GROUP INSURANCE CERTIFICATE

THE EYECARE ADVANTAGE PLAN

UNDERWRITTEN BY

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

HM Life Insurance Company certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy.

President

Group Policy Number	503716
Name of Policyholder	Board of Supervisors of Louisiana State University and Agricultural and Mechanical College
Type of Coverage	Vision Care Expense Insurance
Group Policy Effective Date	July 1, 2010
Group Policy Delivered in	Louisiana and governed by the laws of that State and to the extent applicable by the Public Health Service Act (PHSA)

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate of Insurance has a Table of Contents to help you find specific provisions. "You" and "your" refer to the insured Member. "We", "us", and "our" refer to HM Life Insurance Company. Other defined terms are printed with an initial capital letter.

TABLE OF CONTENTS

Part 1. ELIGIBILITY 1
- A. DEFINITION OF EMPLOYEE, RETIREE and DEPENDENT 1
- B. ELIGIBILITY FOR INSURANCE 1
- C. ENROLLMENT AND PARTICIPATION 2

Part 2. SCHEDULE OF BENEFITS 4

Part 3. EXCLUSIONS AND LIMITATIONS 6

Part 4. OTHER VISION CARE INSURANCE PROVISIONS 7
- A. FREE CHOICE OF PROVIDER 7
- B. INCURRED DATE 7
- C. COORDINATION OF BENEFITS PROVISION 8
- D. CONFORMITY WITH STATE STATUTES 8

Part 5. WHEN A COVERED PERSON'S INSURANCE ENDS 8

Part 6. WHEN A DEPENDENT'S INSURANCE ENDS 8

Part 7. BECOMING INSURED AGAIN AFTER INSURANCE ENDS 9

Part 8. PAYMENT OF CLAIMS 9
- A. IN-NETWORK CLAIMS 9
- B. OUT-OF-NETWORK CLAIMS 10
- C. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE 11
- D. NOTICE OF DECISION OF CLAIM 11
- E. REVIEW PROCEDURE 12
- F. CHILD SUPPORT PAYMENTS 13
- G. ASSIGNMENT 13
- H. LEGAL ACTIONS 14

Part 9. INCONTESTABLE CLAUSES 14
- A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE 14
- B. INCONTESTABLE CLAUSE FOR GROUP POLICY 14

Part 10. CLERICAL ERROR 14

Part 11. ALLOCATION OF AUTHORITY 15

Part 12. GENERAL DEFINITIONS 15

INDEX

ALLOWANCE 20
APPLICATION 20
CALENDAR YEAR 20
COPAYMENT 20
COVERED EXPENSE 20
COVERED PERSON 20
EFFECTIVE DATE 20
ENDORSEMENT 21
ENROLLMENT 20
ENROLLMENT FORM 20
GROUP POLICY 20
IN-NETWORK PROVIDER 20
INSURANCE 21
LIFE EVENT 21
MATERIALS 21
MEMBER 1
OPEN ENROLLMENT PERIOD 20
OPTIONAL IN-NETWORK ITEMS 21
OUT-OF-NETWORK PROVIDER 21
PROVIDER 21
RIDER 21
SCHEDULED FEE 21
USUAL AND CUSTOMARY CHARGE 21
WE, US, OUR OR THE COMPANY 21

Part 1. ELIGIBILITY

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF EMPLOYEE, RETIREE and DEPENDENT

You must be an eligible Employee or Retiree, or an eligible Dependent of an Employee or Retiree.

B. ELIGIBILITY FOR INSURANCE

All full-time Employees and Retirees of a Participating Employer are eligible to enroll for Insurance on themselves and their eligible Dependents under the Group Policy. As used herein “Participating Employer” means the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.

1. An eligible Employee is defined as set forth below.

   A full-time **Employee** of the Louisiana State University System (“full-time Employee”) means a person employed at 75% effort or greater per pay period (average 30 hours per week), with an appointment of more than 120 days or one academic semester. No person appointed on a restricted appointment, or a temporary appointment, will be considered an eligible Employee.

