



Combined Insurance Company of America
(called We, Our and Us)
5050 Broadway, Chicago, Illinois 60640
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

GROUP POLICY NUMBER: 9664343

POLICYHOLDER: MHMRA of Harris County

DATE OF ISSUE: January 1, 2007

STATE OF DELIVERY: Texas

GROUP VISION CARE INSURANCE POLICY

In consideration of the application for this Policy, copy of which is attached, and the payment of all premiums when due, We agree to pay the benefit described in this Policy in accordance with and subject to the terms and provisions of this Policy.

The provisions of the attached certificate and all riders issued on and after the Policy Date of Issue are made part of this Policy.

This Policy is subject to the laws of the State of Texas.

Signed for Combined Insurance Company of America.

Chairman and Chief Executive Officer

Secretary

PREMIUM CALCULATIONS AND PAYMENT

Premiums are payable based on a mode of payment requested by the Policyholder and agreed to by Us. Premiums must be paid to Us at Our Home Office or to Our authorized administrator.

The payment of any premium will keep the coverage in force to the next premium due date, subject to the Grace Period provision of the Policy Provisions. A 31 day Grace Period will be given, with no interest charge, to pay any late amount due.

We may change the premium for the insurance provided under the Policy by giving the Policyholder a written notice at least 31 days prior to any change.

POLICY PROVISIONS

ENTIRE CONTRACT: This Policy, the application of the Policyholder (a copy attached to this Policy) and individual enrollment forms, if any, will constitute the entire contract between the Policyholder and Us.

No agent or other individual except Our President or Secretary has the authority to make or modify this Policy or extend the time for payment of any premium. No change in this Policy will be valid unless made by endorsement or by amendment signed by the Policyholder and Our President or Secretary and attached to this Policy. Any change so made will be binding on the Insured and on any other person(s) referred to in this Policy.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of premiums after the first premium. The coverage under this Policy will continue in force during such Grace Period, but the Insured will be liable for the premium for any period such coverage continues in force, provided written notice of termination has not previously been given Us.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Policy. No such action will be brought after the expiration of 3 years after written proof of loss is required to be furnished.

CERTIFICATES: We will issue an individual Certificate describing the benefits under the Policy.

NON-PARTICIPATION: This Policy does not share in Our surplus earning.

CONFORMITY TO LAW: Any provision of this Policy which, on Date of Issue, is in conflict with the laws of the state in which the Policy was delivered or issued for delivery, is considered amended to conform to the applicable requirements of such state.

CLERICAL ERROR: Clerical error will not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

TERMINATION OF POLICY: We have the right to terminate the Policy on any premium due date by giving written notice to the Policyholder at least 60 days in advance of such action. The Policyholder may terminate the Policy on any premium due date after the first, by giving Us written notice at least 60 days in advance of such requested action.

CERTIFICATE PROVISIONS MADE PART OF THE POLICY

The remainder of this Policy consists of provisions shown in the Certificate as issued to the Certificateholder. The provisions described in the TABLE OF CONTENTS are part of this Policy. Riders and amendments, if any, adding or changing the provisions of the Certificate are also made part of this Policy.



Combined Insurance Company of America
5050 Broadway, Chicago, Illinois 60640
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

ENDORSEMENT FOR RESIDENTS OF TEXAS

This endorsement is issued as a part of the Policy and to any Certificate to which it is attached. Notwithstanding anything to the contrary in the Policy, the following changes and/or additions apply with respect to an Insured who resides in the state of Texas.

The following are added or changed:

1. **Dependent** - means Your spouse and any of the following persons to age 25:

Your:

- a. unmarried child from birth;
- b. stepchild;
- c. grandchild
- d. adopted child from the moment You are party in an court agreement to adopt the child or a child for whom You required by court or administrative order to provide medical support.

