BlueCross BlueShield Nebraska

INDIVIDUAL VISION POLICY
OPTIONALLY RENEWABLE
This is a Limited Benefit Policy
Please read this Policy Carefully.

PPO

This Contract is a Preferred Provider limited benefit plan offered by Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), a domestic insurance company, licensed by the State of Nebraska. This Contract is made in and governed by the laws of the State of Nebraska. Defined terms are capitalized throughout this Contract.

This Contract is underwritten and administered by Us. The Contract provides In-network benefits for specific health Services provided to Covered Persons by In-network Physicians, Hospitals and other health care providers. These providers have agreed to furnish Services to Covered Persons in a manner reasonably expected to effectively manage health care costs. This Contract also provides Out-of-network benefits for health care Services performed by Out-of-network Providers.

We agree to make payment for the health Services described, defined and limited herein during the term of this Contract. This Contract is effective beginning 12:01 a.m. on the effective date stated in the Application, in consideration of the payment of premiums, charges or as provided in the Application or attachments thereto.

This entire Contract consists of the Application, the enrollment information, this document and any addenda, attachments or endorsements thereto. Only We can approve a change to this Contract and that change must be in writing. Any change will affect all Covered Persons and no agent may change the Contract in any way. If, after examination of this Contract, You are not satisfied for any reason, it may be returned to Blue Cross and Blue Shield of Nebraska or its agent within ten days of its delivery to You. If returned, any premium paid will be refunded, the Contract will be void from the beginning, and all parties will be in the same position as if no Contract had been issued.

The Group, as the agent representing the group health plan, binds all Subscribers and their covered Eligible Dependents who are beneficiaries of such plan, to the terms and conditions of this Contract.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

Jeff Russell, President and
Chief Executive Officer

THIS POLICY IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Blue Cross and Blue Shield of Nebraska
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BENEFITS

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

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

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost of any service or supply at the time the service or supply is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits for any service or supply covered under the Policy.

Vision Examination Benefit. An Insured Person is eligible for the Vision Examinations shown in the Schedule of Benefits one time in each Benefit Frequency.

Vision Materials Benefit. If a Vision Examination results in an Insured Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials shown in the Schedule of Benefits and prescribed by Providers will be supplied, subject to certain limitations and exclusions of this Policy, as follows:

- Lenses and Lens Options, up to two lenses, provided one time in each Benefit Frequency, if shown in the Schedule of Benefits.
- Frames, one frame, provided one time in each Benefit Frequency, if shown in the Schedule of Benefits.
- Contact Lenses provided one time in each Benefit Frequency in lieu of lenses and/or frames, if shown in the Schedule of Benefits.

LIMITATIONS AND EXCLUSIONS

Limitations.
Fees charged by a Provider for services other than those covered under this Policy must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under this Policy.

Out-of Network Provider expenses do not apply toward In-Network Provider expenses and In-Network Provider expenses do not apply toward Out-of Network Provider expenses.

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

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear, required as a condition of employment and safety eyewear;

4. services provided as a result of any Workers' Compensation law, similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. Plano (non-prescription) lenses;
6. non-prescription sunglasses; or
7. two pair of glasses in lieu of bifocals.

Any sales tax charged by the Provider as part of the transaction for covered services are not covered under this Policy.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

This Policy will end on the earliest of the following dates:

1. the last day for which the required premium is not paid, subject to the Grace Period provision;
2. the date it is determined by a court of competent jurisdiction that an Insured Person has committed fraud against the Company;
3. any premium due date on or after the first Policy Anniversary Date. The Company will give at least a 31-day written notice of the Company's intent to non-renew;
4. on any date on or after the date the Company receives the Insured's written request for cancellation of coverage. Any unearned premium will be refunded on a pro rata basis; or
5. upon termination of the Insured's accompanying medical or dental plan. This Policy is contingent upon the Insured having either a medical or dental plan.

