HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Policy.

President

POLICYHOLDER:	Pima County Government
POLICY EFFECTIVE DATE:	July 01, 2016
CERTIFICATE EFFECTIVE DATE:	July 01, 2016
STATE OF ISSUE:	Arizona

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the Policyholder's address. The laws of the State of Issue shown above govern this Certificate.

"You" and "your" refer to the Employee; "we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

GROUP VISION POLICY - NON-PARTICIPATING

THE POLICY PROVIDES LIMITED BENEFITS

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. We thank you for your loyal patronage.

ADMINISTERED BY

Davis Vision Inc., 175 E. Houston Street, San Antonio, TX 78205
For Customer Service Call: 800-328-4728

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INTRODUCTION

This Certificate is intended to be read in its entirety. In order to understand how benefits are calculated and all the conditions, exclusions and limitations applicable to its benefits, please read all the Certificate provisions carefully.

Subject to the terms and conditions of the Policy, we agree to provide the benefits described in this Certificate in consideration of the Policyholder's remittance of the premium when due, or if you are being billed directly your payment of the required premium when due.

WAITING PERIOD

The Waiting Period is the period of time that must elapse from the date you are hired before you or your Dependents are eligible for a benefit payment under the Policy. This period is determined by the Policyholder's personnel practices. We will not pay for benefits received during the Waiting Period. If your coverage ends you may have to satisfy a new Waiting Period in order to become insured again under the Policy. See Reinstatement for exceptions.

COVERED PERSONS

Member

Dependents

SCHEDULE OF BENEFITS

Subject to the terms of the Policy, benefits are payable per Covered Person as shown in the Schedule of Benefits.

A Covered Person may use the Provider of their choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers). The payment of benefits varies depending on the type of Provider chosen.

When services or Materials are received from a Provider who is part of the Network, you are responsible for:

1. The Copayment, if a cash payment is due the Provider; or

2. If an Allowance is provided - the difference between the Allowance and the Allowable Charge. We will pay the dollar amount of the Allowance or the Allowable Charge, if less. If the Allowable Charge is more than the Allowance an In-Network Provider may bill you for the difference. Most In-Network Providers will offer an additional Discount to help with any overage; or

3. If only a Discount is provided - the difference between the Discount and the Allowable Charge. If the Allowable Charge is less than the Discount we will pay the Allowable Charge. If the Allowable Charge is less than the Discounted cost an In-Network Provider may bill you for the difference.

Benefits for services or Materials received from a Provider outside of the Network are shown in terms of the dollar amount we will pay you for that service or Material. If you use an Out-of-Network Provider your total responsibility is the difference between the Reimbursement and the Provider's Actual Charge -- we will pay the dollar amount of the Reimbursement for that service or Material or the Provider's Actual Charge if less. An Out-of-Network Provider may bill you for the difference.

You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "Included" or "Included -- no Copayment".

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
VISION EXAMINATION					
Comprehensive Eye Examination	$10 Co-payment	$10 Co-payment	$10 Co-payment	$40 Reimbursement	For each Covered Person Once every Plan year
Contact Lenses Evaluation, Fitting and Follow-Up In lieu of eyeglasses lenses					For each Covered Person Once every Plan year
Standard - Collection	Not Available	$10 Co-payment	Not Available	Not Covered	
Standard - Non-Collection	Included	Included	Included	Not Covered	
Specialty - Non-Collection	$60 Allowance Additional discount of 15% on any overage	$60 Allowance Additional discount of 15% on any overage	$60 Allowance Additional discount of 15% on any overage	Not Covered	
Low Vision					
Comprehensive Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	Once every 60 months for each Covered Person
Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	Four visits every 60 months for each Covered Person
VISION MATERIALS					
Spectacle Lenses - per pair					For each Covered Person Once every Plan year
Single Vision	Included	Included	Included	$40 Reimbursement	
Bifocal	Included	Included	Included	$60 Reimbursement	
Trifocal	Included	Included	Included	$80 Reimbursement	
Lenticular	Included	Included	Included	$100 Reimbursement	
Frames					For each Covered Person Once every Plan year
Collection Fashion Designer Premier	Not Available	Included Included $25 Co-payment	Not Available	Not Covered	
Non-Collection	$180 Allowance Additional discount of 20% on any overage	$130 Allowance Additional discount of 20% on any overage	$130 Allowance Additional discount of 20% on any overage	$50 Reimbursement	