Dependent also includes a child who over the age of 25 who is incapable of self sustaining employment because of mental or physical handicap, and is chiefly dependent on You for maintenance and support. Proof of a Dependent's incapacity or dependence shall be furnished to Us within 31 days of a child's attainment of the limiting age. We may request subsequent proof of incapacity or dependency no more than once every year. The insured Student must provide proof that a child continues to be handicapped.

Children for whom You have a legal obligation for the purposes of adoption, will be covered effective from the date the legal obligation begins. Coverage will continue until the legal obligation for the purposes of adoption ends, or the Policy ends, whichever occurs first.

- a. On receipt of written notice from the Texas Department of Health or its designee that states that a person who is otherwise eligible for enrollment under the Policy is a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code, We will permit the person to enroll without regard to any enrollment period restriction.
- b. On receipt of written notice from the Texas Department of Health or its designee that states that a child who is otherwise eligible for enrollment under the Policy is enrolled in the state child health plan under Chapter 62, Health and Safety Code, and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, We will permit the child to enroll without regard to any enrollment period restriction.
- c. If a person in a. or b. above is not eligible to enroll unless a family member is also enrolled, We, on receipt of the written notice, will enroll both the person and the family member.

Unless enrollment occurs during an established enrollment period, enrollment takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by Us.

We will permit a person who is enrolled under 1. above and any family member of the person enrolled under 3. above to terminate enrollment not later than the 60th day after the date on which he provides satisfactory proof to Us that he is no longer: (a) a recipient of medical assistance under the state Medicaid program; or (b) a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code.

We will permit a person who is enrolled under 2. above and any family member of the person enrolled under 3. above to terminate enrollment not later than the 60th day after the date on which he provides satisfactory proof to Us that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan.

2. **Your Coverage Starts** – Coverage for You and/or Your Dependent will start on the later of:
1. the date requested by the Policyholder and agreed to by Us; or
 2. the date We accept Your enrollment, if you do not enroll within 31 days of Your becoming eligible. We may require a waiting period before accepting Your enrollment when you seek to enroll more than 31 days after you are eligible. See Your employer for any waiting period.

Your Dependents are eligible for coverage on the date You are eligible or on date You first acquire a new Dependent.

3. **Newborn Infant Coverage** - Your newborn child is covered from the moment of birth. If any additional premium is required it must be paid within 45 days after the date of birth to continue coverage beyond the first 45-day period. This provision includes the coverage for an adopted newborn child when You are responsible for the expenses associated with such birth.

Adopted Children Coverage - A child placed with You for adoption is covered from the date of such placement. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement. If any premium is required it must be submitted to us within 45 days after the date of such placement to continue coverage beyond the first 45-day period.

4. The differential between the amount of reimbursement for the services of a Network Provider and a Non-Network Provider will never be greater than 30%.
5. The following is added to the "Notice of Claim" provision:

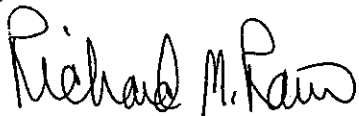
We will pay to the Texas Department of Human Resources, any amounts which would have been paid to the Insured but were paid by the Department through the Medical Assistance Act of 1967, as amended.

Benefits payable on behalf of a dependent child covered under the Policy will be paid to the Texas Department of Human Services upon written notification if: a) the Insured is a possessory conservator of the child by court order in this state or is not entitled to possession or access to the child and is required by court order or agreement to pay child support; b) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 and 32 of the Texas Human Resources Code; and c) notification is given in writing attached to the first submitted claim that such claim reimbursement should be paid to the Texas Department of Human Services.

For a dependent child covered under the Policy, benefit reimbursement may be made on behalf of that child to a person who is not a group Insured but who is named managing conservator by court order issued by a court of competent jurisdiction of any state. The managing conservator must submit to Us: 1) a proper claim form; 2) written notice naming the conservator; and 3) certified copy of court order or other evidence allowed by rule of the State Board of Insurance. This paragraph will not apply when a valid assignment of benefits has been exercised or to claims submitted by the Insured where he has paid any portion of a bill that would be covered under the terms of the Policy.

