CompBenefits Company

A Prepaid Limited Health Service Organization
Licensed Under Chapter 636, Florida Statutes

Certificate of Benefits

This certificate outlines the features of the Group Vision Contract issued to your Group by CompBenefits Company. Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Contract. If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 865-3676.

President

DEFINITIONS

Copayment- the amount paid by Member for services rendered or materials purchased.

Contract- means the written agreement between Vision Care, Inc. and the Group.

Contribution- a periodic payment due to Vision Care, Inc. by or on behalf of Member to receive benefits as provided by the Certificate.

Dependent– means any of the following persons: your spouse; your children; from birth to age 19 and dependent upon you for support; or 19 years of age through the end of the calendar year in which the child reaches the age of 25, if the child meets all of the following: the child is dependent upon you for support; and the child is living in your household, or the child is a full-time or part-time student. A child also includes adopted children, as well as stepchildren or foster children living with the Subscriber in a parent-child relationship.

Group- means the aggregate of individuals eligible to be covered under the Plan as established by the terms of the Contract.

Member- means the Subscriber and covered Dependents of a Subscriber.

Plan, We, Us or Our- means Vision Care, Inc.

Schedule of Benefits – means the listing of benefits showing what is paid.

Subscriber- an individual in good standing for whom the necessary contributions and Copayments have been made and to whom a Certificate evidencing coverage has been issued.

VisionCare Plan Network Provider- a licensed optometrist or ophthalmologist under agreement with Vision Care, Inc. to provide vision services to Plan Members.

LIMITATIONS

The Plan is designed to cover visual needs rather than cosmetic choices. Covered Materials that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits. The Member is responsible for the following extra items selected, unless otherwise listed as a covered benefit in the Schedule of Benefits. These items include but are not limited to:

* Coated or laminated lenses.
* Blended or progressive multifocal lenses.
* Tinted or photochromic lenses, sunglasses, prescription and plano.
* A frame that costs more than the Plan allowance.
* Groove, drill or notch, and roll and polish.

EXCLUSIONS

The Plan does not pay benefits for services or materials connected with:

* Orthoptics or vision training and any associated supplemental testing;
* Subnormal vision aids, non-prescription or aniseikonic lenses;
* Contact lenses, except as covered in the Schedule of Benefits;
* Hi Index, aspheric and non-aspheric styles;
* Oversized 61 and above lens or lenses;
* Experimental or non-conventional treatment or device;
* Medical or surgical treatment of the eyes;
* Charges incurred after coverage ends;
* Cosmetic items, unless specifically covered in the Schedule of Benefits;
* Any injury or illness covered paid any Workers Compensation or similar law;
* Two pairs of glasses in lieu of bifocals, trifocals or progressives;

* Services or materials from a provider that is not a VisionCare Plan Network Provider; or
* Any services and/or materials required by an employer as a condition of employment.

USING YOUR PLAN

Benefit Form Method: You must obtain a Benefit Form before scheduling an appointment. Benefit forms may be requested by (i) calling the Plan's Member Services Department at 1-800-865-3676; (ii) connecting to Our Web site at www.visioncare.com; (iii) faxing toll free at 1-800-421-0100 or (iv) mailing Us at P.O. Box 30349, Tampa, FL 33630-3349.

A Benefit Form, valid for sixty (60) days along with a list of VisionCare Plan Network Providers in your area, will be sent to you. Members' use of benefits under another vision plan will affect determination of benefits under this Plan. Members must choose a VisionCare Plan Network Provider from the list and schedule an appointment. Please identify yourself as a VisionCare Plan Member and have your group name and policy number available.

Present the original Benefit Form to the VisionCare Plan Network Provider you selected at the time of your first scheduled appointment. The VisionCare Plan Network Provider will provide the covered service and bill the Plan directly. You will pay your Copayment and any extra costs for services and materials not covered by the Plan.

PLEASE NOTE: If you visit a VisionCare Plan Network Provider and do not follow the proper procedures to verify your eligibility and benefits in advance, you will be treated as a private patient. This means that the VisionCare Plan Network Provider is not obligated to accept the Plan's fees and he can charge you his usual fees.

PROBLEM-SOLVING

Informal Grievances

Any Member who has a suggestion for improving services or wishes to register a complaint for any matter arising out of the Certificate or for covered services rendered or materials received, may submit an informal oral grievance to the Plan. Assistance with the Plan's grievance procedures, including informal oral grievances, may be obtained by contacting the Member Services Department at the address and phone number shown below. Informal oral grievances will be responded to as soon as possible. The Member has the right to file a formal written grievance with the Plan and to grieve directly to the State of Florida Department of Insurance.

Submission of Formal Grievances

Any Member who has a suggestion for improving services or wishes to register a complaint for any matter arising out of the Certificate, or for covered services or materials received, may submit a formal written grievance to the Plan. The written grievance must be identified as such and submitted to the Plan's Grievance Coordinator within one (1) year from the date of the occurrence of the events upon the grievance is based. The grievance must contain the Member's name, address, phone number, ID number, signature, date, and the action requested. Assistance with the Plan's grievance procedures may be obtained by contacting the Member Services Department at the address and phone number shown below.