2. An eligible Retiree is defined as set forth below.

   Retiree means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one (1) of the following categories:

   a. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan;

   b. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:

      i. Began employment prior to September 16, 1979, has 10 years of continuous state service, and has reached the age of 65; or

      ii. Began employment on or after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or

      iii. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or

      iv. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.

   c. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.

d. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

3. An eligible Dependent is defined as set forth below.

Dependent – any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee, and (b) whose relationship to the Employee has been documented, as required by HM Life:

a. The covered Employee's legal Spouse;

b. A never-married Child from date of birth up to 21 years of age and dependent upon the Employee for support (must be added to coverage by completing appropriate enrollment documents);

c. A never-married Child who is a full-time student under 24 years of age and financially dependent upon the Employee for support;

d. A never-married Child of any age who meets the criteria set forth in the section entitled "Over-Age Dependents" herein.

e. Overage Dependents. If a never-married Dependent Child is incapable (and became incapable prior to attainment of age 21) of self-sustaining employment by reason of mental retardation or physical incapacity, and is dependent upon the covered Employee or Retiree for support, the coverage for the Dependent Child may be continued for the duration of incapacity.

(1) Prior to the Dependent Child reaching age 21, an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Policyholder to establish eligibility for continued coverage as set forth above. The Policyholder, in its discretion, may consider applications and attending Physician's information submitted after the Child reaches age 21, if the application and information indicate that the Child's incapacity was present prior to the Child reaching age 21, but was not apparent or diagnosed until after the Child reached age 21.

(2) Upon receipt of the application for continued coverage, the Policyholder may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as he may deem necessary thereafter.

Please refer to Policy definition of "CHILD or CHILDREN"
for additional information on eligibility of children.

Note: No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee. If a covered spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage.

C. ENROLLMENT AND PARTICIPATION

LSU conducts an Annual Enrollment generally during the month of April. LSU Employees can elect, cancel, or change coverage level for the following Plan Year, effective July 1st.

D. EFFECTIVE DATE OF COVERAGE

Coverage for each Employee who completes the applicable enrollment form and agrees to make the required payroll contributions or payments, as applicable, to his Participating Employer is effective as follows:

1. For newly eligible Employees, coverage will be effective the 1st of the month following the first full calendar month of employment. For example, an Employee hired on July 1st will have an effective date of August 1st; an Employee hired on July 18th will have an Effective Date of September 1st.

2. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will not be able to enroll again until the following Annual Enrollment.

3. An Employee who transfers employment from one Participating Employer to another must complete a "transfer form" within 30 days following the date of transfer to maintain coverage without interruption. If this form is completed after 30 days following the date of transfer, the Employee will not be able to enroll again until the following Annual Enrollment.

E. QUALIFIED MEDICAL CHILD SUPPORT ORDER ELIGIBILITY PROVISIONS

1. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your Child, that Child will be eligible for coverage as required by the order and will not be considered a Late Entrant for Dependent Insurance. You must notify your employer and elect coverage for that Child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

2. Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for Child support or provides for health benefit coverage for such Child and relates to benefits under the group health plan, and satisfies all of the following:

a the order recognizes or creates a Child's right to receive group health benefits for which a participant or beneficiary is eligible;

b. the order specifies your name and last known address, and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address;

c. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

d. the order states the period to which it applies; and

e. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

3. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the Child, or the Child's custodial parent or legal guardian, shall be made to the Child, the Child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the Child.

Part 2. SCHEDULE OF BENEFITS

Subject to all the terms of the Group Policy, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either an In-Network or an Out-of-Network Provider for Covered Expenses. If an In-Network Provider is used, you will only be billed for the difference between the applicable Copayment, if any, shown below and the Scheduled Fee for the Covered Expense. Use of an Out-of-Network Provider may result in additional charges to you. Out-of-Network Providers may bill you for the difference between the Allowance shown below and the Provider's *actual charge* for the eye examination and materials.

