

SERFF Tracking Number:	UCIN-126921778	State:	Arkansas
Filing Company:	United Concordia Insurance Company	State Tracking Number:	47422
Company Tracking Number:	AR/UCIC/004-10		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	FFS Vision Rider		
Project Name/Number:	Vision Phase 1/AR/UCIC/004-10		

Filing at a Glance

Company: United Concordia Insurance Company

Product Name: FFS Vision Rider

SERFF Tr Num: UCIN-126921778 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-Closed
State Tr Num: 47422

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: AR/UCIC/004-10 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor
Disposition Date: 12/01/2010

Authors: Michelle Shutt, Benjamin Schaefer, Krista Maddigan, Kathleen McGonigle, Stacy Bell

Date Submitted: 12/01/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Vision Phase 1

Status of Filing in Domicile: Not Filed

Project Number: AR/UCIC/004-10

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 12/01/2010

Explanation for Other Group Market Type:

State Status Changed: 12/01/2010

Deemer Date:

Created By: Stacy Bell

Submitted By: Stacy Bell

Corresponding Filing Tracking Number:

Filing Description:

United Concordia Insurance Company (UCIC), NAIC number 85766 a licensed Life, Accident and Health insurer offering group and individual dental policies, is submitting this filing for approval. The filing introduces a new vision benefit rider. This rider to the company's approved Dental Group Policy and Certificate of Insurance will be marketed to groups that purchase the company's group dental insurance products. The filing contains rider V9802 (10/10). The Company's dental rates are not being revised.

A Statement of Variability for the vision rider is provided with this filing for informational purposes.

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 Product Name: FFS Vision Rider
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Company and Contact

Filing Contact Information

Stacy Bell, Filing Project Manager stacy.bell@ucci.com
 4401 Deer Path Road 717-260-7252 [Phone]
 DPLR4 717-260-7494 [FAX]
 Harrisburg, PA 17110

Filing Company Information

United Concordia Insurance Company CoCode: 85766 State of Domicile: Arizona
 4401 Deer Path Road Group Code: 812 Company Type: LAH
 Harrisburg, PA 17110 Group Name: Highmark State ID Number:
 (800) 929-0538 ext. 57225[Phone] FEIN Number: 86-0307623

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Rider = \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$50.00	12/01/2010	42484514

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2010	12/01/2010

SERFF Tracking Number: UCIN-126921778 *State:* Arkansas
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Product Name: FFS Vision Rider
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Disposition

Disposition Date: 12/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *UCIN-126921778* *State:* *Arkansas*
Filing Company: *United Concordia Insurance Company* *State Tracking Number:* *47422*
Company Tracking Number: *AR/UCIC/004-10*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *FFS Vision Rider*
Project Name/Number: *Vision Phase 1/AR/UCIC/004-10*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Vision Rider	Approved-Closed	Yes

SERFF Tracking Number: UCIN-126921778 State: Arkansas
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 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: FFS Vision Rider
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Form Schedule

Lead Form Number: V9802 (10/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 12/01/2010	V9802 (10/10)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Vision Rider	Initial			Vision Rider.pdf

{UC Vision} or {Alternate Name of Program}

RIDER

to the

GROUP POLICY and CERTIFICATE OF INSURANCE

Policyholder: {insert group name}

Group Number(s): {insert group number(s)}

Rider Effective Date: {insert rider effective date}

On the Effective Date stated above and in consideration of the premium paid, this Vision Rider makes a vision benefit available to the Members enrolled in the Policyholder's Group Policy. {Vision benefits are administered by:

Davis Vision, Inc.¹
159 Express Street
Plainview, NY 11803
For Customer Service call: {800-332-0366}

A Member's dental Plan enrollment determines enrollment under this Vision Rider. When enrolled in a dental Plan that includes this Vision Rider, Members are covered under this Vision Rider on the later of the Member's Effective Date or the Rider Effective Date listed above. Members' coverage under this Vision Rider ends when their enrollment in the dental Plan terminates.

The Company will pay the vision benefits described in this Vision Rider and any addenda, riders, endorsements or amendments attached thereto, subject to the Group Policy terms. This Vision Rider is hereby incorporated into the Group Policy under the General Provisions section thereof.

{¹ In California, Davis Vision operates as Davis Vision Insurance Administrators.}

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INTRODUCTION

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

DEFINITIONS

Please note that certain words used in this Vision Rider have specific meanings. Capitalized terms have the specific meanings as set forth in the Definitions section of the Dental Plan Certificate of Insurance unless otherwise defined below.

Administrator – The entity designated by the Company and specified on the first page of this Rider to perform certain functions necessary to support the benefits offered under this Rider.

Allowance - A flat dollar amount payable under this Vision Rider toward the retail price of a Covered Expense from an In-Network Provider. Allowances, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. If the Provider's charge is less than the Allowance, We will only pay up to the Provider's charge.}

{Collection – Administrator's frame or Contact Lens Collection shown in the *Schedule of Benefits* section of this Vision Rider. The Collection is available at most independent In-Network Provider offices and is subject to change without notice.}

Copayment - The amount a Member is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider.

Covered Expense - The benefits listed in the *Schedule of Benefits* section of this Vision Rider. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or materials that are not listed in the *Schedule of Benefits* section of this Vision Rider; or
2. Any services or materials shown as "Not Available" or "Member is responsible for the entire cost" in the *Schedule of Benefits* section of this Vision Rider; or
3. An additional examination, 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 options) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Discount - The percentage that an In-Network Provider has agreed to reduce his charge for the requested service, Material or procedure. Discounts, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. Discounted vision services, Materials, supplies and treatments described in the *Schedule of Benefits* section of this Vision Rider are not underwritten by Us.

Discounted Price - The reduced price or percentage discount that an In-Network Provider has agreed to accept from Members for the requested service, Material or procedure. Discounted Prices, if applicable

to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. Discounted vision services, Materials, supplies and treatments described in the *Schedule of Benefits* section of this Vision Rider are not underwritten by Us. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.

Frequency or Frequency of Use Period - The time period shown in the *Schedule of Benefits* section of this Vision Rider during which You are eligible for the Covered Expenses, also shown in the *Schedule of Benefits* section of this Vision Rider. This time period is measured from the date of Your last eye examination or the date You received the eyeglasses, frame or spectacle lenses or contact lenses.

In-Network – Refers to Covered Expenses received from In-Network Providers.

In-Network Provider - A Provider who has entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials for a set of Scheduled Fees. These Providers are part of Our Network or Our Administrator's Network.

Materials – Frames, spectacle lenses and contact lenses provided to a Member for ophthalmic correction under the terms and conditions of this Vision Rider.

Network - A group of Providers who have entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials for a set of Scheduled Fees.

Out-of-Network – Refers to Covered Expenses received from Out-of-Network Providers.

