



**Opticare [[of Utah][Plus Vision]]
Dba Opticare Plus Vision**

A(n) Utah Limited Health Plan
Home Office: 1901 West Parkway Blvd.
Salt Lake, City, UT 84119
Phone: [800-363-0950]
[\[www.opticareofutah.com\]](http://www.opticareofutah.com)

**GROUP VISION CARE PREFERRED PROVIDER ORGANIZATION (PPO)
INSURANCE CERTIFICATE**

Group Policyholder: [XYZ Employer Company]

Group Policy Number: [123456]

Effective Date of Policy: [January 1, 2015]

Premium Due Date: [First day of each month][First day of each quarter][Annually on the Policy Anniversary Date]

Policy Renewal Date: [January 1, 2016, and every January 1 thereafter]

Policy Anniversary Date: [January 1 of each year]

Policy Delivery State: Utah

Opticare [of Utah] agrees to pay the benefits and provide the other rights set forth in this policy, in consideration of the policyholder's application and payment of premiums.

By accepting delivery of this policy, the policyholder agrees to be bound by the terms of this policy.

This policy will take effect as of the effective date of this policy as set forth above, provided that it has been signed by an officer of Opticare [of Utah], and the policyholder has signed the attached application for this policy.

NOTICE TO BUYER: THIS POLICY PROVIDES VISION COVERAGE ONLY.

PLEASE READ YOUR POLICY CAREFULLY.

Signed for Opticare [of Utah] at its Home Office.

President	Vice President

**This is a Limited Benefit Policy
Guaranteed Renewable
Nonparticipating**

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SCHEDULE OF BENEFITS

**[[Opticare of Utah][Opticare Plus Vision]] Web Site: [[www.opticareofutah.com][www.opticareplus.com]]
For Claim Inquiries, please call [[Opticare of Utah][Opticare Plus Vision]] Claims Department: [1-800-363-0950]**

Insured persons have the right to obtain covered vision care from providers of their choice; however, as shown below, certain benefits are paid at a lower level if the care is obtained from an out-of-network provider.

Benefit Period: [Plan Year – March 1 – April 30] [Calendar Year]

Benefit Plan: [Net 1]

Frequency of Services: [Once every [12][24] months for [Eye Examinations,] Lenses, and Frames]

[Once every [12][24] months for [Eye Examinations and] Lenses, and once every [12][24] months for Frames]

<u>Covered Benefit</u>	<u>Select Preferred Provider Network</u>
<u>Eye Examination Benefit</u>	
Eyeglass Examination	[\$0 -\$125 Co-pay][Not Covered]
Contact Examination	[\$0 -\$125 Co-pay][Not Covered]
Routine Dilation	[[100% Covered][\$0-\$125 Co-pay][Retail][Not Covered]]
Contact Fitting	[[100% Covered][\$0-\$125 Co-pay][Retail][Not Covered][\$0-\$500 Allowance]]
<u>*Eyeglass Benefit</u>	
Materials Co-pay	[\$0-\$125 Co-pay]
Lenses	
Single Vision (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]
Bifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]
Trifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]
Lenses – Options	
Progressive (Standard Plastic)***	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
Premium Progressive Options	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
Ultra Progressive Options	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
Glass Lenses	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
Polycarbonate	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
High Index	[[No][0%-100%][\$0-\$125][Discount][Co-pay]]
Lenticular	[[100% Covered][\$0-\$125 Co-pay]]
Coatings	
Scratch Resistance Coating	[[100% Covered][\$0-\$125 Co-pay]]
Ultra Violet Protection	[[100% Covered][\$0-\$125 Co-pay]]
Other Options (A/R, Edge Polish, Mirrors, or other options Approved by us)	[[Up to][0%-50% Discount]]
Frames****	
Allowance Based on Retail Pricing	[\$0-\$500 Allowance]
Additional Prescription Glasses	[[Up to][0%-100%][Discount][Off Retail]]
<u>*Contact Lenses Benefit</u>	
Contact Lenses in Lieu of Eyeglasses	[\$0-\$500 Allowance][\$0-\$500 Maximum]
Additional Contact Purchases:	
Conventional	[[Up to][5%-50% off Retail][Retail]]
Disposables	[[Up to][5%-50% off Retail][Retail]]
Medically necessary contacts	[[0%-100% Covered][of Usual & Customary][\$0-\$500 Allowance]]
Refractive Surgery Discount****	[\$0-\$1500 Off Per Eye]

This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

*The insured person may choose either eyeglasses or contact lenses during the benefit period; however, no benefits will be payable for both eyeglasses and contact lenses during the same benefit period.

**The [allowance][co-pay] shown for Lenses (Single Vision, Bifocal, and Trifocal lenses) is the total amount that will apply to the total combined purchases for Lenses, Lenses-Options, and Coatings. All Network discounts vary by provider.

***Co-pays for progressive lenses may vary with any chosen Premium Progressive Upgrade.

****Up to 20% discount on balance over plan allowance.

****Refractive Surgery Discount applies only if the surgery is performed by [Standard Optical (the designated provider)]. Refer to Section 6, **Benefits**, for additional information.

Plan does not pay sales tax.

- ❖ For more information regarding Provider Networks, Out of Network claims, and access to print an ID card, please visit www.opticareofutah.com.

SCHEDULE OF BENEFITS

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Benefit Period: [Plan Year – March 1 – April 30] [Calendar Year]

Benefit Plan: [Net 2]

Frequency of Services: [Once every [12][24] months for [Eye Examinations,] Lenses, and Frames]
 [Once every [12][24] months for [Eye Examinations and] Lenses, and once every [12][24] months for Frames]