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
Contact Lenses-- (only one option available per benefit frequency) In lieu of eyeglasses					For each Covered Person Once every Plan year
Collection Planned Replacement Disposable	Not Available	4 boxes 8 boxes	Not Available	Not Covered	
Non-Collection	$130 Allowance Additional discount of 15% on any overage	$130 Allowance Additional discount of 15% on any overage	$130 Allowance Additional discount of 15% on any overage	$105 Reimbursement	
Visually Required Contact Lenses - with prior approval	Included	Included	Included	$225 Reimbursement	
Lens Options - per pair					For each Covered Person Once every Plan year
Oversize Lenses	Included	Included	Included	Not Covered	
Cataract Lenses	Included	Included	Included	Not Covered	
Tint Solid or Gradient	Included	Included	Included	Not Covered	
Glass-Grey #3 Sunglass Lenses	Not Available	Not Available	Not Available	Not Covered	
Glass Lenses	Not Available	Not Available	Not Available	Not Covered	
Ultraviolet (UV) Coating	$12 Co-payment	$12 Co-payment	$12 Co-payment	Not Covered	
Scratch Resistant Coating	Included	Included	Included	Not Covered	
Scratch Protection Plan (single vision)	$20 Co-payment	$20 Co-payment	$20 Co-payment	Not Covered	
Scratch Protection Plan (multifocal)	$40 Co-payment	$40 Co-payment	$40 Co-payment	Not Covered	
Polycarbonate Lenses	$30 Co-payment	$30 Co-payment	$30 Co-payment	Not Covered	
Polycarbonate Lenses (For covered Children, monocular patients, patients with prescriptions ≥ +/- 6.00 diopters)	Included	Included	Included	Not Covered	
Blended Segment Lenses	Not Available	Not Available	Not Available	Not Covered	
Intermediate Vision Lenses	Not Available	Not Available	Not Available	Not Covered	
Standard Progressive Lenses (add on to Bifocal)	$50 Co-payment	$50 Co-payment	$50 Co-payment	Not Covered	
Premium Progressive Lenses (add on to Bifocal)	$90 Co-payment	$90 Co-payment	$90 Co-payment	Not Covered	
Ultra Progressive Lenses (add on to Bifocal)	$140 Co-payment	$140 Co-payment	$140 Co-payment	Not Covered	
Photochromic Glass Lenses	Not Available	Not Available	Not Available	Not Covered	

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
Plastic Photosensitive Lenses	$65 Co-payment	$65 Co-payment	$65 Co-payment	Not Covered	
Polarized Lenses	$75 Co-payment	$75 Co-payment	$75 Co-payment	Not Covered	
Standard Anti-Reflective (AR) Coating	$35 Co-payment	$35 Co-payment	$35 Co-payment	Not Covered	
Premium Anti-Reflective (AR) Coating	$48 Co-payment	$48 Co-payment	$48 Co-payment	Not Covered	
Ultra Anti-Reflective (AR) Coating	$60 Co-payment	$60 Co-payment	$60 Co-payment	Not Covered	
High-Index Lenses	$55 Co-payment	$55 Co-payment	$55 Co-payment	Not Covered	
Low Vision Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	
Laser Vision Correction Surgery					
Discount	Up to 25% or receive an additional 5% discount on any advertised specials	Up to 25% or receive an additional 5% discount on any advertised specials	Up to 25% or receive an additional 5% discount on any advertised specials	Not Covered	

Davis Vision Collection

In lieu of the frame Allowance, Covered Persons may choose to select any frame from the Davis Vision's Collection. The Collection is available at most participating independent provider offices and features three levels of frames.