Out-of-Network Provider - Providers of optometric services who have *not* entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials.

Professionally Indicated - A service, supply, Material or treatment that 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.

Provider - 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. This Vision Rider 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:

- A person employed or retained by the Policyholder;
- A person living in the Member's household; or
- A parent, sibling, spouse, domestic partner or child of the Member.

Reimbursement - A flat dollar amount payable under this Vision Rider toward a Covered Expense from an Out-of-Network Provider. Reimbursement levels, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. If the Provider's charge is less than the Reimbursement We will only pay up to the Provider's charge.

Scheduled Fee - The amount negotiated between an In-Network Provider and Us or Our Administrator as full payment for a Covered Expense received or purchased by a Member.

CHOICE OF PROVIDER

You may use the Provider of Your 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).

In-Network

When choosing to receive Covered Expenses from an In-Network Provider, You must contact the In-Network Provider before receiving services. The In-Network Provider will verify Your eligibility for Covered Expenses with Us or Our Administrator before services are rendered. The Provider will submit Your claim directly to Us or Our Administrator.

When services or Materials are received from an In-Network Provider, You are responsible for:

- {
1. The Copayment or Discounted Price, if a cash payment is due the Provider; or
 2. The difference between the Allowance plus any negotiated Discount, if applicable, and the Scheduled Fee - We will pay the dollar amount of the Allowance, or the Provider's actual charge, if less; or
 3. The difference between any negotiated Discount and the Scheduled Fee; or
 4. The difference between the Discount Price and the Provider's retail price minus any negotiated Discount; or
 5. The Provider's retail price minus any negotiated Discount.}

Out-of-Network

When You use an Out-of-Network Provider You must first pay the Provider's billed charge and then submit a claim.

Benefits for services or Materials received from Out-of-Network Providers are shown in terms of the dollar amount We will reimburse You for that service or material, not the total amount for which You are responsible. If You use an Out-of-Network Provider Your total responsibility is the difference between the Reimbursement and the total amount charged by the Provider - We will pay the dollar amount of the Reimbursement for that service or material or the Provider's actual charge, whichever is less.

SCHEDULE OF BENEFITS

Benefits are payable per Member. You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "\$0 Copayment."

Covered Expense	Frequency	In-Network	Out-of-Network
{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	{Benefit includes one examination every {other}{plan year} {{12; 24} months}} {*} {* {Or }{once every {other} {12} {24} {months} {plan	{{ \$0 - 75} Copayment} {Member is responsible for the entire cost}	{ { \$10 - 200} Reimbursement} {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
examination; <ul style="list-style-type: none"> • 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 the Member on matters pertaining to vision care; • Form completion - school, motor vehicle, etc.; and • A 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. 	year} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis} {Not Available}		
{Eyeglass Frames} {Collection frames are available through most independent In-Network Providers.} {Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for frames. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. Special frames may require additional cost.}			
<ul style="list-style-type: none"> • {Fashion Frame Collection} 	{Benefit includes {either} one {Collection frame or one non-Collection} frame {once every {other}{ plan year} {{12; 24} months}.} {*}	{{\$0 - 50} Copayment}{Member is responsible for the entire cost}	{Not Available}
<ul style="list-style-type: none"> • {Designer Frame Collection} 	{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}}	{{\$0 - 50} Copayment}{Member is responsible for the entire cost}	{Not Available}
<ul style="list-style-type: none"> • {Premier Frame Collection} 	under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}	{{\$0 - 50} Copayment} {Member is responsible for the entire cost}	{Not Available}
<ul style="list-style-type: none"> • {Non-Collection Frame} 	{Eyeglass frame benefit is not available if You receive a benefit for contact lenses during the same Frequency of Use Period.}	{{\$10 - 300} Allowance} {plus an additional {5-30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.}	{ {\$10 - 300} Reimbursement} {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
	{Not Available}		
• {Frame priced up to {\$50-150} retail		{Discounted Price: {\$40-80}} {Member Discount: {10-30%}} off Provider's retail price}	{Member is responsible for the entire cost}
• {Frame priced over {\$50-150} retail		{Discounted Price: {\$40-80}} {plus an additional {10-30%}} off the Provider's retail price over {\$50-150}} {Member Discount: {10-30%}} off Provider's retail price}	{Member is responsible for the entire cost}
<p>{Spectacle Lenses} {(per pair)}{**}</p> <p>{**Includes all ranges of prescriptions and sizes, scratch-resistant coating{ and Your choice of glass or plastic lenses}.}</p> <p>{Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for spectacle lenses. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. Special lens designs, materials and powers may require additional cost.}</p>			
• {Single Vision Lenses}	{Benefit includes one pair of lenses {once every {other}{ plan year} {{12; 24} months}} {*}	<p>{{\$0 - 300} Copayment}</p> <p>{{\$5-300} Allowance} {plus an additional {5,...30%}} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$15-50}}{Member is responsible for the entire cost}</p>	{ {\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Bifocal Lenses}	<p>{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}</p> <p>{Spectacle lens benefit is not available if You receive a benefit for contact lenses during the same Frequency of Use Period}</p>	<p>{{\$0 - 300} Copayment}</p> <p>{{\$5-300} Allowance} {plus an additional {5,...30%}} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$35-80}} {Member is responsible for the entire cost}</p>	{ {\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Trifocal Lenses}	{Not Available}	<p>{{\$0 - 300} Copayment}</p> <p>{{\$5-300} Allowance} {plus an additional {5,...30%}} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$45-90}} {Member is responsible for the entire cost}</p>	{ {\$10 - 300} Reimbursement} {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
<ul style="list-style-type: none"> • {Lenticular Lenses} 		{{\$0 - 300} Copayment} {{\$5- 600} Allowance} {plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$90-135}} {Member is responsible for the entire cost}	{ {\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
{Additional Spectacle Lens Options {(per pair)}} {Other lens options, powers and frames not listed below may require an additional cost to the Member.} {Only offered In-Network to Members at the Discount Prices specified below. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. There is no Plan payment for additional spectacle lens options.}			
<ul style="list-style-type: none"> • {Oversize Lenses} 	{Not Available}	{{\$0 - 100} Copayment} {{\$10 - 100} Allowance}}{ plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Member is responsible for the entire cost}	{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
<ul style="list-style-type: none"> • {Glass Lenses} 	{Not Available}	{{\$0 - 100} Copayment} {{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}}{Member is responsible for the entire cost}	{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
<ul style="list-style-type: none"> • {Polycarbonate Lenses} 	{Not Available}	{{\$0 - 100} Copayment} {No charge for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.} {{\$10 - 100} Allowance}} {Discounted Price: {\$15-50}} {Member is responsible for the entire cost}	{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
<ul style="list-style-type: none"> • {Fashion tinting of plastic lenses} 	{Not Available}	{{\$0 - 100} Copayment} {{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}	{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}
<ul style="list-style-type: none"> • {Gradient tinting of plastic lenses} 	{Not Available}	{{\$0 - 100} Copayment} {{\$10 - 100} Allowance}}{Discounted Price: {\$5-30}} {Member is responsible for the entire	{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
		cost}	
• {Fashion and gradient tinting of plastic lenses}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Solid Tint}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Gradient Tint}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Glass-Grey #3 prescription sunglass lenses}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Ultraviolet Coating}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Scratch Protection Plan (single vision)}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Scratch Protection Plan (multi-focal vision)}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Blended Segment Lenses}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$5-30}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Intermediate Vision Lenses}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$15-50}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Standard Progressive Addition}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$55-100}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}
• {Premium Progressive Addition}	{Not Available}	{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance}} {Discounted Price: {\$105-150}} {Member is responsible for the entire cost}}	{{{\$10 - 300} Reimbursement} {Member is responsible for the entire cost}}

