Phorometry/Binocular testing - far and near: how well eyes work as a team;

I. Tonometry, when indicated: test pressure in eye (glaucoma check);

J. Ophthalmoscopic examination of the internal eye;

K. Confrontation visual fields;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

O. Dilation (when indicated) - Examine the internal structures of the eye;

P. Specific recommendations; and

Q. Any other related services as designated by the Company.

Or in lieu of a routine exam, Refraction to determine power of corrective lenses for distance and near vision.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

Contact lenses are necessary if the Covered Person has:

A. Keratoconus;

B. Anisometropia;

C. Irregular corneal/astigmatism;

D. Aphakia;

E. Facial deformity;

F. Corneal deformity; or

G. Any other condition the Company designates.

Contact Lens Fitting & Evaluation

A contact lens evaluation and fitting includes examination and measurement of the eyes and adjacent structures to determine the contact lens size, design and power to achieve and maintain eye health, comfort and vision. It may include up to 2 follow-up visits as needed. Contact Lens benefits include the fitting/evaluation fees and contacts.

Section 8: General Exclusions

The following Services and materials are excluded from Coverage under the Policy:

A. Non-prescription items (e.g. Plano lenses) other than those listed in the *Schedule(s) of Covered Vision Services.*

B. Services that the Covered Person, without cost, obtains from any governmental organization or program.

C. Services for which the Covered Person may be compensated under Workers' Compensation Law, or other similar employer liability law.

D. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.

E. Medical or surgical treatment for eye disease, which requires the services of a Physician.

F. Replacement or repair of lenses and/or frames that have been lost or broken.

G. Optional Lens Extras not listed in the Schedule(s) of Covered Vision Services.

H. Missed appointment charges.

I. Applicable sales tax charged on Services.

J. Services that are not specifically covered by the Policy.

K. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

L. Any Vision Service rendered by the Policyholder.

M. Intraocular lenses.

Schedule of Covered Vision Services

The following Vision Services will be covered, subject to a Copayment, when obtained from Network Providers.

When obtaining these Vision Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Vision Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Network Benefit" in the chart below.

When obtaining these Vision Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement for non-Network Providers will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	**FREQUENCY OF SERVICE**	**NETWORK BENEFIT**	**NON-NETWORK BENEFIT**
Routine Vision Examination	Once every 12 months	After a Copayment of $10.00 .	To a maximum of a $40.00 allowance.
Refraction Only in Lieu of Routine Vision Examination	Once every 12 months	$0 allowance	To a maximum of a $40.00 allowance.
Contact Lens Fitting and Evaluation	Once every 12 months	After a Copayment of $25.00 . One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection. To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection.	To a maximum of a $105.00 allowance.
Eyeglass Frames[A]	Once every 24 months	Private Practice Network Provider After a Copayment of $25.00 [B] to a maximum of a $50.00 allowance.	To a maximum of a $45.00 allowance.

		Retail Network Provider After a Copayment of $25.00 [B] to a maximum of a $130.00 allowance.	
Eyeglass Lenses[A]	Once every 12 months		
Single Vision*		After a Copayment of $25.00 .[B]	To a maximum of a $40.00 allowance.
Bifocal-lined		After a Copayment of $25.00 .[B]	To a maximum of a $60.00 allowance.
Trifocal-lined		After a Copayment of $25.00 .[B]	To a maximum of a $80.00 allowance.
Lenticular		After a Copayment of $25.00 .[B]	To a maximum of a $80.00 allowance.
Contact Lenses[A]	Once every 12 months	After a Copayment of $25.00 for up to 4 boxes from the Covered Contact Lens Selection.[C] One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection. To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection.[C]	To a maximum of a $105.00 allowance.
Necessary Contact Lenses[A]	Once every 12 months	After a Copayment of $25.00 .	To a maximum of a $210.00 allowance.

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
  - Scratch-resistant coating

[A]You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision Services, only one Service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

[B]If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[C]Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for lens not from the Covered Contact Lens Selection will be used.

*Single vision lens are defined as one single power across their entire surface with a single optical center and are made from CR-39 or glass material.