In lieu of the non-Collection contact lens Allowance, Members may be fitted with contact lenses from the Davis Vision Collection. Contact lenses from the Davis Vision Collection include the evaluation, fitting and follow-up care.

Examination

An Exam or Eye examination includes (but is not limited to):

- Case history -- chief complaint, eye and vision history, medical history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction -- objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advising on matters pertaining to vision care

- Form completion -- school, motor vehicle, etc.
- Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when professionally indicated.

Visually Required Contact Lenses

Visually Required contact lenses will only be covered when the treating Provider has determined that a Covered Person has a "chronic visual disturbance." For the purposes of this section, chronic visual disturbance means a physiologic change in a Covered Person's vision either innate or acquired that inhibits the Covered Person's ability to achieve functional vision with spectacles such that a Visually Required contact lens is required to achieve the minimum functional vision needed to carry out normal daily activities. Chronic visual disturbance may include the following conditions: Keratoconus, Myopia, progressive or malignant, Hyperopia, Anisometropia, Aniseikonia, Aphakia, Aniridia or Irregular Astigmatism.

Visually Required contact lenses are available only if the treating Provider sends a completed request and supporting documentation showing a diagnosis of one of the foregoing conditions to Davis Vision before the lenses are initially ordered. The Visually Required contact lenses are subject to the maximum benefit Allowance per Frequency period. The Covered Person's benefit is paid in full up to the maximum Allowance during each Frequency period. Any amount due over the Allowance for such lenses during the Frequency period is the Covered Person's responsibility.

Visually Required contact lenses are subject to prior approval. If advance approval for the initial Visually Required contact lenses is not obtained, the standard contact lens benefit may be applied if available. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Contact lens evaluation, fitting and follow-up care applies to standard daily wear, disposable, planned replacement, specialty and the Visually Necessary contact lens benefit.

Low Vision Program

Low vision is a significant loss of vision, but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Covered Person's remaining useable vision.

A comprehensive low vision evaluation is performed in addition to an eye examination when the eye examination indicates a need for such an evaluation. This supplemental evaluation includes a history of functional difficulties that involves daily activities. The result of this evaluation may include prescription of various treatments options, including low vision aids, as well as assist the Covered Person with identifying other resources for vision and lifestyle rehabilitation.

The Low Vision Program is available both in and out of network and is subject to prior approval. A completed request must be sent to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and follow-up visits up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the Allowance above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids and the entire charge for such services or supplies will be the Covered Person's responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Laser Vision Correction Surgery

Laser vision correction is a surgical procedure to correct vision problems such as nearsightedness, farsightedness and astigmatism. Such procedures include Laser Epithelial Keratomileusis (LASEK), Laser in Situ Keratomileusis (LASIK), and Photorefractive Keratectomy (PRK).

Approval must be obtained prior to surgery. A completed request must be sent to Davis Vision prior to the initial evaluation. If the required approval is not obtained, the entire charge for the services will be the Covered Person's responsibility.

Surgery must be performed within six months of the preoperative examination. If a Covered Person does not obtain the surgery within this time period, another pre-operative examination is necessary at the cost of the Covered Person.

Mail Order Replacement Contact Lens Program

Davis Vision's mail order contact lens replacement service is powered by ABB Optical Group. By accessing www.davisvisioncontacts.com, Davis Vision Members can easily order replacement contact lenses at a discount and have them shipped directly to their doorstep.

Eyeglass Warranty

Davis Vision provides a breakage warranty to repair or replace any Collection frame and/or lens(es) for a period of one year from the date of delivery. This warranty applies to eyeglasses (spectacle lenses, frames from the Davis Vision frame Collection and frames obtained from a national retail chain that is part of Davis Vision's Provider Network where the Davis Vision frame Collection is not displayed).