LSU Vision Plan		**LSU First Member**
In-Network Benefits		**In-Network**
Eye Exams[1]		Not Covered under Davis Vision; Covered under LSU First, once every 12 months
Exam Frequency		
Materials (Lens and frames)		No Copayment
Lens Frequency		Once Every 12 Months
Single		Paid in Full
Bifocal		Paid in Full
Trifocal		Paid in Full
Lenticular Lens		Paid in Full
Other Lens Options	Average Retail Price[2]	Additional cosmetic options are available at set prices
All Ranges of Prescriptions and sizes	$80.00	Included
Choice of glass or plastic lenses	$35.00	Included
Oversized Lenses	$20.00	Included
Tinted Lens	$20.00	Included
Scratch coating	$40.00	Included
Standard Progressive Lens	$180.00	Included
Premium Progressive Lens	$225.00	Included
Photochromic Glass Lenses	$45.00	$20 Co-Pay
Polycarbonate for children	$65.00	Included
Polycarbonate for adults(binocular)	$65.00	$30 Co-pay
Polycarbonate for adults (monocular)	$65.00	Included
Polycarbonate for adults (+/- 6.0 diopters or greater)	$65.00	Included
Ultra Violet Coating	$30.00	Included

Plastic Photosensitive Lenses	$120.00	$65 Co-Pay
Standard Anti-reflective Coating	$60.00	$35 Co-pay
Premium Anti-reflective Coating	$75.00	$48 Co-pay
Ultra Anti-reflective Coating	$120.00	$60 Co-pay
Intermediate Vision Lens	$150.00	$30 Co-pay
Blended invisible Lens	$45.00	$20 Co-Pay
Hi-Index (Thinner and lighter) lens	$125.00	$55 Co-pay
Polarized Lens	$110.00	$75 co-pay
Scratch Protection Plan	$75.00	Included
Frames		Choose from the Davis Vision Fashion or Designer Frame Collection (retail value of $125 - $175– No Copayment Choose from the Davis Vision Premier Collection (retail value of $225) - $25 Copayment OR $130 allowance + 20% off any overage toward the retail cost of any other frame[3]
Frame Frequency		Once Every 12 Months
Contact Lenses		No Copayment
Contact Lens Frequency		Once Every 12 Months
Elective Contacts (Formulary) [4]		Up to 4 boxes of disposables
Elective Contacts (Non-Formulary)		Up to $130 plus a 15% discount off overage[3]
Contact Fitting Fee Included in Allowance		Covered in Full for Formulary Contacts 15% discount for Non Formulary Contacts[3]
Medically Necessary Contact Lenses		Paid in Full with Prior Approval
Out-of-Network Benefits		
Eye Exams		Not Included, Covered Person is responsible for entire cost
Materials (Lens and frames)		
Lens Frequency		Once Every 12 Months
Single		Up to $25
Bifocal		Up to $40
Trifocal		Up to $50
Lenticular Lens		Up to $50
Progressive Lens		Up to $50
Elective Contacts		Up to $130
Medically Necessary Contact Lenses		Up to $210
Frame		Up to $50
Discount on Additional or Replacement Contact Lenses?		Yes, all members are enrolled in LENS 1-2-3 Mail Order Program which guarantees the lowest price on Contact Lenses
Lasik or PRK Network		Yes, 25% discount or 5% off any special
Low Vision Coverage [5]		1 comprehensive Low-Vision Exam every 5 years; Low Vision Aid Allowance of $600 with a lifetime maximum of $1200; Follow-up Care of 4 visits in a 5 year period

Warranty on Frames/Lens	Yes, 1 year unconditional breakage warranty on any Davis Vision Collection Frame or any frame purchased from Wal-Mart or Eye Masters
If purchasing both contacts & spectacles is fee a flat amount or discounted amount off retail?	Discount off retail on second materials
ID Cards Included?	Yes, personalized

[1] Covered Expenses for an eye examination include the following procedures:

- Case history - chief complaint, eye and vision history, medical history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction - objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advise a Covered Person on matters pertaining to vision care
- Form completion - school, motor vehicle, etc
- If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.
-

[2] Average retail prices are representative and subject to change.

