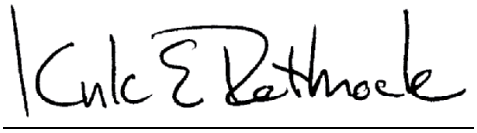
Vision Care, Inc.

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 Vision Care, Inc. 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 26, 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

The Member may choose between either the Benefit Form Method or the Dash Method each time prior to services being received.

Benefit Form Method: You may 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.compbenefits.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.

Dash Method: Before scheduling an appointment, the Member must choose a VisionCare Plan Network Provider from the list of the network providers in the Member's area. The Member must call to schedule an appointment and give the VisionCare Plan Network Provider his/her name, the patient's name, ID number, and the Group name and number. After scheduling the appointment, the VisionCare Plan Network Provider's office verifies the Member's eligibility and benefits before performing the exam. When the exam is completed, the VisionCare Plan Network Provider has the Member sign a claim form. The VisionCare Plan Network Provider submits the form directly to the Plan for payment. The Member is responsible for the Copayment and the costs of 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

Compbenefits Company
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 90 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 90 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.

SCHEDULE OF BENEFITS

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 **$150.00**, 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.

Co-Payment - An Insured's Co-payment is:

1. Vision Examination **$10**
2. Materials **$15**

COMPBENEFITS INSURANCE COMPANY

100 Mansell Court East **Roswell, GA 30076** **(800) 865-3676**

CERTIFICATE

OF

GROUP VISION INSURANCE

This Certificate outlines the features of the Group Vision Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). 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 Policy.

If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 865-3676.

Signed for CompBenefits Insurance Company

President

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SECTION I - DEFINITIONS

Copayment- means the amount an Insured is required to pay when a covered service is rendered or covered Materials are purchased.

Dependent- means any of the following persons:

1. Your spouse;
2. Your child;
   a) from birth to age 19 and dependent upon You for support;
   b) 19 years of age through the end of the calendar year in which the child reaches the age of 26 years of age, if dependent upon You for support and a full-time or part-time student or residing in your household; or
   c) at least 19 years of age and:
      i. primarily dependent upon You for support because of mental or physical handicap;
      ii. was incapacitated and insured under Policy on his 19th birthday; and
      iii. continues to be incapacitated beyond his 19th birthday.

   A child also includes adopted children, as well as stepchildren, children placed in court-ordered custody, including foster children, living with You in a parent-child relationship.

Group- means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

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

Materials- means lenses, frame and contact lenses covered under the Policy.

Policy- means the Policy issued to the Policyholder.

Policyholder – means the Group to whom the Policy has been issued.

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

"**You**" and "**Your**" means the Certificateholder.

"**We**", "**Our**", "**Us**", and "**Plan**" means CompBenefits.

SECTION II - BECOMING INSURED

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. The first of the month following the date first eligible for coverage;
2. The date We accept Your enrollment, if You are not enrolled within 30 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent's enrollment, if he is not enrolled within 30 days of becoming eligible.

Newborn Child- A child born to You or a covered Dependent is covered from the moment of birth for 30 days. If timely notice is given, Plan may not charge an additional premium for coverage of the newborn child for duration of the notice period. If timely notice is not given, Plan may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, Plan may not deny coverage for a child due to the failure of the Plan to timely notify the Plan of the birth the child.

Adopted Children, Foster Children- Benefits applicable to Your Dependent children also apply to an adopted child, court-ordered child or foster child placed in compliance with chapter 63, from the moment of placement in Your residence. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by You prior to the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in Your residence in compliance with chapter 63.

You must notify Us of the birth or placement of the adopted child not less than 30 days after the birth or placement in Your residence of a child adopted by You. If timely notice is given, We may not charge an additional premium for coverage of the child for the duration of the notice period. If timely notice is not given, We may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, We may not deny coverage for the child due to Your failure to timely notify Us of the birth or placement of the child.

Your Coverage Ends- Coverage for You and/or Your Dependent will end at 12:01 a.m. on the earlier of:

1. On the date the Policyholder tells Us that You and/or Your Dependent cease to be eligible for coverage;
2. The last day of the month in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which a premium has been paid; or
4. The date coverage ends for any class or Group to which You belong; or
5. The date the Policy ends.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

SECTION III - PROCEDURES FOR USING BENEFITS

The Insured may receive covered services and Materials from a licensed Optometrist or Ophthalmologist of his choice. The Insured may pay the provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. We will reimburse covered services and Materials only up to the allowance, as shown in the Schedule of Benefits, after deduction of the applicable Copayment. The Insured is responsible for the Copayment, the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered by the Policy. Determination of benefits under this Plan will be affected if a covered service or Material was provided under another vision plan.