At Wal-Mart, Sam's Club and Costco locations a Covered Person will receive the full Allowance toward the location's everyday low pricing. No additional Discounts are available at Wal-Mart, Sam's Club or Costco locations.

DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Allowable Charge means the amount negotiated between an In-Network Provider and us or our authorized representative as full payment for a Covered Expense shown in the Schedule of Benefits received or purchased by a Covered Person.

Allowance means a flat dollar amount payable under the Policy towards a Covered Expense from an In-Network Provider. Allowances are shown in the Schedule of Benefits. If the Providers charge is less than the Allowance we will only pay up to the Providers charge.

Average Retail Price means the charge made by other Providers rendering or furnishing vision care, treatment or supplies within the same geographic area.

We will base our determination of the retail price within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Child or Children means your or your Partner's unmarried natural or unmarried step Child who:

a. is under age 26; or

b. is unmarried, under age 26 and attends an accredited educational institution as a full-time student.

If your Child becomes incapable of self-support due to a developmental disability or physical handicap before reaching the limiting age his coverage may be continued. To continue the Child's coverage we must receive proof of incapacity within 31 days after coverage would otherwise terminate.

This Insurance will continue for as long as the Employee's Insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time but not more often than once a year.

This term includes a Child who:

1. Is living with you or your Partner in a parent Child relationship; or

2. Is adopted by or placed for adoption with, or is party in a suit for adoption by, you or your Partner; or

3. Is required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

Collection means Davis Vision's frame or contact lens Collection shown in the Schedule of Benefits.

Copayment means the amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments are shown in the Schedule of Benefits.

Covered Expense means the benefits listed in the Schedule of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or Materials that are not listed in the Schedule of Benefits; or

2. Any services or Materials shown as "Not Covered" in the Schedule of Benefits; or

3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or

4. More than one type of contact lens at a time during any one Frequency period; or

5. The fitting and follow-up care or adjustments to eyeglasses (frames and spectacle lenses - including Additional In-Network Items) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Covered Person or Covered Persons means a person covered by this Policy. The types of Covered Persons insured under the Policy are shown under Covered Persons in the Schedule of Benefits. For example, if "Member' is shown we insure all eligible Members, if 'Partner' is shown we insure the Employee's eligible Partner, and if "Children" is shown we insure all eligible Children.

Dependent or Dependents means an Employee's:

1. Partner; or

2. Child.

Discount means the percentage that an In-Network Provider has agreed to reduce his charge by for the requested service, Material or procedure. Discounts are shown in the Schedule of Benefits. Discounted vision services, Materials, supplies and treatments described in the Schedule of Benefits are not underwritten by us.

Enrollment Period means a period of time agreed upon by the Policyholder and us or our authorized representative during which a Member may apply for Insurance.

Frequency means the time period shown in the Schedule of Benefits during which you are eligible for the Covered Expenses shown in the Schedule of Benefits.

He, him or his means an individual, male or female.

In-Network Provider means a Provider who has entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on an Allowable Charge basis. These Providers are part of our or our authorized representatives Network and will not bill you for more than:

1. The Copayment; or

2. Any difference between the Allowance and the amount he agreed to as total Reimbursement (the Allowable Charge).

Insurance means the group vision care Insurance provided to you and your Dependents, if any, under the Policy.

Life Event means one of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your Child; (4) the death of your Child; (5) a change in the employment status of your spouse; or (6) a change in your employment status.

Materials means frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

Member means a person:

1. Who is employed by the Policyholder as either an associate or employee; and

2. Who works the minimum number of hours to be eligible for the benefits provided by the Policy as determined by the Policyholder.

Network means a group of Providers who have entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on a Scheduled Fee basis. Available Networks are shown in the Schedule of Benefits.