Response to Formal Grievances

The Grievance Coordinator will investigate the grievance, gather all of the relevant facts review the case with the appropriate parties and respond in writing to the Member and the VisionCare Plan Network Provider, if appropriate, within ten (10) days of completion of the review. If the grievance involves an eyecare related matter or claim, the Plan's Medical Director shall be involved in the resolution. If it

involves denial of benefits or services, the written decision shall state the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days, however, if the grievance involves collection of information from outside the Plan's service area, an additional thirty (30) days will be allowed for processing.

Appeal of Decision

If the Member is not satisfied with the formal grievance decision, the Member may request reconsideration by the Grievance Committee and may also request a personal appearance before the Committee. A request for reconsideration must be made within sixty (60) days after receipt of the written decision. In addition, at any time a Member always has the right to grieve directly to the State of Florida Department of Insurance.

Contact Information

Vision Care, Inc.
P.O. Box 30349
Tampa, FL 33630-3349
Att: Member Services Department
or call, toll free at (800) 865-3676

Florida Department of Insurance
Consumer Assistance
200 East Gaines Street
Tallahassee, FL 32399-032
or call toll free Consumer Hotline at (800) 342-2762

CONVERSION

A Member whose coverage was terminated may receive a converted contract if he was continuously covered under the Plan for at least three (3) consecutive months immediately prior to termination. The converted contract will provide coverage and benefits similar to the Contract previously in effect. A Member is not entitled to a converted contract if termination occurred for any of the following reasons:

* Failure to pay contributions.
* Replacement by similar coverage within thirty-one (31) days.
* Material misrepresentation or fraud in applying for any benefit under the Contract.
* Disenrollment for cause.
* Willful and knowing misuse of the Certificate.
* Willful and knowing furnishing to the Plan incorrect information for the purpose of fraudulently obtaining coverage or benefits.
* The Subscriber has left the Plan’s geographic area with the intent to relocate or establish a new residence outside the Plan’s geographic area.

Subject to the conditions set forth above, the conversion privilege shall also be available to:

* The surviving spouse and/or children, if any, at the death of the Subscriber, with respect to the spouse and such children whose coverages under Plan contract terminate by reason of such death.
* To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.
* To the spouse of the Subscriber upon termination of coverage of the spouse, while the Subscriber remains covered under a group contract, by reason of ceasing to be a qualified family member under the group contract.
* To a child solely with respect to himself or herself, upon termination of coverage by reason of ceasing to be a qualified family member under a group contract.

DURATION OF AGREEMENT

Except under the following conditions, this Certificate shall remain in force for a period of not less than twelve (12) months. Except for nonpayment of Contributions or termination of eligibility, the Plan may cancel this Certificate with forty-five (45) days written notice for the following reasons:

- When a Member commits any action of fraud or material misrepresentation in applying for or presenting any claim for benefits involving the Plan.

- When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation seriously impairs the ability of a VisionCare Plan Network Provider, to provide services to the Member and/or to other Members.

- When a Member misuses the documents provided as evidence of benefits available pursuant to the Contract or this Certificate.

- When a Member furnishes to the Plan incorrect or incomplete information for the purposes of fraudulently obtaining services.

- When a VisionCare Plan Network Provider is not available within the immediate geographical area of the Subscriber.

- When reasonable efforts by the Plan to establish and maintain a satisfactory patient relationship are unsuccessful or when the Member has indicated unreasonable refusal to accept necessary treatment. When a Member refuses to accept treatment from two (2) VisionCare Plan Network Providers, proof of unreasonable refusal shall be presumed conclusively.

- Prior to cancellation, the Plan shall make every effort to resolve the problem through its grievance procedure and to determine that the Member's behavior is not due to use of the vision care services provided or mental illness.

Coverage for a Member will end on the earlier of:

* On the date the Group tells Us that the Member ceases to be eligible for coverage.
* The last day of the month in which a Dependent of Subscriber is no longer a Dependent as defined.
* Subject to the grace period provision, the last day of the month for which a premium has been paid.
* The date coverage ends for any class or group to which Subscriber belongs.
* The date the Contract ends.

EXTENSION OF BENEFITS

Cancellation of this Certificate by the Plan is without prejudice to any continuous loss which commenced while this Certificate was in force. VisionCare Plan Network Providers shall complete all procedures undertaken upon the Member, until the specific treatment or procedure is completed or for ninety (90) days, whichever occurs first.

CONTINUATION OF COVERAGE

Unless cancellation of this Certificate is made for reasons specified in the Section entitled "Duration of Agreement", Members for whom appropriate Contributions and Copayments are paid will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

At the attainment of the applicable age, coverage as a Dependent shall be extended if the individual is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan within thirty-one (31) days of the Dependent's attainment of the limiting age and subsequently as may be required by the Plan but not more frequently than once every two years.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for employers size 20+ requires that certain employers maintaining group medical plans offer employees and their Dependents the opportunity to continue their coverage when such coverage ends under certain conditions. More information about COBRA continuation can be obtained from your employer.