Covered Expense	Frequency	In-Network	Out-of-Network
		cost}	
• {Ultra Progressive Addition}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Photochromic Glass Lenses}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$15-50}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Plastic Photosensitive Lenses}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$45-90}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Polarized Lenses}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$55-100}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Standard Anti-Reflective (AR) Coating}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$25-60}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Premium Anti-Reflective (AR) Coating}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Ultra Anti-Reflective (AR) Coating}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Standard} {Hi-Index Lenses}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$35-80}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
• {Premium Hi-Index Lenses}	{Not Available}	{{ \$0 - 100} Copayment {{ \$10 - 100} Allowance}} {Discounted Price: {\$45-90}} {Member is responsible for the entire cost}	{{ \$10 - 300} Reimbursement} {Member is responsible for the entire cost}
{Contact Lens Evaluation, Fitting and Follow-up Care} {(All types of contact lenses)} {Only offered In-Network to Members at the Discounted Prices specified below. There is no Plan payment for contact lens evaluation, fitting or follow-up care. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.}			
• {Standard Lens Types} {or; and} {Specialty Lens Types}	{Once every {other} { plan year} {{12; 24} months} for {{all contact lens types combined}{standard contact lens types} {and	{For Collection contact lenses: {{ \$0 - 100} Copayment}{Member is responsible for the entire cost}}	{{5,...30%} Discount} {Member is responsible for the entire cost} {The non-Collection

Covered Expense	Frequency	In-Network	Out-of-Network
	<p>specialty lens types}}.}</p> <p>{This evaluation, fitting and follow-up benefit is not available if You received a benefit for contact lenses for specified diseases (below) during the same Frequency of Use Period}</p> <p>{{Once every {other}{ plan year} {{6;12; 24} months} for contact lenses for the following specified diseases:</p> <ul style="list-style-type: none"> o Keratoconus; o Anisometropia; o Corneal Disorders; o Pathological Myopia; o Aniseikonia; o Post-traumatic Disorders; o Aphakia; o Aniridia; and o Irregular Astigmatism. <p>This evaluation, fitting and follow-up benefit is not available if You received a benefit for standard or specialty</p>	<p>{For non-Collection contact lenses: {{\$10 - 100} Allowance} {plus an additional {5,...30%} Discount on any amount over the Allowance} {{5,...30%} Discount} {Member is responsible for the entire cost}}</p> <p>{The non-Collection contact lens Allowance below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Allowance not available for non-Collection contact lenses if the entire Allowance is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Allowance is not applied, Member is responsible for the entire cost.}</p> <p>{Discounted Price: {5-50%} off Provider's retail price}</p>	<p>contact lens Reimbursement below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Reimbursement not available for non-Collection contact lenses if the entire Reimbursement amount is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Reimbursement is not applied, Member is responsible for the entire cost.}</p>
<ul style="list-style-type: none"> • {Specialty Lens Types} 	<p>contact lens types (above) during the same Frequency of Use Period.}</p>	<p>{{{\$0 - 100} Copayment} {{\$10 - 100} Allowance}{plus an additional {5,...30%} Discount on any amount over the Allowance} {{5,...30%} Discount} {Member is responsible for the entire cost}}</p> <p>{The non-Collection contact lens Allowance below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Allowance not available for non-Collection contact lenses if the entire Allowance is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Allowance is not applied, Member is responsible for the entire cost.}</p>	<p>{{5,...30%} Discount} {Member is responsible for the entire cost}</p> <p>{The non-Collection contact lens Reimbursement below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Reimbursement not available for non-Collection contact lenses if the entire Reimbursement amount is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Reimbursement is not applied, Member is responsible for the entire cost.}</p>

Covered Expense	Frequency	In-Network	Out-of-Network
		{Discounted Price: {5-50%} off Provider's retail price}	
<p>{Contact Lenses} {(per pair)}</p> <p>{Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for contact lenses. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.}</p>			
<p>• {Collection Contact Lenses} (single vision spherical only, all types)</p> <p>{Collection contact lenses are available through most independent In-Network Provider offices.}</p>	<p>{Benefit includes the following limits on lenses {once every {other}{ plan year} {{12; 24} months}} {*}:}</p> <p>For Collection contact lenses:</p> <p>{</p> <ul style="list-style-type: none"> • {One-Ten} pair(s) of daily wear contact lenses; or { • {One-Ten} boxes of planned replacement contact lenses; or { • {One-Ten} boxes of disposable contact lenses; or } { • {One-Ten} boxes of disposable contact lenses.} <p>{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}</p> <p>{Benefit is not available if You received a benefit for contact lenses for specified diseases (below) or eyeglasses during the same Frequency of Use Period.}</p> <p>{Not Available}</p>	<p>{{ \$0 - 100 } Copayment}</p> <p>{Member is responsible for the entire cost}</p>	<p>Not Available</p>
<p>• {Non-Collection Contact Lenses}</p> <ul style="list-style-type: none"> ○ Standard lens types ○ Specialty lens types including, but not limited to 	<p>{One Allowance or Reimbursement every {other}{ plan year} {{12; 24} months}} {*}</p>	<p>{{ \$10 - 100 } Allowance} {plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts</p>	<p>{{ \$10 - 500 } Reimbursement} {Member is responsible for the entire cost}</p>