Out-of-Network Provider means Providers of optometric services who have not entered into a contract with us or our authorized representative to provide vision care services. An Out-of-Network Provider may bill you for the difference between the Reimbursement and his total charge (the Provider's Actual Charge).

Partner means your spouse or domestic partner:

1. By marriage; or

2. By a union between two adults having the effect of marriage that is recognized by law in the state where you reside; or

3. By a mutual agreement, recognized by the Policyholder, between two consenting adults who:

   a. are not married or legally separated;

   b. occupy the same residence; and

   c. share household expenses.

Policyholder means the entity shown on the cover page of this Certificate.

Provider means a practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of their license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the State in which the services are provided**.** The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these Definitions for further information.

This term does not include:

1. A person employed or retained by the Policyholder; or

2. A person living in the Covered Person's household; or

3. A parent, sibling, spouse, domestic partner or Child of the Covered Person.

Provider's Actual Charge means the total amount charged by a Provider for a Covered Expense.

Reimbursement means a flat dollar amount payable under the Policy towards a Covered Expense from an Out-of-Network Provider. Reimbursement levels are shown in the Schedule of Benefits. If the Providers charge is less than the Reimbursement we will only pay up to the Providers charge.

Visually Required means a service, supply or treatment which is:

1. Ordered by a Provider;

2. Required for treatment or management of a medical condition or symptom;

3. Provided in accordance with approved and generally accepted medical and surgical practice.

ELIGIBILITY REQUIREMENT

You are eligible for coverage under the Policy provided:

1. You meet the applicable definition shown in Definitions; and

2. You have completed the Waiting Period, if any, shown in the Schedule of Benefits.

Your Dependents are eligible for coverage under the Policy provided both you and your Dependents meet the applicable definition shown in Definitions.

No person is eligible for Insurance under this Policy as both a Member and Dependent at the same time. If both Partners are eligible as a Member one but not both may elect Dependent coverage.

EFFECTIVE DATE

You and your eligible Dependent's Insurance becomes effective on the date:

1. A completed and approved enrollment form, if any, is submitted for the person or persons to be insured; and

2. The required contribution for the person or persons to be insured has been submitted by your Employer or the required premium for the person or persons to be insured has been paid by you.

A newborn Dependent Child is automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. A Child adopted by you or your Partner, or placed for adoption with, or who is a party in a suit for adoption with you or your Partner is covered automatically provided we receive notification:

1. If a newborn within 31 days after the Child's birth; or

2. If not a newborn within 31 days after the date of adoption, date of placement for adoption or the date the Child becomes a party in a suit for adoption by you or your Partner.

A Child required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO) is covered automatically from the date stipulated in the judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

APPLYING FOR COVERAGE

You may only apply for coverage on yourself or your Dependents during the following periods:

1. Within 31 days after the date you are or your Dependent is first eligible for coverage;

2. During an Enrollment Period; or

3. Within 31 days of a Life Event.

You cannot apply for coverage on yourself or your Dependents at any other time. If you do not enroll yourself or your Dependent when first eligible you and/or your Dependents will be considered a Late Entrant.

LATE ENTRANTS

A person who meets the Eligibility Requirement will be considered a late entrant if the Member:

1. Does not apply for his Insurance or the Dependent's Insurance within 31 days of the first day of the month following the date he or that Dependent is first eligible; or

2. Elects coverage on himself and/or his Dependents within 31 days of the date he or that Dependent is first eligible and subsequently voids such coverage within that time period.

If a Member does not apply for his Insurance or Dependents Insurance when he or his Dependent is first eligible he must wait until the Policyholder's next Enrollment Period or a Change in Family Status to enroll himself or his Dependents.