This endorsement takes effect and expires with the Policy and any Certificate to which it is attached. Nothing contained in this endorsement will be held to change, waive or extend any provisions of the Policy except as stated.

Signed for Combined Insurance Company of America:



Chairman and Chief Executive Officer



Secretary



PRIVACY POLICY

We collect nonpublic personal information from the following sources:

- Information we have received from you from your application for insurance coverage or other forms you furnish to us, such as your name, address, telephone number, social security number, insurance coverage selected and premium amount;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer-reporting agency.

We obtain and use nonpublic personal information for business purposes only. We restrict access to nonpublic personal information about you to those employees and affiliates who need to know that information in order to provide you with the selected insurance coverage. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

We do not disclose any nonpublic personal information about our insureds or former insureds to anyone, except as permitted by law.

Thank you for choosing Combined Insurance. Should you have any questions about our privacy policy, please contact us at:

Combined Insurance Company of America
Select Programs
112 Madison Avenue
New York, NY 10016



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Certificate of Group Insurance

YOUR GROUP INSURANCE

This is the certificate of group insurance for persons who have enrolled and who are insured under the Policy. The benefits described in this certificate will be applicable to Your Dependents, only if Dependent benefits are provided and only if You enroll Your Dependents, as required.

GENERAL INFORMATION

This certificate explains the plan of insurance underwritten by Combined Insurance Company of America. Read it closely to become familiar with Your coverage. In the Policy and this certificate the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Important Notice - Unless otherwise stated, benefits are payable only for expenses incurred while Your coverage is in force.

No agent has the right to change the Policy or to waive any part of it.

The Policy is not assignable, except with Our prior written consent.

The Policy, under which this certificate is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Signed for Combined Insurance Company of America.

Handwritten signature of Richard M. Raw in cursive.

Chairman and Chief Executive Officer

Handwritten signature of Ronald J. Oberhauser in cursive.

Secretary

GROUP VISION INSURANCE

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DEFINITIONS

Dependent - means any of the following persons:

1. Your spouse;
2. Each unmarried child from birth to age 19 who is primarily dependent on You for support and maintenance and each unmarried child 19 years of age to age 25 who is primarily dependent on You for support and maintenance, if a full-time student. A full-time student is enrolled for least 12 semester hours of credit in an accredited university, college or junior college; or is enrolled in a trade school course requiring 20 or more hours weekly for 6 or more months; or
3. Each unmarried child at least 19 years of age:
 - a. who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
 - b. who was incapacitated and insured under the Policy on his 19th birthday; and
 - c. who continues to be incapacitated beyond his 19th birthday.

Eligible Expenses – means covered vision care expenses.

Insured - means You and Your Dependent covered under the Policy.

Materials - means lenses, frame and contact lenses.

Orthoptics - means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Policy - means the Policy issued to the Policyholder.

Policyholder – means the legal entity in whose name the Policy is issued.

Service - means an examination, selection of Materials, fitting of glasses and related adjustments.

Schedule - means the part of this certificate showing what is covered.

Reasonable and Customary – means the lowest of:

1. the usual, customary and regular charge for Services or Materials for the area where the expense is incurred; or
2. the actual charge for the Services or Materials.

We, Our, Us - means Combined Insurance Company of America.

You, Your, Yours - means the Certificateholder.

Whenever a personal pronoun in the masculine gender is used herein, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary.

CONDITIONS FOR INSURANCE

Your Coverage Starts – Coverage for You and/or Your Dependent will start on the later of:

1. the date requested by the Policyholder and agreed to by Us; or
2. the date We accept Your enrollment, if you do not enroll within 31 days of Your becoming eligible.

Your Dependents are eligible for coverage on the date You are eligible or on date You first acquire a new Dependent.

Newborn Infant Coverage - Your newborn child is covered from the moment of birth. If any additional premium is required, a notice of birth together with the premium must be submitted to Us.