[3] At Wal-Mart locations, members will receive the full allowance toward Wal-Mart's everyday low prices. Additional discounts not applicable

[4] The contact lens collection is available at most participating independent provider offices. The contact lens collection is subject to change. All contact lenses in the collection are single vision spherical lenses.

[5] The low vision program is available both in and out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be your responsibility.

Part 3. EXCLUSIONS AND LIMITATIONS

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

1. For services or supplies not recommended by a Provider.

2. For periodic vision examinations, except as provided for in Part 2.

3. For eye examinations required by a Employer as a condition of employment.

4. For services or materials provided in connection with special procedures such as orthoptics and visual

training, or in connection with medical or surgical treatment.

5. For lenses which do not provide vision correction.

6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.

7. For sickness or injury covered by a workers' compensation act or other similar legislation.

8. Incurred as a direct or indirect result or war (declared or undeclared).

9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

10. For services or supplies furnished to a Covered Person before the effective date of the Group Policy or after the date a Covered Person's Insurance ends.

11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.

12. For services rendered by practitioners who do not meet the definition of Provider.

13. Except to the extent payment of such expenses is explicitly provided for in this Policy, or such expenses are payable under the “Coordination of Benefits” provisions in Section 8 of this Policy, for expenses covered by:

    a. Any other group insurance other than LSU First; or
    b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association; or
    c. Any union welfare plan.

14. For any expenses covered by any governmental program or a plan required by law.

15. For medically necessary contact lenses prescribed for a Covered Person for which prior approval was not obtained from Davis Vision.

16. Except as provided in the applicable section of this Policy entitled “Low Vision Program,” for comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

Part 4. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or

2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

This Group Policy does not coordinate benefits with other vision, health care or similar coverage making the benefits provided by this Group Policy primary. Thus a claim for benefits under this Group Policy will always be paid without regard to the possibility that another vision, health care or similar plan may cover some expenses.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes, regulations, or directives of the state in which the Policy is delivered or issued for delivery, the provision is automatically amended to meet the minimum requirements of such statutes, regulations, or directives.

Part 5. WHEN A COVERED PERSON'S INSURANCE ENDS

Your Insurance under the Group Policy will end automatically on the earliest of the following dates:

1. The date you cease to be a Covered Person as defined in Part 1.

2. The date you become a full time member of the armed forces of any country.

3. The date the Group Policy terminates.

4. On the last day of the last period for which you make the required contribution for your Insurance, if you contribute toward the cost of your Insurance.

Continued Coverage For Reservists

Insurance on a reservist will not end solely because you are called to active duty in the armed forces of the United States. If you are a reservist who is called to active duty in the armed forces of the United States, you may continue your Insurance while you remain on active duty. You must elect to continue your coverage no later than 31 days after you are called to active duty in the armed forces of the United States, and agree to pay to the Employer the amount of the premium which would otherwise be deducted from your compensation.

You are a reservist if you are a member of the Army National Guard of the United States, Army Reserve, Naval Reserve, Marine Corps Reserve, Air National Guard of the United States, Air Force Reserve, or Coast Guard Reserve.

Part 6. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.

2. The date the person ceases to be eligible as your Dependent, as defined in Part 1.

3. The date your Dependent becomes a full time member of the armed forces of any country.

4. On the last day of the last period for which you made the required contribution for Insurance on your Dependents, if you contribute toward the cost of the Insurance on your Dependents.

Part 7. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You and your Dependents, if any, may become insured again under the Group Policy after Insurance ends. The general rule is that you and your Dependents, if any, may become insured again on the same basis as a new Employee, as provided in Parts 1 and 2. However, for purposes of becoming insured again, the following rules will apply:

1. If Insurance ends because you cease to be an Employee, you and your Dependents, if any, will be immediately eligible for Insurance if you become an Employee again within 90 days after your Insurance ends. If you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible for Insurance again the person or persons applying for Insurance will not be eligible until the next Open Enrollment Period.