<u>Covered Benefit</u>	<u>In Network Provider</u>	<u>Out-of Network Provider</u>
<u>Eye Examination Benefit</u>		
Eyeglass Examination	[\$0-\$125 Co-pay][Not Covered]	[\$0-\$500 [Allowance][Co-pay][Not Covered]]
Contact Examination	[\$0-\$125 Co-pay][Not Covered]	[\$0-\$500 [Allowance][Co-pay][Not Covered]]
Routine Dilation	[[100% Covered][\$0-\$125 Co-pay][Retail][Not Covered]]	[[Included in Examination][Not Covered]]
Contact Fitting	[[100% Covered][\$0-\$125 Co-pay][Retail][Not Covered][\$0-\$500 Allowance]]	[[100% Covered][\$0-\$125 Co-pay][Retail][Not Covered] [\$0-\$500 Allowance]]
<u>*Eyeglass Benefit</u>		
Materials Co-pay	[\$0-\$125 Co-pay]	
<u>Lenses</u>		
Single Vision (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]	[\$0-\$500 [Allowance][Co-pay]**
Bifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]	[\$0-\$500 [Allowance][Co-pay]**
Trifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0-\$125 Co-pay]]	[\$0-\$500 [Allowance][Co-pay]**
<u>Lenses – Options</u>		
Progressive (Standard Plastic)***	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
Premium Progressive Options	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
Ultra Progressive Options	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
Glass Lenses	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
Polycarbonate	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
High Index	[[No][0%-100%][\$0-\$100][Discount][Co-pay]]	**
<u>Coatings</u>		
Scratch Resistance Coating	[[100% Covered][\$0-\$125 Co-pay]]	**
Ultra Violet Protection	[[100% Covered][\$0-\$125 Co-pay]]	**
Other Options (A/R, Edge Polish, Mirrors, or other options Approved by us)	[[Up to][0%-50% Discount]]	**
<u>Frames****</u>		
Allowance Based on Retail Pricing	[\$0-\$500 Allowance]	[\$0-\$500 Allowance]
<u>Additional Prescription Glasses</u>	[[Up to][0%-100%][Discount][Off Retail]]	Not Covered
<u>*Contact Lenses Benefit</u>		
Contact Lenses in Lieu of Eyeglasses	[[0-\$500 Allowance][0-\$500 Maximum]]	[[0-\$500 Allowance][0-\$500 Maximum]]
Additional Contact Purchases:		
Conventional	[[Up to][5%-50% off Retail][Retail]]	Not Covered
Disposables	[[Up to][5%-50% off Retail][Retail]]	Not Covered
Medically necessary contacts	[[0%-100% Covered][of Usual & Customary][0-\$500 Allowance]]	[[Up to][0-\$500 Retail]]
<u>Refractive Surgery Discount****</u>	[\$0-\$1500 Off Per Eye]	Not Covered

This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

*The insured person may choose either eyeglasses or contact lenses during the benefit period; however, no benefits will be payable for both eyeglasses and contact lenses during the same benefit period.

**The [allowance][co-pay] shown for Lenses (Single Vision, Bifocal, and Trifocal lenses) is the total amount that will apply to the total combined purchases for Lenses, Lenses-Options, and Coatings. All Network discounts vary by provider.

***Co-pays for progressive lenses may vary with any chosen Premium Progressive Upgrade.

****Up to 20% discount on balance over plan allowance.

****Refractive Surgery Discount applies only if the surgery is performed by [Standard Optical (the designated provider)]. Refer to Section 6,

Benefits, for additional information.

Plan does not pay sales tax.

❖ For more information regarding Provider Networks, Out of Network claims, and access to print an ID card, please visit www.opticareofutah.com.

SCHEDULE OF BENEFITS

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Insured persons have the right to obtain covered vision care from providers of their choice; however, as shown below, certain benefits are paid at a lower level if the care is obtained from an out-of-network provider.

Benefit Period: [Plan Year – March 1 – April 30] [Calendar Year]

Benefit Plan: [Net 3]

Frequency of Services: [Once every [12][24] months for [Eye Examinations,] Lenses, and Frames]

[Once every [12][24] months for [Eye Examinations and] Lenses, and once every [12][24] months for Frames]

Covered Benefit	Select Preferred Provider Network	Broad Preferred Provider Network	Out-of Network Provider
<u>Eye Examination Benefit</u>			
Eyeglass Examination	[[\$0 - \$125 Co-pay][Not Covered]]	[[\$0 - \$125 Co-pay][Not Covered]]	[[\$0 - \$500 [Allowance][Co-pay][Not Covered]]
Contact Examination	[[\$0 - \$125 Co-pay][Not Covered]]	[[\$0 - \$125 Co-pay][Not Covered]]	[[\$0 - \$500 [Allowance][Co-pay][Not Covered]]
Routine Dilation	[[100% Covered][\$0 - \$125 Co-pay][Retail][Not Covered]]	[[100% Covered][\$0 - \$125 Co-pay][Retail][Not Covered]]	[[Included in Examination][Not Covered]]
Contact Fitting	[[100% Covered][\$0 - \$125 Co-pay][Retail][Not Covered][\$0 - \$500 Allowance]]	[[100% Covered][\$0 - \$125 Co-pay][Retail][Not Covered][\$0 - \$500 Allowance]]	[[Included in Examination][Not Covered]]
<u>*Eyeglass Benefit</u>			
Materials Co-pay	[[\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	**
Lenses			
Single Vision (Standard Plastic)	[[100% Covered][\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	[[\$0 - \$500 [Allowance][Co-pay]]**
Bifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	[[\$0 - \$500 [Allowance][Co-pay]]**
Trifocal (FT 28) (Standard Plastic)	[[100% Covered][\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	[[\$0 - \$500 [Allowance][Co-pay]]**
Lenses – Options			
Progressive (Standard Plastic)***	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
Premium Progressive Options	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
Ultra Progressive Options	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
Glass Lenses	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
Polycarbonate	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
High Index	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	[[No][0%-100%][\$0 - \$100][Discount][Co-pay]]	**
Coatings			
Scratch Resistance Coating	[[100% Covered][\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	**
Ultra Violet Protection	[[100% Covered][\$0 - \$125 Co-pay]]	[[\$0 - \$125 Co-pay]]	**
Other Options (A/R, Edge Polish, Mirrors, or other options Approved by us)	[[Up to][0%-50% Discount]]	[[Up to][0%-50% Discount]]	**
Frames****			
Allowance Based on Retail Pricing	[[\$0 - \$500 Allowance]]	[[\$0 - \$500 Allowance]]	[[\$0 - \$500 Allowance]]
Additional Prescription Glasses	[[Up to][0%-100%][Discount][Off Retail]]	[[Up to][0%-100%][Discount][Off Retail]]	Not Covered
<u>*Contact Lenses Benefit</u>			
Contact Lenses in Lieu of Eyeglasses	[[\$0 - \$500 Allowance][\$0 - \$500 Maximum]]	[[\$0 - \$500 Allowance][\$0 - \$500 Maximum]]	[[\$0 - \$500 Allowance][\$0 - \$500 Maximum]]
Additional Contact Purchases:			
Conventional	[[Up to][5%-50% off Retail][Retail]]	[[Up to][5%-50% off Retail][Retail]]	Not Covered
Disposables	[[Up to][5%-50% off Retail][Retail]]	[[Up to][5%-50% off Retail][Retail]]	Not Covered
Medically necessary contacts	[[0%-100% Covered][of Usual & Customary][\$0 - \$500 Allowance]]	[[0%-100% Covered][of Usual & Customary][\$0 - \$500 Allowance]]	[[Up to][\$0 - \$500 Retail]]
Refractive Surgery Discount****	[[\$0 - \$1500 Off Per Eye]]	Not Covered	Not Covered

This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

*The insured person may choose either eyeglasses or contact lenses during the benefit period; however, no benefits will be payable for both eyeglasses and contact lenses during the same benefit period.