This must be done within 45 days after the date of birth to continue coverage beyond the first 45-day period. This provision includes the coverage for an adopted newborn child when You are responsible for the expenses associated with such birth.

Adopted Children Coverage - A child placed with You for adoption is covered from the date of such placement. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement. If any premium is required, a notice of placement for adoption together with the premium must be submitted to us. This must be done within 45 days after the date of such placement to continue coverage beyond the first 45-day period.

Your Coverage Ends - Coverage for You and/or Your Dependent will end on the earlier of:

1. the date You cease to be eligible for coverage;
2. the date Your Dependent is no longer a Dependent as defined;
3. subject to the grace period provision, the end of the period for which a required premium has been paid by You or on Your behalf; 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 You voluntarily end Your coverage and wish to re-enroll at a later date, We may require a 1 year waiting period. Your 1 year waiting period will begin on the date Your insurance ended.

COORDINATION OF BENEFITS

If any person under the Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and
2. the benefits that would be payable under all other plans without provisions for coordination in those plans would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits is applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other plans will not exceed the total of those Eligible Expenses. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the benefits of a plan covering such person as a dependent.
2. Except as stated in (3) below, when this Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - a. 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
 - b. if both parents have the same birthday, the benefits of the plan covering the parent longer determined before benefits of the plan covering the other parent for the shorter period of time. However, if the other plan does not have the rule described in "a." above, but instead uses a different method, 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.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:
 - a. first, the plan of the parent with custody of the child;
 - b. then, the plan of the spouse of the parent with custody of the child; and
 - c. 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 such parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any Claim Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as the employee's dependent). 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 4. is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a plan covering the person the shorter period of time.

If We are responsible for secondary coverage for Eligible Expenses, We will not deny coverage or payment of the amount We owe as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This will not require Us to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Plan or any similar provisions of other plans, We may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which We consider necessary.

Any person claiming benefit under this Plan will furnish Us with any information necessary.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other plans, We will have the right, at Our sole discretion, to pay any organizations making these payments any amount We determine to be due. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, We will be fully discharged from liability under this Plan.

Whenever payments have been made by Us, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, We will have the right to recover the excess from one or more of the following: (1) other insurance companies; (2) other organizations; or (3) persons to or for whom payments were made.

BENEFITS SUBJECT TO COORDINATION. All benefits provided under the Policy are subject to coordination.

DEFINITIONS. The following definitions apply only to this Coordination of Benefits section:

1. The term "plan" means coverage providing hospital, medical or vision benefits or services by:
 - a. group or blanket insurance coverage except school accident coverage;
 - b. group Blue Cross, group Blue Shield, group practice or other pre-payment coverage on a group basis; or
 - c. any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans.

The term "plan" will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

2. The term "Eligible Expense" means any necessary, reasonable and customary item of expense all or part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.
3. The term "Claim Period" means a calendar year or portion of a calendar year for a claim on a person covered under this Plan.

GENERAL PROVISIONS

Right to Contest - All statements made by the Policyholder or by any Insured are deemed representations and not warranties. No such statement will be used in any contest under the Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person or his beneficiary, if any.

The validity of coverage under the Policy cannot be contested, except for non-payment of premiums, after it has been in force for two years from its effective date.

No statement, except a fraudulent misstatement, made by any Insured will be used to contest the validity of his coverage after such coverage has been in force for a period of 2 years during such Insured's lifetime, nor unless it is contained in written

instrument, signed by him, and a copy of such instrument is or has been furnished to him, his beneficiary or his representative.

Conformity to Law - If any provision of the Policy is contrary to any law to which it is subject, the provision is amended to conform to the minimum requirements of such law.

Notice of Claim - When applicable, written notice of claim must be given within 30 days of loss. Notice must be given to Us with enough information to identify the Insured. Failure to submit a notice will not invalidate nor reduce any claim if it was not reasonably possible to give notice in time. However, the notice must be given as soon as reasonably possible.