2. If your Insurance ends because you become a full time member of the armed forces of the United States, you will not be required to satisfy any eligibility waiting period shown in Part 1 again if you qualify as an Employee and return to work for the Employer within the time period(s) specified in the Uniform Services Employment and Reemployment Rights Act of 1994 as now in effect or hereinafter amended.

3. If Insurance ends because you fail to make the required premium contribution, you and your Dependents, if any, will not be eligible until the next Open Enrollment Period.

4. If you did not apply for Insurance within 31 days after becoming eligible again and experience a Life Event, you and your Dependents, if any, will be immediately eligible for Insurance. However, if you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible again due to a change in family status you may not apply until the next Open Enrollment Period.

Insurance which becomes effective again will not be retroactive to the date the Insurance ended.

Part 8. PAYMENT OF CLAIMS

A. IN-NETWORK CLAIMS

1. Paperless System

   The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the examination takes place. The Provider will submit Covered Person's claim directly to Davis Vision.

2. Payment of Benefits

   All in-network benefits will be paid directly to the Provider.

B. OUT-OF-NETWORK CLAIMS

1. Payment of Benefits

Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor, or otherwise not competent to give a valid release, we may pay the indemnity to an amount not exceeding $1,000 to any of your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

2. Notice of Claim

Written notice of a claim must be given to Davis Vision within 20 days after the incurred date of the Covered Expense or as soon thereafter as reasonable possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Davis Vision directly by the Provider on behalf of the Covered Person.

3. Claim Forms

All claims for benefits should be submitted on our forms. All claims for out-of-network benefits should be submitted on our forms. You or the Provider should obtain claim forms from the Employer or Davis Vision. You may also request claim forms from us. If we fail to provide you with claim forms within 15 days of your request, you:

a. May submit your claim in a letter stating the medical expense for which the claim is made.

b. Will be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

4. Proof of Loss

Proof of each of the following elements of proof of loss must be provided to us at your expense. No benefits for such charges will be paid until we receive satisfactory written proof:

a. That a Covered Person has incurred a Covered Expense.

b. That the charges for which benefits are claimed are not subject to any exclusion.

c. That a Covered Person's Insurance under the Group Policy was in effect on the date the charge was incurred.

d. Of such additional information as we reasonably require in connection with the claim for benefits.

You must provide your written authorization for us to obtain the records and information needed to evaluate your eligibility for benefits. Such proof must be given to us within 90 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

Claims not filed within these time limits will be denied and no benefits will be paid. These time limits will not apply during any period when a Covered Person lacked the legal capacity to file a claim.

5. Time Payment of Claim

Subject to satisfactory written proof of loss, any benefits payable under the Group Policy will be paid within 35 days of our written receipt of such proof of loss (see NOTICE OF DECISION OF CLAIM), if later.

C. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

D. NOTICE OF DECISION OF CLAIM

Following our receipt of your claim you will receive an initial decision on the claim within:

1. 72 hours for urgent care claims;

2. 15 days for pre-service claims;

3. 30 days for post-service claims.

If you do not follow our procedures for filing a claim we will notify you as soon as possible but not later than 5 days (24 hours for urgent care claims) following our receipt of the claim.

We may extend the initial period for pre-service claims and post-service claims by 15 days if circumstances beyond our control require an extension. Any notice of an extension will be in writing and issued prior to the end of the initial 15-day period for pre-service claims, or the initial 30-day period for post service claims.

If such an extension is necessary due to your failure to submit the information necessary to decide the pre-service or post-service claim, you have 45 days from receipt of that notice to provide us with the information specified in that notice (48 hours to provide information for urgent care claims).

In any event, however, we will make a decision on your claim within 15 days for pre-service claims and 30 days for post-service claims from the date notification of an extension is mailed unless the extension is necessary due to the failure of the claimant to submit the necessary information to file the claim.