**The [allowance][co-pay] shown for Lenses (Single Vision, Bifocal, and Trifocal lenses) is the total amount that will apply to the total combined purchases for Lenses, Lenses-Options, and Coatings. All Network discounts vary by provider.

***Co-pays for progressive lenses may vary with any chosen Premium Progressive Upgrade.

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Benefit Period: [Plan Year – March 1 – April 30] [Calendar Year]

Benefit Plan: [Net 4]

Frequency of Services: [Once every [12][24] months for [Eye Examinations,] Lenses, and Frames]
 [Once every [12][24] months for [Eye Examinations and] Lenses, and once every [12][24] months for Frames]

Covered Benefit	Select Preferred Provider Network	Broad Preferred Provider Network
Eye Examination Benefit		
Eyeglass Examination	[\$0 -\$125 Co-pay][Not Covered]]	[\$0 -\$125 Co-pay][Not Covered]]
Contact Examination	[\$0 -\$125 Co-pay][Not Covered]]	[\$0 -\$125 Co-pay][Not Covered]]
Routine Dilation	[[100% Covered]][\$0-\$125 Co-pay][Retail][Not Covered]]	[[100% Covered]][\$0-\$125 Co-pay][Retail][Not Covered]]
Contact Fitting	[[100% Covered]][\$0-\$125 Co-pay][Retail][Not Covered]] Covered]][\$0-\$500 Allowance]]	[[100% Covered]][\$0-\$125 Co-pay][Retail][Not Covered]] [\$0-\$500 Allowance]]
*Eyeglass Benefit		
Materials Co-pay	[\$0 -\$125 Co-pay]	[\$0 -\$125 Co-pay]
Lenses		
Single Vision (Standard Plastic)	[[100% Covered]][\$0-\$125 Co-pay]]	[\$0 -\$125 Co-pay]
Bifocal (FT 28) (Standard Plastic)	[[100% Covered]][\$0-\$125 Co-pay]]	[\$0 -\$125 Co-pay]
Trifocal (FT 28) (Standard Plastic)	[[100% Covered]][\$0-\$125 Co-pay]]	[\$0 -\$125 Co-pay]
Lenses – Options		
Progressive (Standard Plastic)***	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
Premium Progressive Options	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
Ultra Progressive Options	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
Glass Lenses	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
Polycarbonate	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
High Index	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]	[[No][0%-100%]][\$0-\$100][Discount][Co-pay]]
Coatings		
Scratch Resistance Coating	[[100% Covered]][\$0-\$125 Co-pay]]	[\$0 -\$125 Co-pay]
Ultra Violet Protection	[[100% Covered]][\$0-\$125 Co-pay]]	[\$0 -\$125 Co-pay]
Other Options (A/R, Edge Polish, Mirrors, or other options Approved by us)	[Up to][0%-50% Discount]]	[Up to][0%-50% Discount]]
Frames****		
Allowance Based on Retail Pricing	[\$0-\$500 Allowance]	[\$0-\$500 Allowance]
Additional Prescription Glasses	[[Up to][0%-100%]]Discount][Off Retail]]	[[Up to][0%-100%]]Discount][Off Retail]]
*Contact Lenses Benefit		
Contact Lenses in Lieu of Eyeglasses	[[[\$0-\$500 Allowance]][\$0-\$500 Maximum]]	[[[\$0-\$500 Allowance]][\$0-\$500 Maximum]]
Additional Contact Purchases:		
Conventional	[[Up to][5%-50% off Retail][Retail]]	[[Up to][5%-50% off Retail][Retail]]
Disposables	[[Up to][5%-50% off Retail][Retail]]	[[Up to][5%-50% off Retail][Retail]]
Medically necessary contacts	[[0%-100% Covered][of Usual & Customary]][\$0-\$500 Allowance]]	[[0%-100% Covered][of Usual & Customary]][\$0-\$500 Allowance]]
Refractive Surgery Discount****	[\$0-\$1500 Off Per Eye]	Not Covered

This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

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SECTION 1 – DEFINITIONS

The following are key words used in this policy. When they are used, they have the following meaning.

[Allowance means the maximum amount we will cover for a covered benefit as shown in the schedule of benefits. The allowance is based on the provider's retail price list as displayed for materials and services. An allowance cannot and will not be combined with discounts or other promotional offers provided by the provider.]

[Benefit Period means the period of time when benefits are payable. The benefit period is the plan year as shown on the schedule of benefits.]

[Co-pay or Co-payment means a fixed dollar amount the insured person is required to pay for specifically listed covered benefits. The required co-pay or co-payment must be paid before benefits are payable under this policy. The co-pay or co-payment is shown in the schedule of benefits.]

[Coverage Effective Date means the date the insured person's coverage becomes effective under this policy.]

[Covered Benefit means the vision care materials or services that are covered under this policy. Covered benefits are shown in the schedule of benefits.]

[Covered Dependent means an eligible dependent whose coverage has become effective under this policy and has not terminated.]

[Covered Employee means an eligible employee who is enrolled for coverage under this policy and for whom the required premium has been received by us.]

[Covered Expenses means reasonable and customary charges for vision care treatments, services, materials or products that are covered benefits under this policy:

1. which are incurred by an insured person; and
2. for which the insured person is legally obligated to pay and are not otherwise excluded or limited in this policy.

Covered expenses are incurred on the date that the material or service is performed or obtained.]

[Discount means a merchandise discount for materials and services. A discount is not an insured benefit. A discount is the amount we will discount from the reasonable and customary charge for the materials and services. The only discounts for materials and services are specified in the schedule of benefits. Other discount offers provided by providers will not apply to benefits payable under this policy. Select Network discounts vary by provider. See provider for details.]