Claim Forms - When We receive a notice of claim, We will send the forms for filing proof of loss. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proof of Loss - Written proof of loss must be given to Us not later than 90 days after the date of such loss. Failure to give such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible, but in no event, except in the absence of legal capacity of the claimant, later than 1 year from the date of time such proof is otherwise required.

Time of Payment of Claim - Subject to Proof of Loss, We will pay immediately, or within 30 days following receipt of written proof of loss, all benefits due under the Policy.

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

Records - We have the right at all reasonable times to inspect such records of any insured group under the Policy as We deem necessary for the administration of the Policy.

PREMIUMS

Premium Payments - Premiums are payable based on a mode of payment selected by the Policyholder and agreed to by Us. Premiums must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep the coverage under the Policy in force to the next premium due date, subject to the Grace Period provision.

Grace Period - A Grace Period of 31 days will be granted for the payment of premiums after the first premium. The coverage under the Policy will continue in force during such Grace Period, but the Insured will be liable for the premium for any period such coverage continues in force, provided written notice of termination has not previously been given Us.

Change in Premiums - We have the right to change the premium rates on any premium due date of the Policy. We will give written notice to the Policyholder at least 31 days in advance of any such change.

SCHEDULE

A. WHAT IS COVERED FOR A NETWORK PROVIDER:

The Services rendered and Materials furnished by a Network Provider. The Network Provider is a licensed provider who has contracted to accept, as full payment, Your Co-payment, and the contracted payment from Us. We will pay benefits if the Services are rendered or Materials furnished in, at or by, the Network Provider. Use of the Network Provider does not guarantee that all expenses will be covered under the Policy

Use of a Network Provider does not guarantee that all expenses will be covered under the Policy. Network Provider locations are identified by contacting the Administrator's automated response unit or website.

B. ELIGIBLE EXPENSES FOR A NETWORK PROVIDER: We will pay for Eligible Expenses incurred by or on behalf of You or any Dependent while covered under the Policy.

1. **SERVICES:** Coverage is available for eye examination services for You once every 12 months and for Dependents once every 12 months and include the items listed below:

If Your provider recommends Dilation, Your Co-payment of \$0.00 is due when Service is rendered. Also, Your provider may recommend additional services that are not part of the services covered and this will be an additional cost to You.

Spectacle lens exam – An examination, refraction and prescription. Your Co-payment of \$0.00 is due when Service is rendered.

Contact lens exam – A complete examination, refraction, additional measurements, trial fitting, follow-up visit and prescription which is covered in full. Your Co-payment of \$0.00 is due when Service is rendered. Payment reimbursement will be IN LIEU OF ALL OTHER SERVICES BENEFITS.

Benefits will be payable at Network Provider levels when a Network Provider is not available and a Non-Network Provider renders the Service or Material or because the Network Provider is unable to render the necessary Service or furnish the necessary Materials.

2. **MATERIALS:** Basic benefits include:

SPECTACLE LENSES – We will pay for You once every 12 months and for Dependents once every 12 months for new prescription Standard Lenses of uncoated plastic, regardless of size or power in accordance with Exclusions. Your Co-payment of \$0.00 is due when the Materials are furnished.

FRAMES – We will pay for You once every 12 months and for Dependents once every 12 months for new Standard Frames up to a retail value of \$110.00. Your Co-payment of \$0.00 is due when the Materials are furnished. When selecting a frame with a retail value in excess of \$110.00, You are required to pay 80% of the difference between the amount covered by the Policy and the provider's Reasonable and Customary charge.

CONTACT LENSES – When You choose contact lenses, We will pay for You once every 12 months and for Dependents once every 12 months up to a retail value of \$110.00. Your Co-payment of \$0.00 is due when the Materials are furnished. When selecting contact lenses with a retail value in excess of \$110.00, You are required to pay 85% (conventional contact lenses) or 100% (disposable contact lenses) of the difference between the amount covered by the Policy and the provider's Reasonable and Customary charge. If You have a prescription for therapeutic (medically necessary) contact lenses, however, We will pay for You the retail value. Payment reimbursement will be IN LIEU OF ALL OTHER MATERIALS BENEFITS.