If the extension is necessary due to your failure of the claimant to submit the necessary information to file the claim we will make a decision on your claim within - 15 days for pre-service claims, and 30 days for post-service claims from the date we receive all information necessary to process the claim; or following the end of the 45 day period from the date you received the request for additional information, if later.

"Post-service claim" means any claim for a benefit under the Plan that is not an Urgent Care Claim or a Pre-service Claim as defined.

"Pre-service claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care or treatment.

"Urgent care claim" means any claim with respect to which the application of the time periods for making non-urgent care determinations (1) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If we deny all or any part of your claim, you will be advised of the following in writing:

1. The reason for the denial.

2. The specific reference to the provisions of the Group Policy or Plan on which the denial was based.

3. Any additional material or information necessary for further review of the claim and explanation of why such information is necessary.

4. A description of the expedited review process applicable to denial of an urgent care claim, if applicable.

5. Notice of your right to appeal the denial.

6. An explanation of our review procedure.

7. If an internal rule or guideline was relied upon in making the determination to deny the claim, you will be provided with a copy of such rule or guideline upon request.

8. If applicable, notice of your right to a civil action ~~under ERISA section 502(a)~~ the Public Health Service Act following a decision on appeal.

E. REVIEW PROCEDURE

To obtain a review, you must submit a request for review to us within 180 days after you receive notice of the denial. No special form is required. A request for review of an urgent care claim may be made over the phone. Any request for review of a pre-service claim or post-service claim must be in writing.

In connection with the review, you have the right to: (a) see the Group Policy and other papers affecting the claim; (b) argue against the denial in writing; (c) have a representative act on your behalf in the appeal.

The person conducting the review will: (a) not be, or be subordinate to, the person who originally reviewed the claim; and (b) have medical expertise relevant to the claim, if the denial was based on medical judgment.

We will review your claim promptly after receiving your request for review. You will receive written notice of our decision for:

1. Urgent care claims as soon as reasonably possible taking into account medical exigencies but not later than 72 hours after we receives your request for review of an adverse benefit determination.

2. Pre-service claims within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after we receives your request for review of an adverse benefit determination.

3. Post-service claims within a reasonable period of time but not later than 60 days after we receive your request for review of an adverse benefit determination.

Any notice of extension will be in writing, explain the special circumstances that may dictate an extension of the time period needed to review your appeal and give the date by which we expect to make our decision. In any event, however, you will receive written notice of our decision no later than 60 days after your request for review is received (120 days if there are special circumstances that require an extension for processing of the claim and notice was given). The written decision you receive will include:

1. The reason(s) for the decision.

2. A reference to any applicable standards or guidelines we used to make the determination.

3. A reference to the provisions of the Group Policy or Plan on which the decision is based.

4. Notice of your right to a copy of and access to any guidelines, rules, and protocols we relied upon in making the adverse determination.

5. Notice of your right to access all documents, records and other information relevant to your claim, without regard to whether we relied on the material in making the adverse determination.

6. Upon request, the names of medical professionals, if any, consulted as part of the claims process.

If applicable, notice of your right to bring a civil action ~~under ERISA section 502(a))~~ the Public Health Service Act following a determination on appeal.

Other voluntary alternative dispute resolution options, such as mediation, may be available.

One way to find out what may be available is to contact your state insurance regulatory agency.

F. CHILD SUPPORT PAYMENTS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either the parent sharing custody, or temporary control, of the child as may be necessary for the child to obtain benefits;

2. Permit either the parent sharing custody, or temporary control, of the child, or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and

3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

G. ASSIGNMENT

No assignment of interest under the Group Policy will be binding upon us unless and until the original or a duplicate is received at our home office, or by our authorized representative. We do not assume any responsibility for the validity of an assignment.

H. LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us. No such action will be brought after the expiration of two years after the time written proof of loss is required to be furnished.

Part 9. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.

2. Your misrepresentation is contained in a written instrument signed by you.

3. You have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for two years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be eligible for coverage, and (2) submit and have approved an Enrollment Form.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Employer to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Employer will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if the truth had been known.