Covered Expense	Frequency	In-Network	Out-of-Network
toric, rigid gas permeable and multifocal lenses}	<p>{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}</p> <p>{Non-Collection contact lens benefit is not available if You receive a benefit for Collection contact lenses (above), contact lenses for specified diseases (below) or eyeglasses during the same Frequency of Use Period}</p>	are available on frames or contact lenses purchased at Wal-Mart.) {Member is responsible for the entire cost}	
<p>• {Contact Lenses for Specified Diseases} Benefit includes contact lenses prescribed for the following diagnoses:</p> <ul style="list-style-type: none"> ○ Keratoconus; ○ Anisometropia; ○ Corneal Disorders; ○ Pathological Myopia; ○ Aniseikonia; ○ Post-traumatic Disorders; ○ Aphakia; ○ Aniridia; and ○ Irregular Astigmatism <p>(You may be required to pay Your Provider in full at the time the contact lenses are dispensed and submit a claim to Us for reimbursement up to the benefit amount.)}</p>	<p>{Benefit includes one pair of lenses every plan year.}</p> <p>{This benefit for contact lens benefit is not available if You already received a benefit for Collection or Non-Collection contact lenses or eyeglasses during the same Frequency of Use Period.}</p> <p>{Not Available}</p>	<p>{{{\$0 - 100} Copayment} {{{\$10 - 100} Allowance} {Member is responsible for any cost of the lenses that exceeds the Allowance.} {Member is responsible for the entire cost}</p>	<p>{{{\$10 - 500} Reimbursement} {Member is responsible for the entire cost}</p>
<p>• {Conventional Contact Lenses} (in lieu of eyeglasses)</p>		Discounted Price: {5-50%} off Provider's retail price	Member is responsible for the entire cost}
<p>• {Disposable or Planned Replacement Contact Lenses} (in lieu of eyeglasses)</p>		Discounted Price: {5-50%} off Provider's retail price	Member is responsible for the entire cost}
<p>• {Laser Vision Correction}</p>		Discounted Price: up to {5-50%} off Provider's retail price or an additional {5-15%} discount on any advertised specials, whichever is lower	Member is responsible for the entire cost}

}

{Low Vision Coverage

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 Member'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 treatment options, including low vision aids, as well as assisting the Member to identify other resources for vision and lifestyle rehabilitation.

This program is available only In-Network.

Low vision aids will be provided as prescribed up to the maximum Allowance per aid, subject to the lifetime maximum for all aids shown below. Any amount due over the Allowance for an evaluation, follow-up visits or aids is the Member's responsibility.

Covered Expense	Frequency	In-Network	Out-of-Network
Comprehensive Evaluation	One comprehensive evaluation every 60 months (includes four follow-up visits in that period)	}\${50 – 600} Allowance per visit	Member is responsible for the entire cost
Follow-up Visit		}\${50 – 600} Allowance per visit	Member is responsible for the entire cost
Low Vision Aid		}\${50 - 600} Maximum Allowance per aid }\${250 - 1200} Lifetime Maximum Allowance for all aids	Member is responsible for the entire cost

}

SCHEDULE OF EXCLUSIONS

Benefits will not be paid and the term "Covered Expenses" will not include charges:

{

1. For any service, supply, Material or procedure not shown in the *Schedule of Benefits* section of this Vision Rider.
2. For eye examinations required by an employer as a condition of employment.
3. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment (including laser vision correction) except as specified in the *Schedule of Benefits* section of this Vision Rider.
4. For lenses that do not provide vision correction, except as specified in the *Schedule of Benefits* section of this Vision Rider.
5. For charges to replace lost or stolen lenses or frames.
6. For sickness or injury covered by a workers' compensation act or other similar legislation.
7. Incurred as a direct or indirect result of war (declared or undeclared).

8. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
9. For services or supplies furnished to a Member before the Effective Date of his/her insurance under the Group Policy, before the Rider Effective Date shown on the first page of this Rider, or after the date a Member's insurance ends.
10. For any medical treatment rendered or material supplied outside the United States or Canada.
11. For services rendered by practitioners who do not meet the definition of Provider.

PAYMENT OF BENEFITS - CLAIM PROVISIONS

In-Network

A Member 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 Administrator before the examination takes place. The Provider will submit Member's claim directly to Us or Our Administrator.

Out-of-Network

When You use an Out-of-Network Provider You 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 or Our Administrator 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 Administrator's Office as specified below, or such other place as We may designate for the purpose.

{Davis Vision {Insurance Administrators}
711 Troy Schenectady Road
Suite 301
Latham, NY 12110}

Notice should include the Policyholder's name and the Member's name, address and Member identification 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 stated immediately below 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 the location specified under Notice of Claim, above, 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 Vision Rider for any loss immediately upon receipt of due written or authorized electronic proof of such loss. We do not coordinate benefits with other vision plans.

All benefits will be paid in United States currency. All benefits payable under this Vision Rider, unless otherwise stated, will be payable to the Member or to his estate.

If We are to pay benefits to the Member'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.

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 Vision Rider and for deciding appeals of denied claims. In this role We shall have the authority, in Our discretion, to interpret the terms of this Vision Rider, 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 Vision Rider except as described herein. It is understood that Our sole liability to the Policyholder and Members under this Vision Rider shall be for the payment of benefits provided under this Vision Rider.

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 Vision Rider. 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 Vision Rider.

If there is an overpayment due when the Member dies, We may recover the overpayment from the Member's estate.

CLAIM REVIEW

If Your claim is wholly or partly denied, Our notice will include:

1. Reasons for such denial;
2. Reference to specific rider 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.

Your request for a review of Our claim decision 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.

GENERAL PROVISIONS

Conformity with Statutes

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

Compensation Insurance

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

Other Provisions

Except where specifically changed by this Rider, all of the terms and conditions of Your dental Plan's Group Policy and Certificate of Insurance, to which this Rider is attached, also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance or Group Policy, this Rider shall control.

SERFF Tracking Number: UCIN-126921778 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 47422
 Company Tracking Number: AR/UCIC/004-10
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: FFS Vision Rider
 Project Name/Number: Vision Phase 1/AR/UCIC/004-10

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification.pdf	Approved-Closed	12/01/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The rider will be used in conjunction with our filed and approved Applications, form numbers 9801BP (07/05), 9801L (07/05) and 9801-SM (07/05). All approved 06/27/2005.	Approved-Closed	12/01/2010

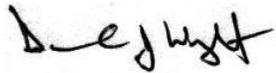
	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: SOV Vision Rider .pdf	Approved-Closed	12/01/2010

READABILITY CERTIFICATION

I, Daniel J. Wright, Vice President and Treasurer of United Concordia Insurance Company do hereby certify and affirm that the attached **Vision Rider (V9802 (10/10))** rates **48.6**, on the Flesch Reading Ease Test Scale, meeting the minimum Flesch Score of 40 required by the state of Arkansas cited as, ACA 23-80-206.

Date: _____ December 1, 2010 _____

Signature: _____


Daniel J. Wright
Vice President and Treasurer

United Concordia
STATEMENT OF VARIABILITY

This statement of variability applies to the following form:

V9802 (10/10)

The above referenced form is attached following this statement. The numbering of the variable statements below corresponds to the indicated numbers on the keyed form attached.