For Dependents. A Dependent's insurance will automatically terminate on the first of the following:

1. the date the Insured's coverage ends;
2. the end of the policy year in which the Dependent ceases to be an eligible Dependent; or
3. the last day for which the required premium is not paid, subject to the Grace Period provision.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination. Vision Materials ordered prior to the termination of this Policy, but not yet received, will be payable under this Policy.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the Policy Effective Date. Subsequent premiums are due on the due date. All premiums are payable to the Company at the Company's office or to the Company's authorized agent.

Premium Changes. The Company has the right to change the table of premium rates for

all members of the Insured's class on any premium due date on or after the first Policy Anniversary Date, but not more than once in any six-month period. The Company will provide written notice at least 31 days before the date of change to the Insured's last known address. The premium rates also may be changed at any time the terms of this Policy are changed, such as changes to the covered benefits or Benefit Frequency.

Grace Period. This Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums that are due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company or Insured gives written notice to the other party of the Company's or Insured's intent not to continue this coverage. The Company must give at least 31 days advance written notice of the Company's intent not to continue this Policy.

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

Reinstatement. If the Insured does not pay a premium due by the end of the grace period, this Policy is terminated. However, reinstatement may be allowed if the Insured completes the application for reinstatement provided to him or her, pays the required premium, and meets the underwriting requirements of this Policy. This Policy will be reinstated upon the date of the Company's approval or on the 45th day after the date of the Company's receipt of the application and required premium if the Company does not mail to the Insured at the address in the Company's files a disapproval of the application. If the Company or one of the Company's agents authorized to receive premiums accepts the premium without requiring an application, this Policy is reinstated.

The Insured will have the same rights as the Insured had under this Policy immediately before the date of the defaulted premium, subject to any Riders added to this Policy at the time of reinstatement.

Any premium accepted in connection with this reinstatement will be applied to a period for which premiums have not been paid, but not to any period more than 60 days prior to the date of reinstatement.

CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after any loss covered by this Policy, or as soon after that as is reasonably possible. Notice given by or for the Insured to the Company at the Company's home office at 3130 Broadway, Kansas City, Missouri 64111, or to any of the Company's authorized agents with sufficient information to identify the Insured, will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured within 15 days after notice of claim is received. If the Company does not send the forms within that time, the Insured will be deemed to have complied with the requirements of the Policy for filing written proof of loss upon submitting the occurrence, character and extent of loss for which the claim is made, within the time fixed in this Policy for filing proof of loss.

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

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

Payment of Claims. All benefits will be payable to the Insured, unless the Company receives a written assignment of benefits. Any benefits payable on or after the Insured's death will be paid to the Insured's estate. If any benefits are payable to the Insured's estate, the Company may pay up to $1,000 to any of the Insured's relatives by blood or marriage whom the Company deems is entitled to the benefits. Any payment the Company makes in good faith under this provision fully discharges the Company to the extent of that payment.

Assignment. Benefits under this Policy may be assigned. However, an assignment is not binding until the Company has received and acknowledged in writing the original or a copy of the assignment before payment of the benefit. The Company does not guarantee the legal validity or effect of such assignment.

Right to Recovery. If payments for claims exceed the benefit amount payable under any benefit provisions of this Policy, the Company has the right to recover the excess of such payments. The Company must notify the Insured or Provider within six months of such overpayments and must recover such overpayments within three years.

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

Complaints/Appeals. Complaints/Appeals will be acknowledged via formal letter within 3 business days of receipt and a formal resolution letter will be provided within 30 calendar days of receipt. All written dispute, appeal, regulatory and complaint cases from members, providers and providers on behalf of members should be directed to:

EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040

Fax: 1-513-492-3259
Email: eyemedqa@eyemed.com

Requests for appeals should include:

1. Plan/Group Name and/or ID Number;

2. Claim ID Number;
3. Claim Service Date;
4. Your name;
5. Your member ID number;
6. Your date of birth;
7. Any comments, documents, records, or other information that you would like considered as part of the review of the claim.