2. The misrepresentation is contained in a written instrument signed by the Policyholder and attached to the application.

3. A copy of the written instrument has been given to the Policyholder.

The validity of the Group Policy will not be contested after it has been in effect for two years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 10. CLERICAL ERROR

Clerical error by the Employer will not:

1. Cause you to become insured.

2. Invalidate Insurance otherwise validly in force.

3. Continue Insurance otherwise validly terminated.

Part 11. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Employer, we have the full and exclusive authority to administer claims and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. Our authority includes, but is not limited to, the following:

1. The right to resolve all matters when a review has been requested.

2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it.

3. The right to determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

If you disagree with any denial by us of all or any part of your claim, you have a right to request a review as described in Review Procedure, to bring an action at law or in equity (see Legal Actions), or to file a complaint with the Louisiana Insurance Department (504-342-5900).

Part 12. GENERAL DEFINITIONS

ALLOWANCE means the flat dollar amount payable under the Group Policy for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

ANNUAL ENROLLMENT PERIOD means the period of time, established by the Employer, during which you have an opportunity to select your benefits and your Dependent's benefits for the coming year.

APPLICATION means the written request of a duly authorized representative for Insurance under the Group Policy on a form acceptable to us.

CALENDAR YEAR means the twelve month period beginning on January 1st and ending on December 31st.

CHILD or CHILDREN includes:

1. A legitimate, duly acknowledged, and/or legally adopted Child of the Employee and/or the Employee’s legal spouse’s who is dependent upon the Employee for support;

2. A Child in the process of being adopted by the Employee through an agency adoption, who is living in the household of the Employee, and is or will be included as a Dependent on the Employee’s federal income tax return for the current or following tax year (if filing is required);

3. A Child in the legal custody of the Employee, who lives in the household of the Employee and is or will be included as a Dependent on the Employee’s federal income tax return for the current or following tax year (if filing is required);

4. A grandchild of the Employee who is not in the legal custody of the Employee, who is dependent upon the Employee for support and whose parent is a covered Dependent. If the Employee seeking to cover a grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

Note: If the Employee Dependent parent becomes ineligible for coverage under the policy, the Employee’s Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

COPAYMENT means the amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in Part 2. Schedule of Benefits.

COVERED EXPENSE means an expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Group Policy.

COVERED PERSON means an Employee or Retiree insured under the Group Policy or a Dependent of an Employee or Retiree insured under the Group Policy. An individual seeking to become a Covered Person and an individual who has become a Covered Person may be referred to as "you" in this Policy.

EFFECTIVE DATE means the date shown on the cover page. This is the date on which the Group Policy becomes effective.

ENROLLMENT, ENROLLMENT FORM means the written request for enrollment in the plan of Insurance by an eligible person on a form acceptable to us.

GROUP POLICY means our group policy number 503716, issued to the Policyholder.

IN-NETWORK PROVIDER means a provider who has entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE means the group vision care insurance provided to you and your Dependents, if any, under the Group Policy.

LIFE EVENT means one of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse; or (6) a change in your employment status.

MATERIALS means frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

OPTIONAL IN-NETWORK ITEMS means materials provided under the Group Policy that can be selected at the Covered Person's option, subject to a Copayment, if any, shown in Part 2. Schedule of Benefits.

OUT-OF-NETWORK PROVIDER means providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

POLICYHOLDER means the legal entity to whom the Group Policy is issued.

PROVIDER means a practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided**.** The Group Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

RIDER/ENDORSEMENT means a formal document, signed by one of our authorized officers and attached to the Group Policy or a Certificate of Insurance issued under the Group Policy, that amends the Group Policy to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE means the amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

USUAL AND CUSTOMARY CHARGE means that portion of a charge, as determined by us, made by a Provider

for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

WE, US, OUR OR THE COMPANY means with respect to group vision insurance benefits, the insurance company identified on the cover page.