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	503949
Name of Policyholder	Amerisafe, Inc
Type of Coverage	Vision Care Expense Insurance
Group Policy Effective Date	January 1, 2011
Policy Delivered in	Louisiana and governed by the laws of that State and to the extent applicable by the Employment Retirement Income Security Act (ERISA)

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.

HLGC902-VIS

TABLE OF CONTENTS

Part 1. BECOMING INSURED 1
B.ELIGIBILITY FOR INSURANCE 1
C.APPLICATION FOR INSURANCE 1
D.EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE 1
E.ACTIVE WORK REQUIREMENT 2
Part 2. INSURING YOUR DEPENDENTS 2
A.DEFINITION OF DEPENDENT 2
B.ELIGIBLE DEPENDENTS 3
C.APPLICATION FOR INSURANCE ON YOUR DEPENDENTS 3
D.EFFECTIVE DATE OF DEPENDENT INSURANCE 3
E.MEDICAL CHILD SUPPORT ORDERS 4
Part 3. SCHEDULE OF BENEFITS 5
A.FREQUENCY OF USE 5
B.IN-NETWORK BENEFITS 5
C.OUT-OF-NETWORK BENEFITS 6
D.LOW VISION PROGRAM 7
Part 4. COVERED EXPENSES 7
A.EYE EXAMINATION 7
B.FITTING OF EYEGLASSES 8
C.MATERIALS 8
D.LOW VISION PROGRAM 9
Part 5. EXCLUSIONS AND LIMITATIONS 9
Part 6. OTHER VISION CARE INSURANCE PROVISIONS 10
A.FREE CHOICE OF PROVIDER 10
B.INCURRED DATE 10
C.COORDINATION OF BENEFITS PROVISION 10
D.CONFORMITY WITH STATE STATUTES 14
Part 7. WHEN A MEMBER'S INSURANCE ENDS 14
Part 8. WHEN A DEPENDENT'S INSURANCE ENDS 15
Part 9. BECOMING INSURED AGAIN AFTER INSURANCE ENDS 16
Part 10. PAYMENT OF CLAIMS 17
A.PAPERLESS SYSTEM 17
B.PAYMENT OF BENEFITS 17
C.NOTICE OF CLAIM 17
D.CLAIM FORMS 17
E.PROOF OF LOSS 17
F.TIME PAYMENT OF CLAIMS 18
G.INDEPENDENT EXAMINATION AND AUTOPSY 18
H.RIGHT TO RECOVER BENEFITS PAID BY MISTAKE 18
I.NOTICE OF DECISION OF CLAIM 18
J.REVIEW PROCEDURE 19
K.CHILD SUPPORT PAYMENTS 20
L.ASSIGNMENT 21
M.LEGAL ACTIONS 21
Part 11. INCONTESTABLE CLAUSES 21
A.INCONTESTABLE CLAUSE FOR YOUR INSURANCE 21
B.INCONTESTABLE CLAUSE FOR GROUP POLICY 21
Part 12. CLERICAL ERROR 22
Part 13. ALLOCATION OF AUTHORITY 22
Part 14. GENERAL DEFINITIONS 22

Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D plus the Active Work requirement.

A. DEFINITION OF MEMBER

You must be a Member. You are a Member if you are all of the following:

1. An active employee of the Employer, other than a temporary or seasonal employee or a full time member of the armed forces of any country.

2. Regularly scheduled to work at least 30 hours per week.

3. A citizen or resident of the United States or Canada.*

* A reservist who has been called to active duty in the armed forces of the United States is an eligible Member during the period of active duty. See Part 7. When Insurance Ends.

B. ELIGIBILITY FOR INSURANCE

You must be eligible for Insurance. You are eligible for Insurance on the later of the following dates, if you are a Member on that date:

1. The effective date of the Group Policy.

2. The first day of the month following 90 days as a Member.

C. APPLICATION FOR INSURANCE

Your Insurance is Voluntary. If you wish to become insured, you must apply for Insurance and agree to make the required contributions to the Policyholder by signing a completed Enrollment Form.