GENERAL PROVISIONS

Conformity to Law. Any provision of this Policy which on the Policy Effective Date is in conflict with the laws of the federal government or the state in which the Insured resides on such date is amended to conform to the minimum requirements of such law.

Entire Contract. This Policy, including any endorsements and Riders, and the Insured's application, a copy of which is attached to this Policy when issued, are the entire contract between the parties. All statements made by an Insured Person will, in the absence of fraud, be deemed representations and not warranties and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Insured Person, a copy of which has been furnished to the Insured, Insured Person or the Insured Person's beneficiary.

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

Time Limit on Certain Defenses. After this Policy has been in force for two years during the Insured Person's lifetime, no misstatement, except a fraudulent misstatement, made by an Insured Person in the application for this Policy will be used to void the Policy or deny a claim. If this Policy is reinstated, the contestable period will begin again upon reinstatement, but only in regard to statements made in the reinstatement application.

Misstatement of Age. If the age of the Insured Person has been misstated, all amounts payable under this Policy will be such as the premium paid would have purchased at the correct age. If the Insured Person is not eligible for coverage because of age, the Company will refund all premiums paid for such Insured Person as of the date the Insured Person was no longer eligible.

Workers' Compensation. This Policy is not a Workers' Compensation Policy. It does not satisfy any requirement for coverage by Workers' Compensation Insurance.

DEFINITIONS

When used the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits. The Benefit Frequency begins on the Policy Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

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

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items," including dilation if the Provider determines it is necessary. Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons:

1. the Insured's lawful spouse or Domestic Partner;
2. the Insured's or the Insured's spouse's or Domestic Partner's child under age 26; or
3. the Insured's or the Insured's spouse's or Domestic Partner's unmarried child at least 26 years of age who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap. Proof of incapacity must be furnished to the Company, but not more than once in any 12-month period.

Child includes stepchild, foster child, grandchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. The Insured is responsible for notifying the Company within 31 days of the birth, adoption or placement for adoption of any child.

An extension of coverage request must be received within 31 days of the end of the month in which the child reaches age 26 and after that, as required (but not more often than yearly after two years of such disability). Determination of eligibility under this provision will be made by Us, subject to meeting the requirements of a.,b. and c. above, and meeting the disability standards and criteria stated in this paragraph 3. Any extended coverage under this paragraph will be subject to all other provisions of this Contract.

Physical or intellectual disability means a severe disability of a person which: a) is attributed to a physical or mental impairment or combination of physical or mental impairments; b) is manifested before the person attains age 26; c) is likely to continue indefinitely; and d) results in incapability of performing self-sustaining employment.

Severe disability means substantial functional limitations in three (3) or more of the following areas of major life activities: a) self-care; b) receptive and expressive language; c) learning; d) mobility; e) self-direction; or f) capacity for independent living; and reflects the person's need for treatment or other services which are of an indefinite duration and are individually planned and coordinated.

A Physician's statement may be required.

A determination of eligibility to continue a dependent child's coverage under this provision will be made within 45 days. A Subscriber has a right to appeal an adverse benefit determination (denial) regarding an extension of coverage due to disability. An appeal request must be submitted to Us in writing within 180 days of the determination. The Subscriber has a right to have access to, and request copies of the documentation relevant to the adverse benefit determination. Written notification of the appeal decision will be provided within 45 days after receipt of the request.

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. The term "spouse," wherever used, will include a Domestic Partner.

Insured means the Policyholder.

Insured Person means the Insured and the Insured's Dependents, if elected on the application.

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

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means this Policy issued to the Policyholder.

Policyholder means the person in whose name this Policy is issued.

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

Preferred Provider Agreement means a contract between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

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

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means an eye or visual examination.

Vision Materials mean those materials used to aid in the correction of vision.