EFFECTIVE DATE OF COVERAGE

If you qualify under the rules of your group medical insurance and have selected to receive vision care benefits under this Plan, you will be covered on the later of:

- The first of the month following the date first eligible for coverage.
- The date Vision Care, Inc. accepts your enrollment if you are not enrolled within 30 days of becoming eligible.

Dependents will be covered on the later of:

- The date you first acquire a new Dependent.
- The date the Plan accepts a new Dependent's enrollment if the Dependent is not enrolled within 30 days of becoming eligible.

Newborn Child- A child born to you or your Dependent spouse is covered from the moment of birth for 30 days. If you elect to cover your newborn under this Plan, you must enroll the child within 60 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 30 day period.

Adopted Child- A child placed with you for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants you conservatorship of the child; or 3) the date the child is placed with you for adoption; and additional premium, if any, is paid.

COORDINATION WITH OTHER BENEFITS

APPLICABILITY

This Coordination With Other Benefits provision applies to This Plan when you or your covered Dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in the Section entitled Effect on the Benefits of this Plan.

DEFINITIONS

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, visual care specifically related to a vision exam, lenses and frames. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a

separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Certificate.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits or the amount Vision Care, Inc. is obligated to pay the Vision Care Plan Network Provider for the service or material pursuant to the terms of the parties written agreement.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents": (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

This section applies when this Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these rules. The Plan has the right to decide which facts are needed. Vision Care, Inc. may get needed facts from, or give them to, any other organization or person. Vision Care, Inc. need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Vision Care, Inc. any facts deemed necessary to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, Vision Care, Inc. may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Vision Care, Inc. will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Vision Care, Inc. are more than should have paid under this provision, Vision Care, Inc. may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

CONTRIBUTIONS AND COPAYMENTS

Payments- It is agreed that in order for Member to be eligible for and entitled to receive benefits provided by this Certificate, The Plan must receive all Contributions in advance. The VisionCare Plan Network Provider must receive all Copayments for services rendered or materials obtained under the terms of the Plan.

Grace Period- The Contract under which this Certificate is issued has a thirty (30) day grace period. This provision means that if any required Contribution is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the Contract and this Certificate will stay in force. If full payment is not received within the thirty (30) day grace period, coverage will be terminated effective the first day of the grace period. Subscriber will be liable for the cost of all services and materials received during the grace period.

Reinstatement – Subscribers whose coverage is terminated for non-payment of Contributions prior to the expiration of thirty (30) day grace period only may have their coverage reinstated if a request for reinstatement is submitted by the Group for consideration by the Plan. The Plan may or may not agree to such request.

CHANGES IN CONTRIBUTIONS AND BENEFITS

Contract Changes- The Plan may increase Copayments or delete, amend, or limit any benefits under the Contract upon not less than 120 days prior written notice to the Group prior to renewal of the Contract. It is the responsibility of the Group to notify all Members of any such changes to the Contract.

Premium Changes- Contributions charged by Vision Care, Inc. for coverage under the Plan may be changed upon not less than 120 days advance written notice to the Group. It is the responsibility of the Group to notify all Members of such change in Contributions.

GENERAL PROVISIONS

Incontestability – In the absence of fraud, all statements made by the Subscriber are considered representations and not warranties during the first two years of coverage. The Plan may avoid providing coverage at any time if Subscriber makes a fraudulent statement in a written application.

Conformity with Florida Law- This Certificate shall be interpreted in accordance with the laws of the State of Florida and any action or claim, including arbitration, shall be brought within the State of Florida. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over Vision Care, Inc. shall have the effect of amending this Certificate to conform with the minimum requirements thereof. In the event any portion of this Certificate is held to be void, it shall not affect any other provisions.

Notice of Independent Contractor Relationship – The Plan assumes responsibility of fulfilling the terms of this Certificate. VisionCare Plan Network Providers are independent contractors, and the Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a VisionCare Plan Network Provider for any damage which result from any defective or dangerous condition in or about any facility which services are rendered or materials are provided hereunder.

Worker's Compensation Act – The coverage under the Contract is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

Charlotte County School Board
SCHEDULE OF BENEFITS
In Network

The following vision services and materials are only covered when provided by a VisionCare Plan Network Provider. The Member is responsible for payment of the applicable Copayment, if any.

Vision Examinations - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities: 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once in any **12 month** period.

Materials - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses - We will pay for one pair of prescription lenses once in any **12 month** period.

Frames - We will pay for a new frame once in any **24 month** period. The VisionCare Plan Network Provider will show the Insured the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the amount the Plan covers, the Insured is responsible for the difference in cost.

Contact lenses when necessary – We will pay for one pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month** period and only if prior authorization is obtained from the Plan. The Copayment is waived.

Contact lenses when elective - Benefits include: (1) The cost of an annual vision examination, subject to the Copayment; and (2) the cost of contact lenses, any fitting cost and follow-up visit up to a maximum of **$105.00**, not subject to the Copayment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any **12 month** period.
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Co-Payment - An Insured's Co-payment is:

Vision Examination and Materials **$10**