THE LENS ALLOWANCE EQUALS TWO (2) LENSES. IF ONLY ONE (1) LENS IS NEEDED, THE ALLOWANCE WILL BE HALF (½) THE LENS ALLOWANCE.

THE SCHEDULED AMOUNTS SHOWN ARE MAXIMUMS. THE ACTUAL AMOUNT TO BE PAID FOR ANY SERVICE OR MATERIAL WILL BE THE LESSER OF THE SCHEDULED AMOUNT FOR SUCH SERVICE RENDERED AND/OR MATERIALS PURCHASED OR THE ACTUAL AMOUNT CHARGED.

THERE IS NO ASSURANCE THAT THE SCHEDULED AMOUNT WILL BE SUFFICIENT TO PAY THE FULL COST OF THE SERVICE RENDERED OR THE MATERIALS SELECTED.

C. WHAT IS COVERED AND ELIGIBLE EXPENSES FOR A NON-NETWORK PROVIDER:

The Services rendered and Materials furnished by a Non-Network Provider. A Non-Network Provider is a licensed provider NOT under contract with Us. After the applicable Co-payment and/or deductible, if any, We will pay the Reasonable and Customary charge for the following Services and Materials, up to the scheduled amount shown below in lieu of all other Services and Material Benefits.

We will pay for Eligible Expenses incurred by or on behalf of You or any Dependent while covered under the Policy.

a. Vision Examination		\$35.00
b. Contact Examination		\$35.00
c. Materials		
Frames		\$47.00
Lenses	Single vision	\$30.00
	Bifocals (pair)	\$50.00
	Trifocals (pair)	\$60.00
	Lenticular Lens	\$100.00
Contact Lenses		
	Conventional	\$86.00
	Disposable	\$86.00
	Medically Necessary	\$86.00

Services and Materials will be covered at the benefit levels for a Non-Network Provider when: a) the provider rendering the Service or furnishing the Materials is no longer a Network Provider; or b) the Insured elects NOT to use the Services or Materials of a Network Provider.

The Insured is responsible to pay the **Non-Network Provider** in full at the time Service is rendered. For reimbursement, call the EyeMed Vision Care, LLC Vision Care Service Center at 1-800-334-7591 to verify eligibility and get a claim form or call Your Benefits Department. Mail the completed claim form with a copy of the bill to:

EyeMed Vision Care, LLC
Attn: Vision Care Department
P.O. Box 8504
Mason, OH 45040-7111

Please call 1-800-334-7591 to receive a current Provider Directory.

Claim Form – means a form obtained by the Insured from the Administrator for filing Non-Network Provider claims for vision care expenses.

Co-payment – means the dollar amount an Insured is required to pay, if any, when a Service is rendered or Materials are purchased.

Limitations - In no event will payment exceed the lesser of the actual cost of covered Services or Materials; or the limits of the Policy, shown in this Schedule.

EXCLUSIONS

(Exclusions Apply to Network and Non-Network Benefits)

Exclusions - We will not cover:

1. Orthoptic or vision training and any associated supplemental testing.
2. Plano lenses.
3. Lens Coatings
4. Two pair of glasses, in lieu of bifocals or trifocals.
5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
7. Any injury or illness when covered under any Workers' Compensation or similar law, or which is work-related.
8. No-line bifocal or progressive lenses.
9. Photochromatic lenses.
10. Low vision aids or non-prescription lenses.
11. Charges in excess of the Reasonable and Customary charge for the Service or Materials.

12. Charges incurred after:
 - a) the Policy ends; or
 - b) the Insured's coverage under the Policy ends, except as stated in the Policy.
13. Experimental or non-conventional treatment or device.
14. High Index lenses of any material type.
15. Spectacle lens treatments or "add ons", except solid tints (#1 & #2), and oversize lenses.