[Domestic Partner means individuals of the same or opposite gender who:

1. Cohabit and reside together, have done so for the previous six consecutive months, and intend to do so indefinitely;
2. Have an exclusive mutual commitment in which each individual agrees to be jointly responsible for each other's common welfare and share financial obligations;
3. Are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside;
4. Are not currently married to nor legally separated from anyone else;
5. Are not currently a member of another Domestic Partnership;
6. Are not in this Domestic Partnership solely for the purpose of obtaining insurance coverage;
7. Are both at least 18 years of age and competent to consent to contract, and
8. Have filed registration of a Declaration of Domestic Partnership or its equivalent, in the city, county, or state in which they reside, if it offers the ability to register a Domestic Partnership.

Individuals who meet the above criteria have created a Domestic Partnership. An Employee is allowed to consider one Domestic Partner a Dependent specific to eligibility for any benefits for covered services allowed by this Plan. In addition, a Domestic Partner is subject to the eligibility requirements and terms and conditions for termination of coverage. The term "spouse," wherever used, will include a Domestic Partner.]

[Domestic Partner's Dependent means any child:

1. Who lives with the Domestic Partner in a parent/child relationship;
2. Who is the Domestic Partner's unmarried natural blood related child, stepchild, or legally adopted child;
3. Who is of an age less than the limiting age of a Dependent child; and
4. Who is primarily dependent upon the Domestic Partner for support.]

[Eligible Dependent means any of the following:

1. The Insured's legal spouse or Domestic Partner;
2. The Insured's or the Insured's spouse's or Domestic Partner's child, from birth to age 26; and
3. The Insured's or the Insured's spouse's or Domestic Partner's unmarried child at least 26 years of age who is dependent upon you for support and maintenance because he or she is incapable of self-sustaining employment by reason of mental or physical impairment. To continue coverage beyond age 26, we must receive proof of the child's incapacitation 30 days prior to his or her 26th birthday.]

[Eligible Employee means a person who:

1. is an employee of the policyholder;
2. meets the policyholder's eligibility requirements for vision care coverage;
3. enrolls for vision care coverage under the policy;
4. for whom the required premium has been received by us.]

[Frequency of Services means the number of times covered benefits for eye examinations (if included), lenses for eyeglasses, eyeglass frames, or contact lenses will be payable under this policy during each benefit period. The Frequency of Services is shown in the schedule of benefits.]

[Immediate Family means the insured person's parent, grandparent, spouse, child, brother, or sister. This includes persons who are adopted, in-laws, and step-relatives.]

[Insured person means the covered employee and his or her covered dependents, if any, insured under this policy.]

[Materials mean lenses, frames, or contact lenses covered under this policy as shown in the schedule of benefits.]

[Medically Necessary means materials that are deemed medically necessary to restore or maintain a patient's visual acuity.]

[Out-of-Network Provider means any licensed Optometrist, Ophthalmologist or Optician that is not contracted with Opticare [of Utah] to provide benefits under this policy. An out-of-network provider is not a preferred provider.]

[Plan Year means the benefit period beginning and ending on the month and day of each year as shown in the schedule of benefits.]

[Policy means this group vision policy issued to the policyholder.]

[Preferred Provider means a provider who has a participation contract in effect with us, directly or through another entity, to provide vision care materials and services to insured persons. The participation status of providers will change from time to time. The preferred provider's participation contract must be in effect with us at the time covered benefits are provided to the insured person in order for benefits to be eligible for payment under this policy.]

[Provider means:

1. a credentialed Optician with dispensary;
2. a licensed doctor of Optometry;
3. a licensed doctor of Ophthalmology;

acting within the scope of his or her license and rendering care or treatment to the insured person that is appropriate for the conditions and locality. A provider may be a preferred provider or an out-of-network provider. A provider will not include the covered employee, his or her covered dependents, if any, or the immediate family of any insured person.

[Retail means the provider's list retail price as displayed, for products and services, before discounts or allowances.]

[Reasonable and Customary Charge means the average amount charged by most providers for treatment, service, materials or products in a geographic area where the treatment, service or product is provided.]

[Service means an examination, contact lens fitting, material selection, fitting of glasses, related adjustments, or manufacturing of ophthalmic lenses covered under this policy as shown in the schedule of benefits.]

[We, Our, Us, or the Company means Opticare [of Utah.]

[You, Your, Yours means the group policyholder.]

SECTION 2 – ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

[Employee Enrollments

Enrollments of eligible employees under this policy will be for a 12-month period. Premiums for each eligible employee's enrollment will be required for the entire 12-month period, and each 12-month period thereafter while this policy is in force, unless the eligible employee's coverage under this policy terminates due to his or her:

1. termination of employment with the policyholder;
2. death; or
3. divorce.]

[However, if the policyholder has an annual open enrollment period that has been approved by us, a covered employee may terminate his or her coverage under this policy during the policyholder's annual open enrollment period. During the annual open enrollment period, any eligible employee of the policyholder may also enroll for coverage under this policy. The policyholder will inform eligible employees of the annual open enrollment period, if provided.]

[Eligibility and Effective Date of Coverage

Coverage under this policy will be provided for all full-time active employees who are employed with the policyholder on the effective date of this policy. Such employees and their eligible dependents, if any, must be enrolled for coverage under this policy.]

[Coverage for new full-time active employees will become effective on the first of the month following date of hire. If an employee elects not to enroll for coverage under this policy when he or she is first eligible to do so, he or she may enroll during the policyholder's annual open enrollment period approved by us. Unless otherwise specified, the annual open enrollment period will take effect on this policy's anniversary date of each year.]

[If both spouses are eligible persons of the policyholder, each may enroll as eligible persons or one may be covered as an eligible dependent of the other, but not both. If both parents of an eligible dependent child are enrolled as an eligible person, only one parent may enroll the child as a covered dependent.]

[No coverage will be provided under this policy unless:

1. this policy is in effect; and
2. the eligible employee and his or her eligible dependents, if any, are enrolled for coverage under this policy and any required premiums have been paid.]

[Coverage for Eligible Dependents

An eligible employee will be eligible for dependent coverage on the date he or she:

1. becomes eligible for coverage under this policy, if he or she has eligible dependents; or
 2. first acquires an eligible dependent;
- subject to enrollment and premium payment requirements described in this policy.

Coverage for a Newly Acquired Dependent

New Dependent Child

Coverage for a new eligible dependent acquired by the covered employee by reason of birth, legal adoption, legal guardianship, placement for adoption, placement for foster care, or court or administrative order will take effect on the date of the event. However, we must receive notification of the event and the required premium payment, if any, within 30 days of the event for coverage to be continued under this policy. If such notification and any required premium are not received by us within the 30-day period following the event, coverage for the newly acquired child will terminate under the policy.