1. This allows marketing of this program under a different name.
2. This allows customization of the group name.
3. This allows customization of the group number.
4. This allows customization of the rider's effective date.
5. This allows a change to the vision benefits administrator's name or address.
6. This allows a change to the telephone number.
7. This language is included in its entirety or, if the provision or definition does not apply to the benefit offered, it is completely removed.
8. This allows the addition, removal or modification of components of the benefit to accommodate plan design requirements, group requests, or the evolution of the standards vision care, or permits the entire bracketed section to be deleted if the benefit is not part of the plan design offered.
9. This allows the frequency of the benefit to be changed to once per the stated number of months or once per the stated number of years to accommodate plan design requirements or group requests, or permits the entire bracketed section to be deleted if the benefit is not part of the plan design offered.
10. This increases the benefit offered during the frequency of use period for members that meet the specified criteria, or permits the entire bracketed section to be deleted if the benefit is not part of the plan design offered.
11. This language is only included when the benefit is not part of the plan design offered.
12. This defines the amount of the member's copayment within the specified dollar range, or permits the entire bracketed section to be deleted if a copayment is not part of the benefit.
13. This defines the amount of the member's reimbursement within the specified dollar range, or permits the entire bracketed section to be deleted if a reimbursement is not part of the benefit.
14. This language is used when the material is offered as a discount only, not as an insured benefit, or it is deleted if the discount material is not part of the plan design.
15. This defines the amount of the member's allowance within the specified dollar range, or permits the entire bracketed section to be deleted if an allowance is not part of the benefit.
16. This defines the amount of the member's discount within the specified percentage range, or permits the entire bracketed section to be deleted if discount is not part of the benefit.
17. The dollar range permits different limits in retail pricing to be used to define the frame benefit, or permits the entire bracketed section to be deleted if discount pricing is not part of the plan design.
18. This defines the member's price when a material is offered as a discount only, not as an insured benefit, or it is deleted if discount pricing is not part of the plan design.
19. This permits limits on number of contact lens boxes to be included, deleted, or changed to accommodate plan design requirements or group requests.

20. This defines the total limit, within the specified dollar range, of all vision aid allowances combined during the member's entire time enrolled under the group policy.
21. This allows the addition, removal or modification of exclusions to accommodate plan design requirements, group requests, or the evolution of the standards vision care.

① {UC Vision} or {Alternate Name of Program}

RIDER

to the

GROUP POLICY and CERTIFICATE OF INSURANCE

②
Policyholder: {insert group name}

③
Group Number(s): {insert group number(s)}

④
Rider Effective Date: {insert rider effective date}

On the Effective Date stated above and in consideration of the premium paid, this ⑤ Vision Rider makes a vision benefit available to the Members enrolled in the Policyholder's Group Policy. {Vision benefits are administered by:

Davis Vision, Inc.¹
159 Express Street
Plainview, NY ⑥ 11303
For Customer Service call: {800-332-0366}

A Member's dental Plan enrollment determines enrollment under this Vision Rider. When enrolled in a dental Plan that includes this Vision Rider, Members are covered under this Vision Rider on the later of the Member's Effective Date or the Rider Effective Date listed above. Members' coverage under this Vision Rider ends when their enrollment in the dental Plan terminates.

The Company will pay the vision benefits described in this Vision Rider and any addenda, riders, endorsements or amendments attached thereto, subject to the Group Policy terms. This Vision Rider is hereby incorporated into the Group Policy under the General Provisions section thereof.

⑤ {¹ In California, Davis Vision operates as Davis Vision Insurance Administrators.}

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INTRODUCTION

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

DEFINITIONS

Please note that certain words used in this Vision Rider have specific meanings. Capitalized terms have the specific meanings as set forth in the Definitions section of the Dental Plan Certificate of Insurance unless otherwise defined below.

Administrator – The entity designated by the Company and specified on the first page of this Rider to perform certain functions necessary to support the benefits offered under this Rider.

Allowance - A flat dollar amount payable under this Vision Rider toward the retail price of a Covered Expense from an In-Network Provider. Allowances, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. If the Provider's charge is less than the Allowance, We will only pay up to the Provider's charge.}

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Collection – Administrator's frame or Contact Lens Collection shown in the *Schedule of Benefits* section of this Vision Rider. The Collection is available at most independent In-Network Provider offices and is subject to change without notice.}

Copayment - The amount a Member is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider.

Covered Expense - The benefits listed in the *Schedule of Benefits* section of this Vision Rider. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or materials that are not listed in the *Schedule of Benefits* section of this Vision Rider; or
2. Any services or materials shown as "Not Available" or "Member is responsible for the entire cost" in the *Schedule of Benefits* section of this Vision Rider; or
3. An additional examination, 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 options) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Discount - The percentage that an In-Network Provider has agreed to reduce his charge for the requested service, Material or procedure. Discounts, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. Discounted vision services, Materials, supplies and treatments described in the *Schedule of Benefits* section of this Vision Rider are not underwritten by Us.

Discounted Price - The reduced price or percentage discount that an In-Network Provider has agreed to accept from Members for the requested service, Material or procedure. Discounted Prices, if applicable

to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. Discounted vision services, Materials, supplies and treatments described in the *Schedule of Benefits* section of this Vision Rider are not underwritten by Us. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.

Frequency or Frequency of Use Period - The time period shown in the *Schedule of Benefits* section of this Vision Rider during which You are eligible for the Covered Expenses, also shown in the *Schedule of Benefits* section of this Vision Rider. This time period is measured from the date of Your last eye examination or the date You received the eyeglasses, frame or spectacle lenses or contact lenses.

In-Network – Refers to Covered Expenses received from In-Network Providers.

In-Network Provider - A Provider who has entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials for a set of Scheduled Fees. These Providers are part of Our Network or Our Administrator's Network.

Materials – Frames, spectacle lenses and contact lenses provided to a Member for ophthalmic correction under the terms and conditions of this Vision Rider.

Network - A group of Providers who have entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials for a set of Scheduled Fees.

Out-of-Network – Refers to Covered Expenses received from Out-of-Network Providers.

Out-of-Network Provider - Providers of optometric services who have *not* entered into a contract with Us or Our Administrator to provide eye examinations and/or Materials.

Professionally Indicated - A service, supply, Material or treatment that 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.

Provider - 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. This Vision Rider 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:

- A person employed or retained by the Policyholder;
- A person living in the Member's household; or
- A parent, sibling, spouse, domestic partner or child of the Member.

Reimbursement - A flat dollar amount payable under this Vision Rider toward a Covered Expense from an Out-of-Network Provider. Reimbursement levels, if applicable to Your benefit plan, are shown in the *Schedule of Benefits* section of this Vision Rider. If the Provider's charge is less than the Reimbursement We will only pay up to the Provider's charge.

Scheduled Fee - The amount negotiated between an In-Network Provider and Us or Our Administrator as full payment for a Covered Expense received or purchased by a Member.

CHOICE OF PROVIDER

You may use the Provider of Your 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).

