



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway  
Kansas City, Missouri 64111-2406  
Phone 800-648-8624  
A STOCK COMPANY  
(Herein Called "the Company")

**POLICY NUMBER:** VC-146  
**POLICYHOLDER:** DISA Global Solutions  
**STATE OF ISSUE:** Texas  
**POLICY EFFECTIVE DATE:** January 1, 2017  
**POLICY ANNIVERSARY DATE:** January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy may be modified by mutual agreement between the Policyholder and the Company.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President

Secretary

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

## **GROUP VISION INSURANCE POLICY**

*Please read the Policy carefully.*

## PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each calendar month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective, unless otherwise mutually agreed;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred, unless otherwise mutually agreed;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred, unless otherwise mutually agreed; or
4. if the number of eligible employees increases or decreases by more than 10% premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of the current month plus six months.

**Premium Rate Change.** The Company has the right to change the premium rate on or after the third Policy Anniversary Date. The Company will provide written notice at least 60 days before the date of change.

**Grace Period.** A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

**Return of Premium.** The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct from the premiums to be returned to the Policyholder an amount equal to the amount of such claims paid.

## TERMINATION OF POLICY

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. any date on or after the third Policy Anniversary Date the Company requests termination. Written notice must be provided to the Policyholder at least 31 days prior to termination;
2. any date on or after the date the Company receives the Policyholder's written request for termination;
3. the date the number of persons covered under the Policy does not meet the minimum participation requirements of 10;
4. the date the required premium has not been paid, except as provided in the Grace Period provision; or
5. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

### **CERTIFICATE**

The Company will furnish the Certificate to the Policyholder for the Insured which will set forth the essential features of the insurance coverage.

### **ADDITIONAL INSUREDS**

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

### **INCORPORATION PROVISION**

The provisions of the attached Certificate and all Rider(s) issued with the Policy or to amend the Policy after the Policy Effective Date are made a part of the Policy.



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## AMENDMENT RIDER

By attachment of this Rider, the third paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

5. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 60 days before the date of change.

This Rider takes effect on the effective date of the Policy to which it is attached. This Rider terminates concurrently with the Policy to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President

Secretary



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Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described in the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number, and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President

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**Workers' Compensation. THE INSURANCE POLICY UNDER WHICH THE CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

## GROUP VISION INSURANCE CERTIFICATE

*Please read the Certificate carefully.*

**THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.**

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SCHEDULE OF BENEFITS ..... Attached (1A)

## DEFINITIONS

**Allowance** means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

**Benefit Frequency** means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Copayment** or **Copay** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

**Comprehensive Eye Examination** means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

**Dependent** means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse or Domestic Partner who is under 26 years of age;
3. each unmarried child at least 26 years of age who is incapable of self-sustaining employment by reason of mental incapacity or physical handicap.

Dependent includes a step-child, foster child, grandchild, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

**Domestic Partner** means a same-sex or an opposite-sex adult who is in a relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise.

**Formulary** means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

**Insured** means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

**Insured Person** means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

**In-Network Provider** means a Provider who has signed a Preferred Provider Agreement with the PPO.

**Medically Necessary Contact Lenses** means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

**Out-of-Area Provider** means an Out-of-Network Provider that is utilized by the Insured Person when there is no In-Network Provider within 75 miles of the Insured Person's residence.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

**Policy** means the Vision Insurance Policy issued to the Policyholder.

**Policyholder** means the employer named as the Policyholder in the face page of the Policy.

**PPO Service Area** means the geographical area where the PPO is located.

**Preferred Provider Agreement** means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

**Preferred Provider Organization ("PPO")** means a network of Providers and retail chain stores within the PPO Service Area that have signed a Preferred Provider Agreement.

**Provider** means a licensed physician, optometrist, therapeutic optometrist or ophthalmologist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

**Refraction** means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

**Vision Examination** means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

**Vision Materials** means those materials provided for visual health and welfare shown in the Schedule of Benefits.

## EFFECTIVE DATES

**Effective Date of Insured's Insurance.** The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
  - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
  - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

**Effective Date of Dependents' Insurance.** Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse or Domestic Partner are both Insureds, one Insured may request to be a Dependent spouse or Domestic Partner of the other. A Dependent child may not be covered by more than one Insured.

**Newborn Children.** A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

**Adopted Children.** A Dependent child for whom the Insured is a party to a suit for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

## **BENEFITS**

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

**In-Network Provider Benefits.** The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

**Out-of-Area.** An Insured Person who does not have reasonable access to an In-Network Provider within 75 miles of the Insured Person's residence may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Area Provider allows assignment of benefits. The Company will pay up to the In-Network Provider Allowance(s) and any cost above the In-Network Provider Copayments as shown in the Schedule of Benefits.

## **LIMITATIONS**

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency.