SECTION IV-LIMITATIONS AND EXCLUSIONS

Limitations - In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;
   unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions - We will not cover:

1. Orthopic or vision training and any associated supplemental testing;
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an Employer as a condition of employment;
5. Any injury or illness paid under any Workers' Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy.
8. Experimental or non-conventional treatment or device;
9. Contact lenses, except as specifically covered by the Policy;
10. Hi Index, aspheric and non-aspheric styles
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

SECTION V-COORDINATION WITH OTHER BENEFITS

1. 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 Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, vision care or treatment. 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 Policy.

"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.

"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.

3. 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.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, 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.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits 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. CompBenefits 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.

7. ERRORS RELATED TO YOUR COVERAGE.

The Plan has the right to correct benefit payments made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payment if any underpayments have been made.

SECTION VI-PREMIUMS

Premium Payments - All premiums are payable in advance for coverage under the Policy on the first day of each calendar month in accordance with the premium rate schedules of CompBenefits in effect for each premium due date.

Grace Periods - A grace period of 31 days is allowed for payment of each premium due after the first premium, during such grace period the Policy shall continue in force, unless the Group has given the Plan written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will charge a pro-rata premium for the time coverage under the Policy remained in force for any Group during such grace period.

Change in Premiums - Premiums are payable to CompBenefits or Our authorized agent. Premiums may be increased for a Policy period on the anniversary date of the Policy. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 90 days prior to the anniversary of the Policy period.

Reinstatement - If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by CompBenefits or by any agent authorized by CompBenefits to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Policyholder and CompBenefits shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which

premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Termination - This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage by this form of Policy or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. You will receive at least one hundred-eighty (180) days advance notice prior to such discontinuance. Unless otherwise permitted under state law, except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination.

This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the expiration date of the grace period.

SECTION VII-CLAIMS

Notice of Claim - Written notice of claim must be given to Us within 60-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 30349, Tampa, FL 33630-3349, or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

Claim Forms - You can get the forms You need for claiming benefits by calling Us at (800) 865-3676 or writing Us at P.O. Box 30349, Tampa, FL 33630-3349. If the forms are not sent to You before the expiration of 15 days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Time of Payment of Claims - Indemnities payable under this Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Proof of Loss – Written proof of loss must be furnished to Us at P.O. Box 30349, Tampa, FL 33630-3349 in the case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90-days after the termination period for which We are liable and, in the case of claim for any other loss, within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Legal Action - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

SECTION VIII- NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA) FOR GROUPS SIZE 20 OR MORE

If Your insurance terminates in accordance with the other terms of this Policy, it will be reinstated as of the date of termination if You elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under this Policy, and if such insurance is terminating due to any of the following Qualifying Events:

1. Termination of Your employment (for reasons other than gross misconduct);
2. Reduction of work hours including lay-off;

3. Death of the Certficateholder;
4. Divorce or legal separation;
5. A child ceases to be a dependent as defined in this Policy;
6. The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

The maximum continuation of coverage period with respect to a reason described above is: (1) 18 months with respect to 1 or 2 above. However, if You are disabled as determined under Title II or XVI of the Social Security Act at the time of the Qualifying Event or any time during the first 60 days of continuation coverage, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months; (2) 36 months with respect to 3, 4 or 5 above; (3) With respect to 6 above, lifetime coverage for You, whereas Your Dependents will be covered until the earlier of: (a) Your death; or (b) death of the Dependent. If, while insurance is being continued, further qualifying events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days.

It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: (1) the date of Qualifying Event; (2) the date of the loss of coverage; or (3) The date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: (1) The end of the maximum continuation of coverage period; (2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; (3) Your becoming covered under another group vision care plan as employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group vision plan; (4) Discontinuance of this vision care benefit provision; or (5) The date Your employer ceases to provide any group vision plan.

SECTION IX-GENERAL PROVISIONS

Representations and Warranties - All statements made by any Insured or the Group are deemed representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You, or in the event of Your death or incapacity, Your beneficiary or personal representative.

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

Conformity with State Statutes - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Limit on Certain Defenses - After the Policy has been in force for a period of two (2) years during the lifetime of the Insured, excluding any period during which the Insured is disabled, it shall become incontestable as to the statements contained in the application.

SCHEDULE OF BENEFITS

The following vision services and materials are covered up to the Allowance shown below after deduction 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 - One pair of prescription lenses once in any **12 month** period.

Frames - One new frame once in any **24 month** period.

Contact lenses when necessary – 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 **$150.00**, 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.

Co-Payment - An Insured's Co-payment is:

1. Vision Examination **$10**
2. Materials **$15**

Allowance – Vision Benefits will be reimbursed according to the following schedule after deduction of the applicable Co-payment.

Vision Examination		$35
Single Vision Lens		$25
Bifocal Lens		$40
Trifocal Lens		$60
Lenticular Lens		$100
Contact Lenses when elective	Exam +	$150
Contact Lenses when necessary		$210
Frame		$50