TERMINATION OF INSURANCE

Please read the Continuation of Insurance section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The Insurance on a Covered Person will end on the earliest date below:

1. The first of the month following the date this Policy or Insurance for a Covered Class is terminated; or

2. The day following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

3. The last day of the last period for which premium is paid; or

4. The day he reports for active duty in the armed forces of the United States or any other country; or

5. The end of any period of continuation, as provided by the Policyholder's personnel practices; or

6. With respect to a Dependent, the first day of the month following the date of the death of the Member or the first of the month following the date the Dependent is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

7. The first of the month following the date the Employee retires from active service with the Policyholder.

Termination will not affect a claim for benefits incurred while coverage was in effect.

CONTINUATION

1. Family and Medical Leave

   Your coverage and your Dependents coverage may be continued during absences for family or medical leave. If you are on a family or medical leave of absence, coverage will continue, provided any required premium is paid when due and the Policyholder has approved the leave in writing. Coverage will be continued for up to the greater of the leave period required by the federal Family and Medical Leave Act or the leave period required by applicable state law.

2. Military Leave

   If you or one of your Dependents is called upon to serve in the armed forces of the United States that person's coverage will be continued during such absence until he reports for active duty. Coverage continued during a military leave of absence is subject to notifying your Employer of such leave in writing and continued payment of any required premium when due.

3. Other Layoff or Leave of Absence

   If you are temporarily laid off or given a leave of absence, other than a military leave or a family or medical leave, your coverage and your Dependents coverage may be continued provided any required premium is paid when due and your Employer has approved the leave in writing. Temporary layoff or leave of absence means you are temporarily absent from work for the period of time that has been agreed to in advance in writing by your Employer. Normal vacation time is not considered a temporary layoff off or leave of absence.

4. COBRA

   In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain church employers) who normally employed at least 20 or more employees in the prior calendar year, to temporarily extend their health care coverage to certain categories of employees and their covered Dependents when, due to certain "qualifying events," they are no longer eligible for group coverage. Contact the Policyholder for more information about COBRA and the events that may allow you or your Dependents to temporarily extend vision coverage.

REINSTATEMENT

If Insurance ends because you become a full time member of the armed forces of the United States you will not have to satisfy any applicable Waiting Period provided you re-enroll yourself and your Dependents and return to Active Service after you leave active military service within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll yourself and your Dependents within 31 days of the date you return to Active Service from a military leave you must wait until the next Enrollment Period or a Life Event to enroll.

If a Dependent's Insurance ends because he becomes a full time member of the armed forces of the United States that person may be re-enrolled if eligible provided he is re-enrolled within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll this person within 31 days you must wait until the next Enrollment Period or a Life Event to enroll this person.

EXCLUSIONS

Benefits will not be paid for, and the term "Covered Expenses" will not include charges arising from:

1. Any Covered Expense not shown in the Schedule of Benefits or any expenses shown as "Not Covered" in the Schedule of Benefits.

2. Eye examinations required by an employer as a condition of employment except, as otherwise provided under the Safety Program.

3. Services or Materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to "Corneal Refractive Therapy" ("CRT), or "orthokeratology"), or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. Materials which do not provide vision correction, except as provided herein.

5. Charges for the replacement of lost or stolen lenses or frames within the applicable benefit Frequency period in the Schedule of Benefits.

6. Sickness or injury covered by a workers' compensation act or other similar legislation.

7. Incurred as a direct or indirect result or war (declared or undeclared).

8. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

9. Services or supplies furnished to a Covered Person before the effective date of his Insurance under the Policy or after the date a Covered Person's Insurance ends.

10. Any medical treatment rendered outside the United States or Canada.

11. Services rendered by practitioners who do not meet the definition of Provider.

12. Expenses covered by any other group insurance.

13. Expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

14. Any expenses covered by any union welfare plan or governmental program or a plan required by law.

15. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from us or our authorized representative.

16. For Visually Required contact lenses prescribed for a Covered Person for which prior approval was not obtained from us or our authorized representative.