In-Network

When choosing to receive Covered Expenses from an In-Network Provider, You must contact the In-Network Provider before receiving services. The In-Network Provider will verify Your eligibility for Covered Expenses with Us or Our Administrator before services are rendered. The Provider will submit Your claim directly to Us or Our Administrator.

When services or Materials are received from an In-Network Provider, You are responsible for:

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1. The Copayment or Discounted Price, if a cash payment is due the Provider; or
2. The difference between the Allowance plus any negotiated Discount, if applicable, and the Scheduled Fee - We will pay the dollar amount of the Allowance, or the Provider's actual charge, if less; or
3. The difference between any negotiated Discount and the Scheduled Fee; or
4. The difference between the Discount Price and the Provider's retail price minus any negotiated Discount; or
5. The Provider's retail price minus any negotiated Discount.)

Out-of-Network

When You use an Out-of-Network Provider You must first pay the Provider's billed charge and then submit a claim.

Benefits for services or Materials received from Out-of-Network Providers are shown in terms of the dollar amount We will reimburse You for that service or material, not the total amount for which You are responsible. If You use an Out-of-Network Provider Your total responsibility is the difference between the Reimbursement and the total amount charged by the Provider - We will pay the dollar amount of the Reimbursement for that service or material or the Provider's actual charge, whichever is less.

SCHEDULE OF BENEFITS

Benefits are payable per Member. You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "\$0 Copayment."

Covered Expense	Frequency	In-Network	Out-of-Network
7 Eye Examination}			
8 {Includes (but is not limited to)- • Case history - chief complaint, eye and vision	9 {Benefit includes one examination every {other}{plan year} {{12- 24} months}} {10	12 {\$0 - 75} Copayment} 11 {Member is responsible for the entire cost}	13 {\$10 - 200} Reimbursement} 11 {Member is responsible for

Covered Expense	Frequency	In-Network	Out-of-Network
<p>history, medical history;</p> <ul style="list-style-type: none"> • 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 the Member on matters pertaining to vision care; • Form completion - school, motor vehicle, etc.; and • A 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.} 	<p style="text-align: center;">10</p> <p>{* {Or } {once every {other} {12} {24} {months} {plan year} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}}</p> <p style="text-align: center;">11</p> <p>{Not Available}</p>		<p>the entire cost}</p>

Covered Expense	Frequency	In-Network	Out-of-Network
<p>7 Spectacle Frames}</p> <p>7 Collection frames are available through most independent In-Network Providers.</p> <p>{Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for frames. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. Special frames may require additional cost.}</p>			
<p>7 Fashion Frame Collection}</p>	<p>9 Benefit includes {either} one {Collection frame or one non-Collection} frame {once every {other}{ 10 year} {{12; 24} months}.} {*</p>	<p>12 {\$0 - 50} Copayment</p> <p>{Member is responsible for the entire cost}</p>	<p>11 {Not Available}</p>
<p>7 • {Designer Frame Collection}</p>		<p>12 {\$0 - 50} Copayment</p> <p>{Member is responsible for the entire cost}</p>	<p>11 {Not Available}</p>
<p>7 • {Premier Frame Collection}</p>	<p>10 {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}</p>	<p>12 {\$0 - 50} Copayment</p> <p>{Member is responsible for the entire cost}</p>	<p>11 {Not Available}</p>
<p>7 {Non-Collection Frame}</p>	<p>7 Spectacle frame benefit is available if You receive a benefit for contact lenses during the same Frequency of Use Period.</p>	<p>15 {{10 - 300} Allowance, plus an additional {5-30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.}</p>	<p>16 {{10 - 300} Reimbursement}</p> <p>11 {Member is responsible for the entire cost}</p>
<p>14 Frame priced up to {50-150} retail</p>	<p>11 {Not Available}</p>	<p>18 Discounted Price: {\$40-80}</p> <p>18 {Member Discount: {10-30%} off Provider's retail price}</p>	<p>11 {Member is responsible for the entire cost}</p>
<p>14 Frame priced over {50-150} retail</p>		<p>18 Discounted Price: {\$40-80} plus an additional {10-30%} off the Provider's retail price over {\$50-150}</p> <p>16 {Member Discount: {10-30%} off Provider's retail price}</p>	<p>11 {Member is responsible for the entire cost}</p>
<p>7 Spectacle Lenses {(per pair)}{**}</p> <p>7 Includes all ranges of prescriptions and sizes, scratch-resistant coating{ and Your choice of glass or plastic lenses.}</p> <p>14 {Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for spectacle</p>			

Covered Expense	Frequency	In-Network	Out-of-Network
lenses. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. Special lens designs, materials and powers may require additional cost.}			
7 Single Vision Lenses}	9 Benefit includes one pair of lenses {once every {other 10 n year} {{12; 24} months}} {*} 10 {* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}	12 \$0 - 300} Copay 15 \$5-300} Allowance, plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$15-50}}{Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
7 Bifocal Lenses}	7 Spectacle lens benefit is not available if You receive a benefit for contact lenses during the same Frequency of Use Period}	12 \$0 - 300} Copay 15 \$5-300} Allowance, plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} 18 Discounted Price: {\$35-80}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
7 Trifocal Lenses}	11 {Not Available}	12 \$0 - 300} Copay 15 \$5-300} Allowance, plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.} {Discounted Price: {\$45-90}}{Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
7 Lenticular Lenses}		12 \$0 - 300} Copay 15 \$5- 600} Allowance, plus an additional {5,...30%} Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
		18 {Discounted Price: {\$90-135}} 11 {Member is responsible for the entire cost}	
7 Additional Spectacle Lens Options {(per pair)}			
7 {Other lens options, powers and frames not listed below may require an additional cost to the Member.}			
14 {Only offered In-Network to Members at the Discount Prices specified below. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided. There is no Plan payment for additional spectacle lens options.}			
7 {Oversize Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment 15 {\$10 - 100} Allowance 16 plus an additional {5,...30%} 13 Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart. 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement 11 {Member is responsible for the entire cost}
7 {Glass Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment 15 {\$10 - 100} Allowance 18 {Discounted Price: {\$5-30}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement 11 {Member is responsible for the entire cost}
7 {Polycarbonate Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment 7 {No charge for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.} 15 {\$10 - 100} Allowance 18 {Discounted Price: {\$15-50}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement 11 {Member is responsible for the entire cost}
7 {Fashion tinting of plastic lenses}	11 {Not Available}	12 {\$0 - 100} Copayment 15 {\$10 - 100} Allowance 18 {Discounted Price: {\$5-30}}	13 {\$10 - 300} Reimbursement 11 {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
		11 Member is responsible for the entire cost}	the entire cost}
7 • {Gradient tinting of plastic lenses}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		18 {Discounted Price: {\$5-30}}	11 Member is responsible for the entire cost}
		11 {Member is responsible for the entire cost}	
7 • {Fashion and gradient tinting of plastic lenses}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		18 {Discounted Price: {\$5-30}}	11 Member is responsible for the entire cost}
		11 {Member is responsible for the entire cost}	
7 • {Solid Tint}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		18 {Discounted Price: {\$5-30}}	11 Member is responsible for the entire cost}
		11 {Member is responsible for the entire cost}	
7 • {Gradient Tint}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		18 {Discounted Price: {\$5-30}}	11 Member is responsible for the entire cost}
		11 {Member is responsible for the entire cost}	
7 • {Glass-Grey #3 prescription sunglass lenses}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		11 {Member is responsible for the entire cost}	11 Member is responsible for the entire cost}
7 • {Ultraviolet Coating}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		18 {Discounted Price: {\$5-30}}	11 Member is responsible for the entire cost}
		11 {Member is responsible for the entire cost}	
7 • {Scratch Protection Plan (single vision)}	11 {Not Available}	12 15 {0 - 100} Copayment {10 - 100} Allowance}}	13 {10 - 300} Reimbursement}
		11 {Member is responsible for the entire cost}	11 Member is responsible for the entire cost}