New Dependent Spouse or Domestic Partner

In the event an eligible employee marries or enters a Domestic Partnership, his or her new spouse or Domestic Partner may be enrolled for coverage under this policy if notification and any required premium for the spouse's or Domestic Partner's enrollment are received by us within 30 days of the event. In the case of Domestic Partner: submits to the Employer proof that they meet the definition of Domestic Partner and have created a Domestic Partnership; or notifies the Employer of their registration of a Declaration of Domestic Partnership or its equivalent, in the city, county, or state in which they reside if it offers the ability to register a Domestic Partnership. The new dependent spouse's or Domestic Partner's coverage will take effect on the first of the month coincident with or next following receipt of the notification and any required premium payment.]

[Disabled Children

A covered dependent child who is dependent upon eligible employee for support and maintenance because he or she is incapable of self-sustaining employment by reason of mental or physical impairment may continue coverage under this policy upon the attainment of age 26 if we receive proof of the child's incapacitation 30 days prior to his or her 26th birthday. Thereafter, we may require such proof not more frequently than annually after the 2-year period following the child's attainment of age 26 (the limiting age). In the absence of such proof, we may terminate the coverage of such covered dependent after the attainment of the limiting age.]

SECTION 3 – TERMINATION AND SUSPENSION OF COVERAGE

Policy Termination

This policy will terminate on the earliest of:

1. the next policy anniversary date following [30][60] days of our receipt of the policyholder's written request to terminate this policy; or
2. the date this policy terminates in accordance with the **Grace Period** provision in Section 4.

Termination of Covered Employees

Coverage for a covered employee will terminate on the earliest of:

1. the date this policy terminates;
2. the first of the month coincident with or next following the date the covered employee is no longer an eligible employee of the policyholder;
3. the first of the month coincident with or next following the date of death of the covered employee;
4. the first of the month coincident with or next following the date the covered employee elects to disenroll for coverage during the policyholder's annual open enrollment period, if any.

Termination of Covered Dependents

Coverage for a covered dependent, if any, will terminate under this policy on the earliest of:

1. the date this policy terminates;
2. the first of the month coincident with or next following the date the covered employee's coverage terminates under this policy for any reason;
3. the first of the month coincident with or next following the date a covered dependent, if any, ceases to be an eligible dependent;
4. the first of the month following [30][60] days of our receipt of the written request to terminate the coverage of a covered dependent.
5. the last of the month coincident with or next following the date a covered dependent child attains the limiting age of 26, subject to the **Disabled Children** provision in Section 3.

Suspension of Coverage

We may suspend coverage under this policy for:

1. all insured persons under this policy if the policyholder fails to pay premiums when due. The policyholder is obligated to pay premiums due for the entire policy year in accordance with the terms and conditions of this policy; therefore, premiums will still be required during the period of suspension.
2. all insured persons under this policy, if the policyholder performs an act or practice that constitutes:
 - a. fraud; or
 - b. intentional misrepresentation of material fact; in applying for or procuring coverage under this policy, subject to the **Incontestability** provision appearing in Section [11.]
3. an insured person who performs an act or practice that constitutes:
 - a. fraud; or
 - b. intentional misrepresentation of material fact; in applying for or procuring coverage under this policy, subject to the **Incontestability** provision appearing in Section [11.]

If any of the above events occur, we will have the right to terminate:

1. this policy based on the actions of the policyholder; and/or
2. the coverage of the insured person based on the actions of the insured person.

SECTION 4 – PREMIUMS

Premiums

Premiums are payable to us at our home office in Salt Lake City, Utah, in accordance with the rates in force on the premium due date. Premiums are required and payable for the entire 12-month period this policy is in force. The first premium is due on the effective date of this policy. Each premium after the first will be due on the premium due date shown in the schedule of benefits.

Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the **Grace Period**. We are not obligated to accept or apply any premium paid which is less than the entire amount due for any premium due date. Premium payments shall be credited to any past due and unpaid premium, in the order in which they are due. Any past due premiums will be assessed interest at 18 percent per annum; the interest amount will be shown in the policyholder's billing invoice for premiums due under this policy.

Grace Period

A grace period of [30][60] days will be granted for the payment of each premium becoming due, except the first premium. During the grace period, this policy will continue in force, unless policyholder gives us written notice to terminate this policy [30] days in advance of the next policy anniversary date, in accordance with the terms of this policy. We will then terminate this policy on the next policy anniversary date following 30 days of our receipt of your termination request. If an amount sufficient to remove this policy from the grace period is not paid, this policy will terminate without further notice at the end of the grace period. You may be liable to us for payment of a pro rata premium for the time coverage was in force during the grace period.

Premium Changes

We reserve the right to change the rates shown on the schedule of benefits on a class basis for all policies on the same form as this policy that are delivered in this state. We will give you at least [45][60] days prior written notice before the effective date of any rate change.

SECTION 5 – PREFERRED PROVIDER ORGANIZATION (PPO) OPTION

Freedom of Choice of Provider

We will provide the covered employee with a current list of the preferred providers under contract with us to provide services for covered benefits under this policy. The list will be updated at least annually and contain toll-free telephone numbers to enable the covered employee, and any covered dependents, to confirm current preferred provider status, as the preferred provider's contract must be in effect at the time services are rendered.

An insured person is not required to go to a preferred provider. At the time of service, the insured person may obtain care or treatment from a preferred provider or an out-of-network provider. However, to maximize the benefit reimbursement level under this policy, a preferred provider must be used.

The insured person does not have to obtain prior approval to use the services of a preferred provider. Please refer to the schedule of benefits for more details regarding the vision PPO benefits provided under this policy.

Benefits of Using a PPO Provider

If the insured person uses the services of a preferred provider, benefits will generally be reimbursed at a higher level ("PPO" level benefits) as shown in the schedule of benefits. The preferred provider's contract with the PPO must be in effect at the time he or she provides services to the insured person in order for PPO level benefits to apply.

Using an Out-of Network Provider

If the insured person uses the services of an out-of-network provider, benefits will generally be reimbursed at a lower level ("out-of-network provider" level benefits) as shown in the schedule of benefits.

SECTION 6 – BENEFITS

Benefits will be provided for the covered benefits shown in the schedule of benefits for the stated frequency of services. The frequency of service for each covered benefit is once every 12 months, unless otherwise stated in the schedule of benefits. Benefits shown as “Not Covered” in the schedule of benefits are not covered benefits under this policy and will not be payable.