17. Laser vision correction for which prior approval was not obtained from us or our authorized representative.

18. Refraction-only claims.

CLAIM PROVISIONS

In-Network

A Covered Person must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify his eligibility for Covered Expenses with us or our authorized

representative before the examination takes place. The Provider will submit Covered Person's claim directly to us or our authorized representative.

Out-of-Network

When a Covered Person uses an Out-of-Network Provider he must first pay the billed charge and then submit a claim.

1. Notice of Claim - written or authorized electronic/telephonic notice of claim must be given to us within 20 days after a Covered Expense is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative. Notice should include the Policyholder's name and the Covered Person's name, address, Policy and Policy Number.

2. Claim Forms - we will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not provided within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

3. Proof of Loss - written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative within 90 days of the loss for which claim is made.

   If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

4. Payment of Claims - we will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

   All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

   If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Right to Receive and Release Needed Information

We have the right to obtain or give information needed to coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person, subject to the consent of the Covered Person. Any Covered Person claiming benefits must furnish us with the necessary information needed to coordinate benefit payments.

Right to Make Payments

We have the right to pay any other organization, as needed, to properly carry out this provision. Any such payments made in good faith are considered benefits paid under the Policy, and fully discharge our liability, to the extent of such payments.

Right to Recovery

We have the right to retrieve any excess amounts that may have been paid out should they exceed the provisions of the Policy. This can be from the Covered Person for whom the payments were made. It can also be from any other insurance company or organization.

Review

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;

2. Reference to specific Certificate provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;

4. Information concerning your right to request that we review our decision; and

5. A description of our review procedures, time limits and notice of your right to bring civil action.

This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or

3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

Claimant Cooperation

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Administration

The Policyholder has given us the authority to review claims for the benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of the Policy, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact. All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no responsibility with respect to the administration of the benefit provided by this Policy except as described above. It is understood that our sole liability to the Policyholder and Covered Persons under the Policy shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Schedule of Benefits. The Policyholder has the sole responsibility to notify Covered Persons of such termination.

Contributions

You may be required to contribute toward all or part of your and your Dependent's Insurance under the Policy. If so you must agree to:

1. Have all or a portion of the cost of both your Insurance and your Dependent's Insurance deducted from your pay; or

2. Remit all or a portion of the cost of both your Insurance and your Dependent's Insurance directly to the Policyholder; or

3. Remit the entire cost of both your Insurance and your Dependent's Insurance directly to us or our authorized representative. A Covered Person may elect to pay any premium billed directly monthly, quarterly, semi-annually or annually.

Direct Billing

If you are being billed directly you will receive a request for payment from us or our authorized representative on or before the premium due date. The premium due date will be shown on the request for payment. You should pay the amount due on or before the premium due date. Payment of the entire premium as it becomes due will maintain the Covered Person's Insurance in force through the date immediately before the next premium due date.

There is a 31 day grace period for remittance of premium billed directly. If you do not pay the premium on or before the premium due date, you may pay the premium during this 31 day period. A Covered Person's Insurance under the Group Policy will remain in force during the grace period. If premium is not remitted before the end of the grace period, the Covered Person's Insurance will terminate automatically at 12:01 A.M. on the last day for which premium was paid.

Termination of a Covered Person's Insurance for nonpayment of premiums billed directly will not influence a Covered Person's right to a claim for benefits which arose prior to the termination. Our liability under the Policy is limited to benefits payable for eligible claims incurred prior to the date of termination.

GENERAL PROVISIONS

Assignment

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his Insurance should see the Policyholder for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's Insurance (including an assignment on a form furnished by us or by the Policyholder).

Incontestability

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative will be given a copy.

After two years from a Covered Person's effective date of Insurance, or from the effective date of increased benefits, no such statement will cause Insurance or the increased benefits to be contested except for fraud.

Clerical Error

A Covered Person's Insurance will not be affected by clerical error or delay in keeping records of Insurance under the Policy. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to the Policy are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.