## **EXCLUSIONS**

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;

9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

## **TERMINATION OF INSURANCE**

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

**For All Insureds.** The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made, subject to the Grace Period provision;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
  - a. does so without individual selection between Insureds; and
  - b. continues to pay any premium contribution for those individuals.

**For Dependents.** A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made, subject to the Grace Period provision.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

## PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

**Premium Changes.** The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 60 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

**Grace Period.** The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

**Unpaid Premium.** When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

## CLAIMS

**Notice of Claim.** Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

**Claim Forms.** The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

**Proof of Loss.** Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

**Time Payment of Claims.** Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

**Payment of Claims.** All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

**Assignment.** Benefits under the Policy may be assigned.

**Right of Recovery.** If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

**Legal Actions.** No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

**Payment to the Texas Department of Human Services.** In the event that the Texas Department of Human Services is paying benefits on behalf of an Insured Person under Chapters 31 or 32 of the Human Resources Code, i.e., financial and medical assistance service program administered pursuant to the Human Resources Code, and the Company is notified through an attachment to the claim when first submitted to the Company which states that all benefits payable are to be paid directly to the Department of Human Services, the Company will pay all benefits under the Policy for the Insured Person to the Texas Department of Human Services.

**Payment to the Texas Department of Human Resources.** In the event that the Texas Department of Human Resources is paying benefits on behalf of an Insured Person, the Company will pay benefits under the Policy for the Insured Person to the Texas Department of Human Resources.

**Payment to Managing Conservator of a Dependent Child.** For a minor child who otherwise qualifies as a Dependent of an Insured Person, benefits may be paid on behalf of the insured Dependent child to a person who is not the Insured Person if an order issued by a court of competent jurisdiction in this or any other state appoints such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of an insured Dependent child must submit to the Company with the claim application written notice that such person is the possessory or managing conservator of the insured Dependent child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as a possessory or managing conservator or other evidence designated by rule of the Texas State Board of Insurance that the person qualifies to be paid the benefits. Such requirements shall not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured Person where the Insured Person has paid any portion of a medical bill that would be covered under the terms of the Policy.

## GENERAL PROVISIONS

**Clerical Error.** Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

**Conformity to Law.** Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

**Entire Contract.** The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

**Amendments and Changes.** No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

**Incontestability.** After the Policy has been in force for two years from its date of issue, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

**Insurance Data.** The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

## SCHEDULE OF BENEFITS

DISA Global Solutions

<b><i>BENEFIT FREQUENCY</i></b>		
<b><u>Vision Examination</u></b>	once every 12 months	Insured Person
<b><u>Vision Materials</u></b>		
<b>Frame</b>	once every 12 months	Insured Person
<b>Lenses</b>	once every 12 months	Insured Person
<b>Contact Lenses</b>	once every 12 months	Insured Person

<b><i>BENEFIT</i></b>	<b><i>In-Network Provider</i></b>	<b><i>Out-of-Network Provider (Reimbursement up to)</i></b>
<b><u>Vision Examination</u></b>		
<b>Comprehensive Eye Examination</b>	\$10 Copayment	\$40
<b><u>Vision Materials</u></b>		
<b>Frame</b>	\$0 Copayment up to \$150 Allowance	\$91
<b>Contact Lenses</b> Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses.		
Conventional	\$0 Copayment up to \$150 Allowance	\$130
Disposable	\$0 Copayment up to \$150 Allowance	\$130
Medically Necessary	Paid in Full	\$210
<b>Standard Plastic Lenses</b>		
Single Vision	\$25 Copayment	\$30
Bifocal	\$25 Copayment	\$50
Trifocal	\$25 Copayment	\$70
Lenticular	\$25 Copayment	\$70
Progressive – Standard	\$90 Copayment	\$50
Progressive – Premium Tier 1	\$110 Copayment	\$50
Progressive – Premium Tier 2	\$120 Copayment	\$50
Progressive – Premium Tier 3	\$135 Copayment	\$50
Progressive – Premium Tier 4	\$90 Copayment up to \$120 Allowance	\$50



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## AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

The Policy/Certificate to which this Amendment Rider is attached is amended as follows:

The following applies when the Policy serves to replace similar coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the prior plan. The Policyholder's coverage under the Policy will not be considered as replacement coverage unless the Policyholder's coverage under the Policy takes effect within 60 days after coverage under the prior plan ends.

In the absence of this provision, an Insured Person who was covered by the prior plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a Hospital.

Each such person will be insured under the Policy if:

1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended; and
2. the person is in a class of persons eligible for coverage under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the prior plan pursuant to any extension of benefits provision.

The Policy, in applying any waiting periods, will give credit for the satisfaction or partial satisfaction of the same or similar provisions under the prior policy.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the terms and conditions of the Policy/Certificate except as stated herein.

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President

Secretary