The insured person may choose either eyeglasses or contact lenses during any benefit period; however, no benefits will be provided for both eyeglasses and contact lenses during the benefit period. Benefits payable under this policy are subject to the terms, conditions, exclusions, limitations of this policy and any attached amendments or endorsements.

Eye Examination Benefit

Benefits will be provided for one eye examination (unless otherwise specified in the schedule of benefits) for each insured person during the benefit period if eye examinations are shown in the schedule of benefits as being a covered benefit. The eye examination may be for one of the following: (1) eyeglasses; (2) contact lenses; or (3) for both eyeglasses and contact lenses during one examination. No benefits will be payable for another eye examination performed during the benefit period. No benefits will be payable for separate eye examinations for eyeglasses and contact lenses during the benefit period.

Eyeglass Benefit: Lenses, Coatings, and Frames

Benefits will be provided for eyeglass lenses, eyeglass coatings, and eyeglass frames as shown in the schedule of benefits. If the insured person chooses and receives benefits for eyeglasses during the benefit period, no benefits will be paid for contact lenses during the same benefit period.

Contact Lenses Benefit

In lieu of eyeglasses, insured persons may receive materials and services for contact lenses as shown in the schedule of benefits. If the insured person chooses and receives benefits for contact lenses during the benefit period, no benefits will be paid for eyeglasses during the same benefit period.

Payment of Benefits

We will pay expenses incurred for covered benefits as shown in the schedule of benefits subject to:

1. the co-pay or co-payment, if any, shown in the schedule of benefits;
2. the exclusions and limitations in Section 7; and
3. all other provisions of this policy.

Covered expenses will be deemed to be incurred on the date that a covered benefit is provided or obtained. Covered expenses for covered benefits must be incurred while this coverage is in force for the insured person.

Refractive Surgery Discount Benefit

This policy provides a discount for Refractive Surgery as shown in the schedule of benefits. The discount applies to the surgeon's reasonable and customary charge for the surgery. Refractive Surgery is not a covered benefit under this policy. This discount will only be given if:

1. the Refractive Surgery is performed by the designated provider; and
2. the pre-operative and post-operative care is performed by the designated provider.

The “designated provider” is a provider designated by us and is shown in the schedule of benefits.

The charge for the Refractive Surgery procedures will be based on the designated provider's current retail fees for such procedures. We will provide the covered employee with the locations of the designated provider(s).

This policy does not provide covered benefits for Refractive Surgery or any other medical or surgical procedures.

SECTION 7 – GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made for any expenses incurred for vision care services, treatments, supplies, materials or any other items:

1. for which no charge is normally made in the absence of insurance;
2. medical or surgical treatment of the eye whether on an emergency or non-emergency basis;
3. for which the insured person, without cost, obtains from any governmental organization or program;
4. which are not specifically covered under this policy as a covered benefit;
5. orthoptics or visual therapy (VT) or any associated supplemental testing;
6. two pairs of glasses in lieu of bifocal or trifocal;
7. replacement of lenses or frames that were furnished under this policy that are lost or broken;
8. corrective vision treatment of an experimental nature;
9. cost for services and/or materials above plan allowances;
10. services and/or materials not indicated as a covered benefit in the schedule of benefits.
11. Any services or supplies when paid under any Worker's Compensation or similar law.
12. Services or materials provided by any other group benefit providing for vision care (no coordination of benefits).
13. Plan does not pay sales tax.

This policy does not provide coverage for laser vision correction, or any surgical procedures or medical treatments for vision care.

SECTION 8 – CONTINUATION OF COVERAGE UPON TERMINATION

A covered employee has the right to extend his or her coverage under this policy for a period of six months upon termination coverage as provided in this provision. Such right to extend coverage includes the following reasons which caused in termination of the covered employee's coverage under this policy: (1) voluntary termination; (2) involuntary termination; (3) retirement; (4) death; (5) divorce or legal separation; (6) loss of dependent status; (7) sabbatical; (8) any disability; (9) leave of absence; or (10) reduction of hours.

No coverage will be extended under this policy for the covered employee if coverage terminated under this policy because the covered employee: (1) failed to pay any required individual contribution; (2) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists; (3) performed an act or practice that constitutes fraud in connection with this policy; (4) made an intentional misrepresentation of material fact under the terms of this policy; (5) was terminated for gross misconduct; (6) has not been continuously covered under this policy for a period of six months immediately prior to the termination of his or her coverage under this policy due to the events set forth in provision; or (7) is eligible for any extension of coverage required by federal law.

Continuation of Coverage for Covered Dependents

A covered dependent, including a surviving covered dependent spouse or child, has the right to extend coverage under this policy when his or her coverage terminates under this policy due to death of the Covered Employee.

Notification of Continuation of Coverage

The policyholder will provide written notification of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments are to be made to: (1) the terminated covered employee; (2) the ex-spouse of the covered employee, if the ex-spouse was a covered dependent under this policy; (3) a surviving spouse of the covered employee if the spouse was a covered dependent under this policy, prior to the death of the covered employee; or (4) the guardian of surviving dependent children, if different from a surviving spouse, if such dependent children were covered dependents under this policy prior to death of the covered employee.

The notification will be sent first class mail within 30 days after the termination date of coverage under this policy to: (1) the terminated covered employee's home address as shown on the records of the policyholder; (2) the address of the surviving spouse, if different from the covered employee's address and if shown on the records of the policyholder; (3) the guardian of any covered dependent's address, if different from the covered employee's address, and if shown on the records of the policyholder; and (4) the address of the ex-spouse, if shown on the records of the policyholder.

We will provide the covered employee or covered dependent the opportunity to continue his or her coverage under this policy for the required premium if:

1. the policyholder does not provide the terminated covered employee the required written notification; and
2. the covered employee or covered dependent eligible for this continuation coverage contacts us within 60 days of his or her termination under this policy.

The premium amount for the continuation coverage will not exceed 102% of the group rate in effect for a covered employee, including the policyholder's contribution, if any, for coverage provided under this policy.

Continuation coverage will be extended without interruption for six (6) months and may not terminate if the terminated covered employee or covered dependent, or, with respect to a covered dependent child who is a minor, the parent or guardian of the terminated insured person:

1. elects to extend coverage under this policy within 60 days of losing group coverage under this policy; and
2. pays the amount required to the policyholder or us.