7 Covered Expense	11 Frequency	12 In-Network	13 Out-of-Network
7 Scratch Protection Plan (multi-focal vision)}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Blended Segment Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$5-30}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Intermediate Vision Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$15-50}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Standard Progressive Addition}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$55-100}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Premium Progressive Addition}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$105-150}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Ultra Progressive Addition}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}
7 Photochromic Glass Lenses}	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$15-50}} 11 Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 Member is responsible for the entire cost}

7 Covered Expense	11 Frequency	12 In-Network	13 Out-of-Network
<ul style="list-style-type: none"> 7 Plastic Photosensitive Lenses} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$45-90}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 {Polarized Lenses} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$55-100}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 {Standard Anti-Reflective (AR) Coating} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$25-60}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 Premium Anti-Reflective (AR) Coating} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 Ultra Anti-Reflective (AR) Coating} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 {Standard} {Hi-Index Lenses} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$35-80}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}
<ul style="list-style-type: none"> 7 {Premium Hi-Index Lenses} 	11 {Not Available}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance}} 18 {Discounted Price: {\$45-90}} 11 {Member is responsible for the entire cost}	13 {\$10 - 300} Reimbursement} 11 {Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
<p>7 Contact Lens Evaluation, Fitting and Follow-up Care</p>	<p>7 (All types of contact lenses))</p>		
<p>14 Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for contact lens evaluation, fitting or follow-up care. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.</p>			
<p>7 (Standard Lens Types, or; and; Specialty Lens Types)</p>	<p>7 {Once every {other}{ plan year} {{12; 24} months} for {all contact lens types combined}{standard contact lens types} {and specialty lens types}}.</p>	<p>7 {For Collection contact lens \$10 - 100} Copayment</p>	<p>16 {{5,...30%} Discount}</p>
	<p>7 {This evaluation, fitting and follow-up benefit is not available if You received a benefit for contact lenses for specified diseases (below) during the same Frequency of Use Period}</p>	<p>11 Member is responsible for the entire cost}}</p>	<p>11 Member is responsible for the entire cost}</p>
	<p>7 {Once every {other}{ plan year} {{6;12; 24} months} for contact lenses for the following specified diseases:</p>	<p>7 {For Collection contact lens \$10 - 100} Allowance plus an additional {5,...30%} Discount on any amount over the Allowance}</p>	<p>7 {The non-Collection contact lens Reimbursement below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Reimbursement not available for non-Collection contact lenses if the entire Reimbursement amount is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Reimbursement is not applied, Member is responsible for the entire cost.}</p>
	<p>9</p> <ul style="list-style-type: none"> o Keratoconus; o Anisometropia; o Corneal Disorders; o Pathological Myopia; o Aniseikonia; o Post-traumatic Disorders; o Aphakia; o Aniridia; and o Irregular Astigmatism. 	<p>16 {{5,...30%} Discount}</p> <p>11 {Member is responsible for the entire cost}}</p>	
		<p>7 {The non-Collection contact lens Allowance below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Allowance not available for non-Collection contact lenses if the entire Allowance is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Allowance is not applied, Member is responsible for the entire cost.}</p>	
		<p>18 {Discounted Price: {5-50%} off Provider's retail price}</p>	
<p>7 (Specialty Lens Types)</p>	<p>This evaluation, fitting and follow-up benefit is not available if You received a benefit for</p>	<p>12 \$10 - 100} Copayment</p> <p>15 \$10 - 100} Allowance plus</p>	<p>16 {{5,...30%} Discount}</p>

Covered Expense	Frequency	In-Network	Out-of-Network
	standard or specialty contact lens types (above) during the same Frequency of Use Period.	an additional {5,...30%} Discount on any amount over the Allowance} {{5,...30%} Discount} {Member is responsible for the entire cost} {The non-Collection contact lens Allowance below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Allowance not available for non-Collection contact lenses if the entire Allowance is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Allowance is not applied, Member is responsible for the entire cost.} Discounted Price: {5-50%} off Provider's retail price}	{Member is responsible for the entire cost} {The non-Collection contact lens Reimbursement below can be applied toward a complete contact lens evaluation, fitting and follow-up care. Additional Reimbursement not available for non-Collection contact lenses if the entire Reimbursement amount is used for evaluation/fitting/follow-up benefit during the same Frequency of Use Period. If Reimbursement is not applied, Member is responsible for the entire cost.}
Contact Lenses (per pair))			
Only offered In-Network to Members at the Discount Prices specified below. There is no Plan payment for contact lenses. Members are responsible for paying all Discounted Prices directly to the In-Network Provider, and We shall not be financially liable for any discounted services provided.			
Collection Contact Lenses (single vision spherical only, all types) Collection contact lenses are available through most independent In-Network Provider offices.	Benefit includes the following limits on lenses {once every {other}{ plan year} {{12; 24} months}} {*}: For Collection contact lenses: • {One-Ten} pair(s) of daily wear contact lenses; or}	{ \$0 - 100} Copayment} {Member is responsible for the entire cost}	Not Available

