UNITED HEALTHCARE INSURANCE COMPANY

VISION INSURANCE

CERTIFICATE OF COVERAGE

FOR

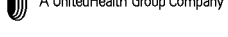
EVERGREEN COMMUNITY CHARTER SCHOOL

GROUP NUMBER: GA7P4105IM VISION PLAN: V1043

EFFECTIVE DATE: October 1, 2012

OFFERED AND UNDERWRITTEN BY

UNITED HEALTHCARE INSURANCE COMPANY



UnitedHealthcare Insurance Company
Group Vision Care Certificate of Coverage

Issued To:	EVERGREEN COMMUNITY CHARTER SCHOOL ("Enrolling Group")
Policy Number:	GA7P4105IM
Policy Effective Date:	October 1, 2012
Policy Anniversary Date:	September 1

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 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.

Many words used in this *Certificate* and the attached *Table of Benefits* 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 *Table of Benefits.*

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

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

Group Vision Care Certificate of Coverage Table of Contents

Read your Certificate Carefully

This is a legal contract between the policyholder and the Company.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

Important Cancellation Information. Please read the provision entitled "Termination of Coverage" in Section 3 of this Certificate.

Section 1: Definitions

Copayment - The charge, in addition to the Premium, 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. The negotiated fee shall base deductibles or copayments on the negotiated fee or the ordinary charge if less than the negotiated fee.

Covered Person - The Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. Reference to "you" and "your" throughout this *Certificate* are references to Covered Persons.

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

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, a foster child from the moment of placement in the home, 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. 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 Provisions* section titled *"Extended Coverage for Dependent Handicapped Children".*

The Subscriber agrees to reimburse the Company 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 "foster child" means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

The term "placement in the foster home" means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

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 - A person who meets all applicable eligibility requirements for vision care coverage.

Employee - A nonseasonal person who works on a full time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part time, temporary, or substitute basis.

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

Enrolling Group - The employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental, Investigational or Unproven Services - Medical, vision, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes 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.

Network Benefits - Coverage for Services provided by a Network Provider.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Non-Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services to Covered Persons.

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

Policy - The Group Vision Care Insurance Policy issued to the Enrolling Group.

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

Service - Any covered benefit listed in *Section 4: Benefits* of this *Certificate.*

Subscriber - An Eligible Person who is properly enrolled for Coverage under the Policy and is the person on whose behalf the Policy is issued to the Enrolling Group.

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. 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.

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 the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 90 days after the first day of employment.

Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by legal guardianship, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days. Enrollment periods will be waived for court ordered dependents.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption or foster home will be effective upon the date of birth or the date of placement in the adoptive/foster home. If additional monthly premiums are required, you must notify the Company and pay the required premium within 31 days of acquiring the new Dependent. If no additional monthly premium will be required, a newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put into effect within 31 days.

Section 3: Termination Provisions

Termination of Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date the entire Policy is terminated for the reasons specified in the Policy. The Enrolling Group is responsible for notifying the Subscriber 45 days in advance of the termination of the Policy.
2. The date the Covered Person ceases to be an Eligible Person.
3. The date requested in such notice when the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.
4. 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, the Company will provide written notice of termination to the Subscriber 45 days in advance of the termination of the Policy:

5. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
6. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
7. The date specified by the Company that, unless the Company has begun legal proceedings against the Covered Person, the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.
8. The date specified by the Company that all Coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.
9. The date specified by the Company that your coverage will terminate because the Subscriber failed to pay a required Premium.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse. If the termination is due to fraud, no statement made by the Enrolling Group, will be used to void this Policy after it has been in force for a period of 2 years.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;

C. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and

D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's coverage under the Policy.

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the *Table of Benefits.* Your rights to Benefits are subject to the terms, conditions, and exclusions of the Policy, including this *Certificate,* and any attached Amendments.

Obtaining Services

To find a Network Provider, you may call the Spectera Locator Service at 1-800-839-3242. You may also access a listing of Network Providers on the Internet at www.myuhcvision.com.

Covered services, with exception to preventive care, will be covered in or out of network.

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. The Company makes 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 in the Wall Street Journal on the date the claim is processed.

Section 5: Benefit Descriptions

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, to include:

1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. 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;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) - objective refraction to determine lens power of corrective Subjective refraction - to determine lens power of corrective lenses;
9. Phorometry/Binocular testing - far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopic examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis; and
17. Specific recommendations.

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, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating. 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 provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

1. Keratoconus;
2. Anisometropia;
3. Irregular corneal/astigmatism;
4. Aphakia;
5. Facial deformity; or
6. Corneal deformity.

Section 6: General Provisions

Legal Actions

No action at law or in equity may 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 this Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. 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.

Time Limit on Certain Defenses

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

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it 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.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

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.

Notice

When the Company provides 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 Covered Persons.

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 state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* 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 *Table of Benefits,* 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 *Table of Benefits.* State mandated items may not be waived.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits.*

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* 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 *Table of Benefits* to the greatest extent legally permissible.

Reinstatement

If any renewal premium is not paid within the time granted to you for payment, a subsequent acceptance of premium by the Company or by an agent duly authorized by the Company to accept such premium shall reinstate the Certificate; provided however, that if the Company or such agent received an application for reinstatement and issued a conditional receipt for the premium tendered. The Certificate will be reinstated upon approval of such application by the Company, or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the Company has previously notified you in writing of its disapproval of the application. The reinstated Certificate will 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 10 days after such date. In all other respects the insured and the Company will have the same rights as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Section 7: Claims

Proof of Loss

Notice of claim as determined by us must be given to us within 180 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

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

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

Time of Payment of Claims

Indemnities payable under this Policy for any loss other than loss for which this Policy provides any period 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 this 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.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information on claim form acceptable to the Company:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name; and
5. Patient date of birth.

Submit the above information to us:

By mail:

Spectera Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursements are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Policy, you should contact the Company's customer service department. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason you believe the claim should be paid.

Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following the receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 9: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

B. All or some of the payment made by the Company exceeded the benefits under the Policy; or

C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the Covered Person does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 10: Exclusions

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

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from a governmental organization or program, except that no health insurer shall take into account that the Covered Person is eligible for, or is provided medical assistance in this or any other state under 42 U.S.C. § 1396a (section 1902 of the Social Security Act) in insuring that Covered Person, or making payments under its health benefit plan for benefits to that Covered Person or on that individual's behalf.
3. Services for which the Covered Person are paid under Workers' Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Optional Lens Extras not listed in the *Table of Benefits.*
8. Missed appointment charges.
9. Applicable sales tax charged on Services.
10. Services that are not specifically covered by the Policy.
11. 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.

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: UnitedHealthcare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

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

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

Differentials in Copayment percentages which are applicable to benefit levels for services provided by Network and Non-Network providers may not exceed 30%.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Routine Vision Examination	Once every 12 months	$15.00	Up to $40.00
Eyeglass Frames	Once every 24 months[1]	$30.00 [2](100% of the billed charged to a maximum of $130)	Up to $45.00
Eyeglass Lenses	Once every 12 months[1]		
• Single Vision		$30.00 [2]	Up to $40.00
• Bifocal Vision		$30.00 [2]	Up to $60.00
• Trifocal Vision		$30.00 [2]	Up to $80.00
• Lenticular Vision		$30.00 [2]	Up to $80.00
Contact Lenses	Once every 12 months[1]	$30.00 from the Covered Contact Lens Selection[3]	Up to $105.00

• Necessary		$30.00	Up to $210.00

Optional Lens Extras:

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

[1]You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

[2]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.

[3]You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of $105.00. No Copayment will apply to non-selection Contact Lenses.