The insured person's continuation coverage provided under this policy may be terminated prior to six months if the terminated insured person:

1. moves out of our service area;
2. fails to pay premiums or contributions in accordance with the terms of this policy, including any timeliness requirements;
3. performs an act or practice that constitutes fraud in connection with the continuation coverage;
4. makes an intentional misrepresentation of material fact under the terms of the continuation coverage;
5. becomes eligible for similar coverage under another group policy; or
6. this policy is terminated, except when the policyholder replaces this policy with another similar policy as provided under *Continuation Coverage Upon Termination and Replacement of This Policy*.

Continuation Coverage upon Termination and Replacement of This Policy

If this policy is terminated and the policyholder replaces the coverage provided under this policy with similar coverage under another group policy, without interruption, the terminated covered employee, covered spouse, or the covered surviving spouse, and guardian of covered dependents will have the right to obtain continuation coverage under the replacement group policy:

1. for the balance of the period the terminated insured person would have extended coverage under the replaced group policy; and
2. if the terminated insured person is otherwise eligible for continuation of coverage.

[Conversion upon Termination of Continuation Coverage

Within 30 days of the covered employee's exhaustion of continuation of coverage, the policyholder will provide written notification of the right to an individual conversion policy to:

1. the terminated covered employee;
2. the terminated ex-spouse of the covered employee; or
3. in the case of the death of the terminated covered employee, the covered dependents of the covered employee, including the surviving spouse, or the guardian of any dependent children.

The notification:

1. will be sent first class mail to:
 - a the terminated covered employee's last-known address as shown on the records of the policyholder;
 - b the address of the surviving spouse, if different from the terminated covered person's address, and if shown on the records of the policyholder;
 - c the guardian of any dependent children last known address as shown on the records of the policyholder, if different from the address of the surviving spouse; and
 - d the address of the ex-spouse as shown on the records of the policyholder, if applicable; and
2. will contain our name, address, and telephone number.]

[SECTION 9 – CONVERSION PRIVILEGE

If coverage for the covered employee and/or his or her covered dependent, if any, terminates under this policy for any reason other than:

1. non-payment of premiums; or
 2. termination of the covered employee's employment with the policyholder due to gross misconduct;
- the covered employee and/or his or her covered dependent, if any, may elect to convert the terminated coverage, without evidence of insurability, to an individual conversion vision policy if the covered employee and/or his or her covered dependent, if any, has been covered under this policy for at least six (6) months.

Conversion Policy

The conversion vision policy will:

1. be an individual vision policy;
2. provide similar vision benefits as the group policy;
3. become effective on the date coverage terminates under the group policy;
4. cover the covered employee and his or her eligible dependents, if any, who were covered under this group policy; or
5. cover a covered dependent whose coverage terminated under this group policy because of his or her attainment the limiting age.

Application and Premium Payment

We must receive an application for conversion and the first premium for the new policy at our home office within 60 days after coverage terminates under this group policy for the covered employee or his or her covered dependent, if any.

Premium for Conversion Policy

The initial premium for the conversion policy for the first 12 months and for subsequent renewal premiums will be determined in accordance with premium rates applicable to the following criteria for the covered employee, and his or her covered dependent, if any: (1) age; (2) class of risk; and (3) the type and amount of insurance provided.]

SECTION [10] – CLAIMS PROVISIONS

Notice of Claim

Written notice of claim must be given to us within 30 days of the date of loss. Written notice of claim given by or on behalf of the insured person to us with information sufficient to identify such person will be considered notice to us. Failure to give notice within the 30 days will not invalidate any claim if it is shown that it was not reasonably possible to give written notice of claim within that time and that written notice of claim was furnished as soon as reasonably possible.

Claim Forms

When we receive the notice of claim, we will send the insured person forms for filing proof of loss. If these forms are not furnished by us within 15 days, the insured person will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the **Proof of Loss** provision. An insured person may also obtain claim forms: (a) on our Web-Site as shown on the schedule of benefits; or (b) by calling our claims department number shown on the schedule of benefits.

Proof of Loss

Written proof of loss must be furnished to us at our home office in Salt Lake City, Utah, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will not invalidate any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as reasonably possible.

Payment of Claims

Payment for expenses incurred for covered benefits provided by a preferred provider will be automatically assigned to the preferred provider. The preferred provider is responsible for filing the claim, and we will make payments directly to the preferred provider for benefits in excess of the insured person's co-payment.

However, when expenses are incurred by insured persons for covered benefits provided by an out-of-network provider, we will pay benefits directly to you, as provided under **Out-of-Network Reimbursement Procedure** in this Section. We will only pay for expenses incurred for covered benefits under this policy. Co-pays or co-payments will not be reimbursed.

Out-Of-Network Reimbursement Procedures

If the insured person incurs expenses for covered benefits from an out-of-network provider, the insured person must pay in full the amount of the incurred expenses at the time of service. We will reimburse the insured person for eligible incurred expenses when he or she submits the claim to us. Please follow the claim procedure below for out-of-network claim reimbursement:

1. the insured person must complete the out-of-network claim form which can be obtained as provided in the **Claim Forms** provision in this Section.
2. The completed claim form must be completed and provided to us at our home office in Salt Lake City, Utah, with the original receipt(s) that includes an itemized breakdown of the materials and services received and/or purchased. The claim should be submitted to us within 30 days as required in the **Notice of Claim** provision.
3. We will reimburse the insured person directly for eligible billed charges for covered benefits less any applicable co-payments, up to the stated allowance shown in the schedule of benefits. We will reimburse the insured person 30 days after we receive the complete claim information. Discounts for merchandise or services provided by or obtained from the out-of-network provider will not be reimbursed.
4. All online purchases must be from a provider which has been pre-approved by us.

Grievance Procedure

If an insured person disputes a claim, he or she may appeal it by filing a grievance with us, and we will reconsider the claim.

Company Internal Review Procedure

If the insured person may submit his or her complaint about a claim to us to resolve as follows:

1. A written complaint may be made to us at our home office. The complaint may be presented on our grievance statement form which may be requested at our home office or on our Web Site shown in the schedule of benefits. However, no special form is needed. The written complaint should include identifying information of the insured person, e.g., name, address, phone number, group number, and type of services or materials obtained, etc. It should also include the names, addresses and phone numbers of any providers we should contact to learn more about the vision care received by the insured person.
2. An Opticare [of Utah] officer will review the written grievance presented to us within 15 days of its receipt. Our officer will:
 - a. contact the complainant and attempt to resolve the complaint through: (1) informal discussions; (2) consultations; or (3) conference; and
 - b. notify the complainant in writing of the resolution of the complaint within 30 days following its receipt.
3. We will send the complainant along with the notice of resolution, a notice that the complainant may appeal our resolution of the complaint by filing a complaint with the State Insurance Commissioner in which the policy is issued.