Covered Expense	Frequency	In-Network	Out-of-Network
	<p>{ 19</p> <ul style="list-style-type: none"> • {One-Ten} boxes of planned replacement contact lenses; or} <p>{ 19</p> <ul style="list-style-type: none"> • {One-Ten} boxes of disposable contact lenses; or } <p>{ 19</p> <ul style="list-style-type: none"> • {One-Ten} boxes of disposable contact lenses.} <p>{ 10</p> <p>{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription change of 0.5 diopter or a 10 degree shift in axis}</p> <p>{ 7</p> <p>{Benefit is not available if You received a benefit for contact lenses for specified diseases (below) or eyeglasses during the same Frequency of Use Period.}</p> <p>{ 11</p> <p>{Not Available}</p>		
<p>{ 7</p> <p>Non-Collection Contact Lenses</p> <ul style="list-style-type: none"> o Standard lens types o Specialty lens types including, but not limited to toric, rigid gas permeable and multifocal lenses} 	<p>{ 9</p> <p>One Allowance or Reimbursement every {other}{ plan or } {{12; 24} months} { } { 10</p> <p>{ 10</p> <p>{* {Or } {once every {once every {other}{ plan year} {{12; 24} months}} under age 19} {, or age 19 and over} {with a prescription</p>	<p>{ 15</p> <p>{{ \$10 - 100 } Allowance, plus an additional { 5,...30% } Discount on any amount over the Allowance except that no additional Discounts are available on frames or contact lenses purchased at Wal-Mart.}</p> <p>{ 11</p> <p>{Member is responsible for the entire cost}</p>	<p>{ 16</p> <p>{ 13</p> <p>{{ \$10 - 500 } Reimbursement}</p> <p>{ 11</p> <p>{Member is responsible for the entire cost}</p>

Covered Expense	Frequency	In-Network	Out-of-Network
	change of 0.5 diopter or a 10 degree shift in axis} 7 Non-Collection contact lens benefit is not available if You receive a benefit for Collection contact lenses (above), contact lenses for specified diseases (below) or eyeglasses during the same Frequency of Use Period}		
8 Contact Lenses for Specified Diseases Benefit includes contact lenses prescribed for the following diagnoses: <ul style="list-style-type: none"> o Keratoconus; o Anisometropia; o Corneal Disorders; o Pathological Myopia; o Aniseikonia; o Post-traumatic Disorders; o Aphakia; o Aniridia; and o Irregular Astigmatism (You may be required to pay Your Provider in full at the time the contact lenses are dispensed and submit a claim to Us for reimbursement up to the benefit amount.)}	9 Benefit includes one pair of lenses every plan year.} 7 This benefit for contact lens benefit is not available if You already received a benefit for Collection or Non-Collection contact lenses or eyeglasses during the same Frequency of Use Period.} 11 (Not Available)}	12 {\$0 - 100} Copayment} 15 {\$10 - 100} Allowance} 7 Member is responsible for any cost of the lenses that exceeds the Allowance.} 11 Member is responsible for the entire cost}	13 {\$10 - 500} Reimbursement} 11 Member is responsible for the entire cost}
14 Conventional Contact Lenses (in lieu of eyeglasses)		16 Discounted Price (10-50%) off Provider's retail price	Member is responsible for the entire cost}

Covered Expense	Frequency	In-Network	Out-of-Network
14 Disposable or Planned Replacement Contact Lenses (in lieu of eyeglasses)		16 Discounted Price: {5-50%} off Provider's retail price	Member is responsible for the entire cost
14 • Laser Vision Correction		16 Discounted Price: up to {5-50%} off Provider's price or an additional {15%} discount on any advertised specials, whichever is lower	16 Member is responsible for the entire cost

7 **Low Vision Coverage**

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 Member'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 treatment options, including low vision aids, as well as assisting the Member to identify other resources for vision and lifestyle rehabilitation.

This program is available only In-Network.

Low vision aids will be provided as prescribed up to the maximum Allowance per aid, subject to the lifetime maximum for all aids shown below. Any amount due over the Allowance for an evaluation, follow-up visits or aids is the Member's responsibility.

Covered Expense	Frequency	In-Network	Out-of-Network
Comprehensive Evaluation	One comprehensive evaluation every 60 months (includes four follow-up visits in that period)	15 {50 - 600} Allowance per visit	Member is responsible for the entire cost
Follow-up Visit		15 {50 - 600} Allowance per visit	Member is responsible for the entire cost
Low Vision Aid		15 {50 - 600} Maximum Allowance per aid 20 {250 - 1200} Lifetime Maximum Allowance for all aids	Member is responsible for the entire cost

SCHEDULE OF EXCLUSIONS

Benefits will not be paid and the term "Covered Expenses" will not include charges:

- 21
1. For any service, supply, Material or procedure not shown in the *Schedule of Benefits* section of this Vision Rider.

2. For eye examinations required by an employer as a condition of employment.
3. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment (including laser vision correction) except as specified in the *Schedule of Benefits* section of this Vision Rider.
4. For lenses that do not provide vision correction, except as specified in the *Schedule of Benefits* section of this Vision Rider.
5. For charges to replace lost or stolen lenses or frames.
6. For sickness or injury covered by a workers' compensation act or other similar legislation.
7. Incurred as a direct or indirect result of war (declared or undeclared).
8. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
9. For services or supplies furnished to a Member before the Effective Date of his/her insurance under the Group Policy, before the Rider Effective Date shown on the first page of this Rider, or after the date a Member's insurance ends.
10. For any medical treatment rendered or material supplied outside the United States or Canada.
11. For services rendered by practitioners who do not meet the definition of Provider.

PAYMENT OF BENEFITS - CLAIM PROVISIONS

In-Network

A Member 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 Administrator before the examination takes place. The Provider will submit Member's claim directly to Us or Our Administrator.

Out-of-Network

When You use an Out-of-Network Provider You 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 or Our Administrator 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 Administrator's Office as specified below, or such other place as We may designate for the purpose.

5 {Davis Vision {Insurance Administrators}
 711 Troy Schenectady Road
 Suite 301
 Latham, NY 12110}

Notice should include the Policyholder's name and the Member's name, address and Member identification 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 stated immediately below 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 the location specified under Notice of Claim, above, 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 Vision Rider for any loss immediately upon receipt of due written or authorized electronic proof of such loss. We do not coordinate benefits with other vision plans.

All benefits will be paid in United States currency. All benefits payable under this Vision Rider, unless otherwise stated, will be payable to the Member or to his estate.

If We are to pay benefits to the Member'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.

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 Vision Rider and for deciding appeals of denied claims. In this role We shall have the authority, in Our discretion, to interpret the terms of this Vision Rider, 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 Vision Rider except as described herein. It is understood that Our sole liability to the Policyholder and Members under this Vision Rider shall be for the payment of benefits provided under this Vision Rider.

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 Vision Rider. 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 Vision Rider.

If there is an overpayment due when the Member dies, We may recover the overpayment from the Member's estate.

CLAIM REVIEW

If Your claim is wholly or partly denied, Our notice will include:

1. Reasons for such denial;
2. Reference to specific rider 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.

Your request for a review of Our claim decision 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.

GENERAL PROVISIONS

Conformity with Statutes

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

Compensation Insurance

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

Other Provisions

Except where specifically changed by this Rider, all of the terms and conditions of Your dental Plan's Group Policy and Certificate of Insurance, to which this Rider is attached, also apply to this Rider. In the

event of a conflict between the provisions in this Rider and the Certificate of Insurance or Group Policy, this Rider shall control.