Complaints Resolved by Independent Review Procedure

At your option, we will provide you with an independent review procedure for the resolution of adverse benefit determinations of medical necessity.

An independent review procedure will be conducted by an independent review organization, person, or entity other than: (1) us; (2) policyholder; (3) the plan or the plan's fiduciary; (4) the employer; or (5) any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with the health plan; (6) any officer, director, or management employee of the health plan; (7) the enrollee; (8) the enrollee's health care provider; (9) the provider's medical group or independent practice association; (9) the health care facility where service would be provided; and (10) the developer or manufacturer of the service being provided.

Independent review organizations will be designated by us, and the independent review organization chosen will not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with: (1) a health insurance plan; (2) a national, state, or local trade association of health insurance plans; and (3) a national, state, or local trade association of health care providers.

The submission to an independent review procedure is purely voluntary and left to the discretion of the claimant.

Our voluntary independent review procedure will:

1. Waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;
2. Agree that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending;
3. Allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals permitted under 29 CFR Subsection 2560.503-1(c)(2), of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for the Administration and Enforcement: Claims Procedure;
4. Upon request from any claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal. This information will contain a statement that the decision to use a voluntary level of appeal will not affect: (1) the claimant's rights to any other benefits under this policy and information about the applicable rules; (2) the claimant's right to representation; and (3) the process for selecting the decision maker.

An independent review conducted in compliance with applicable state law (Insurance Code Section 31A-22-629), and this provision, can be binding on both parties. A claimant's submission to a binding independent review is purely voluntary and appropriate disclosure and notification must be given as required by the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-

Standards for voluntary independent review:

1. Our internal adverse benefit determination process must be exhausted unless we and insured person mutually agree to waive the internal process.
2. Any adverse benefit determination of medical necessity may be the subject of an independent review.
3. The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.
4. We will use the same minimum standards and times of notification requirement for an independent review that are used for internal levels of review, as set forth in 29 CFR Subsection 2560.503-1(h)(3), (i)(2) and (j) of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement

Expedited Review Process

We will provide an expedited review process for cases involving urgent care claims.

A request for an expedited review of an adverse benefit determination of medical necessity may be submitted to us either orally or in writing. If the request is made orally to us, we will, within 24 hours, send written confirmation to the claimant acknowledging the receipt of the request for an expedited review.

An expedited review requires:

1. All necessary information, including the plan's original benefit determination be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method;
2. We will notify the claimant of the benefit review determination, as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and
3. We use the same minimum standard for timing and notification as set forth in 29 CFR Subsection 2560.503-1(h), 503-1(i)(2)(i), and 503-1(j) of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement.

SECTION [11] – GENERAL PROVISIONS

Jurisdiction

This policy has been issued and delivered in the policy delivery state shown on the first page of this policy. The laws of such jurisdiction shall govern its execution, performance and enforcement. Any provision of this policy that is in conflict with such laws shall be deemed amended to meet the minimum requirements of such laws.

Entire Contract

This policy, the application of the group policyholder, certificates, and any amendments, endorsements or riders constitute the entire contract. The application of the group policyholder is evidenced by the copy that was attached to this policy at issue or delivery.

Only our president, a vice president, or corporate secretary has the power on our behalf to execute or amend this policy. No other person will have the authority to bind us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of this policy. Any amendment to this policy will not be valid unless endorsed and attached to this policy. Such amendment will not require the consent of any insured person.

Certificates

We will furnish the policyholder with individual certificates to be issued to each [covered employee.]

Records

The policyholder must furnish all information required by us to compute premiums and maintain necessary administrative records.

Records of the policyholder, which have a bearing on this policy, will be available for inspection by us at any reasonable time at our home office in Salt Lake City, Utah.

Waiver of Rights

No failure by us to enforce any provision of this policy shall affect our right thereafter either to enforce such provision, or to enforce any other provision of this policy.

Information to be provided by the Policyholder

Each premium payment shall be accompanied by a statement from the policyholder showing the number of persons enrolled for coverage during the time period. We shall be permitted access during reasonable business hours to the records of the policyholder for the purpose of verifying such information.

Renewability

This policy is guaranteed renewable. This means that we may not, on our own, cancel or reduce coverage provided by this policy. However, we may change rates. Subject to the **Termination** provision in Section 3 and the **Grace Period** provision in Section 4, this policy will remain in force if the required premiums for this policy are paid.

[Clerical Errors

An adjustment of premium shall be made upon discovery of a clerical error in the records pertaining to the insurance provided under this policy. No such error shall void or continue insurance that is otherwise validly in force or terminated.]

Representations

In the absence of fraud, any statement made by the policyholder or you will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application or enrollment application.

Incontestability

The validity of this policy cannot be contested, except for non-payment of premium, after it has been in force for two (2) years from the effective date of this policy.

No statement made by the policyholder will be used to contest this policy unless:

1. it is contained in a written statement signed by the policyholder; and
2. a copy of the statement is furnished to the policyholder.

Age Misstatement

If the age of any Insured person has been misstated, our records will be changed to show the correct age. The benefits provided will not be affected if the insured person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due us because of past underpayments, will be made so that we receive the premiums due at the correct age payable on the premium due date following our receipt of the age correction notification.

Right to Recover

If we pay benefits under this policy, and the total of such benefits is greater than the amount payable under this policy, we will have the right to recover such excess from:

1. any person to whom, or for whom, such payments were made;
2. any organization which should have made such payments; and
3. future benefit payments, if any.

We will have a right to:

1. reimbursement for benefits paid under this policy, if it is found that such payments were paid in error; and
2. recover any benefits paid under this policy as a result of fraudulent claims submitted for covered benefits not rendered or purchased.

Nonparticipating

This policy does not share in any distribution of surplus. No dividends are payable.

Legal Actions

No action at law or in equity will be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity with State Statutes

If any provision of this policy is in conflict with the statutes of the state in which it is issued, the provisions of this policy will be automatically amended to conform to the minimum requirements of such statutes.

**GROUP VISION CARE PREFERRED PROVIDER ORGANIZATION (PPO)
INSURANCE POLICY**

**This is a Limited Benefit Policy
Guaranteed Renewable
Nonparticipating**