You may apply for Insurance or for a change in the Insurance option you selected during the following periods:

1. Within 31 days after the date you first become eligible for Insurance.

2. During the Open Enrollment Period of each Calendar Year.

3. Within 31 days after a Life Event.

You cannot apply for Insurance or for a change in your Insurance option at any other time.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

   If you meet the Active Work requirement and each of the requirements of Parts 1A through 1C, your Insurance will become effective on:

   a. The date you become eligible for Insurance, if you apply on or before or within 31 days after the date you become eligible for Insurance.

   b. The first day of the calendar month following the Open Enrollment Period.

   c. The date of a Life Event, if you apply within 31 days of the Life Event.

2. Effective date of changes in the amount of your Insurance:

   Changes in the amount of your Insurance become effective on the date of the change, if you meet the Active Work requirement on that date.

Your Insurance will not become effective prior to the effective date of the Group Policy.

E. ACTIVE WORK REQUIREMENT

You must meet an Active Work requirement to become insured.

You will automatically meet the Active Work requirement on the date your Insurance is scheduled to become effective, unless you were Disabled on the day before that date. If you were Disabled on the day before the scheduled effective date of your Insurance, the effective date of your Insurance will be delayed until the first day after the date you complete one full day of Active Work.

For purposes of this Active Work requirement, you are Disabled if you are unable, as a result of your sickness, accidental bodily injury, or pregnancy, to perform the material duties of your own occupation.

This Active Work requirement also applies to any change in your Insurance.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.

2. You must have one or more eligible Dependents.

3. You must apply for Insurance on your eligible Dependents.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your spouse. Your spouse must not be legally separated from you and must meet the legal requirements of a spouse as defined by the laws of the state in which you reside.

2. Your unmarried child from birth through the date your child becomes 25* years of age. The term "child" includes a natural child, a step-child residing in your home, a child who has been placed with you for adoption by a court of competent jurisdiction, a grandchild who is in the legal custody of the grandparent, and any other child you support (a) who is chiefly dependent upon you for support and maintenance; (b) who lives with you in a parent-child relationship; (c) whose parent is your child and is insured as a Dependent under the Group Policy; or (d) who is the subject of a Qualified Medical Child Support Order.

   The term “child” also includes a child who is placed in the home of the Member following execution of an act of voluntary surrender in favor of the Member or the Member’s legal representative shall be considered a Dependent Child.

   "Primary care" means that you provide food, clothing, and shelter on a regular and continuous basis for a child.

3. The term "Dependent" does not include: (a) a spouse legally divorced from you, except when coverage is required by a valid court order; (b) a spouse that no longer meets the requirements of A., 1. above; (c) a spouse that does not meet the legal requirements of a spouse as defined in the State in which you reside; (d) any child for whom a petition for adoption has been denied; or (e) any child in the custody of the state until the final decree of adoption.

*A Dependent child or student's Insurance may be continued beyond these dates if you provide us with satisfactory written proof that the child or student qualifies for continued coverage as a Handicapped Child. See Part 8.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.

2. You may not insure a Dependent for Insurance unless the Dependent is a citizen or resident of the United States or Canada.

3. You may not insure your Dependent for Insurance if your Dependent is a full-time member of the armed forces of any country.

4. You may not insure your Dependent for Insurance if your Dependent is also eligible for Insurance as a Member.

A newly born child, adopted child, grandchild, child placed in your home for adoption, or stepchild residing in your home is eligible from the date of birth, adoption, placement or residence.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must apply for Insurance on your Dependents and agree to pay all or a part of the cost to the Policyholder by signing a completed Enrollment Form.

You are only permitted to apply for Insurance on your Dependents during one of the following periods:

1. Within 31 days after you first acquire the Dependent.

2. During the Open Enrollment Period of each Calendar Year.

3. Within 31 days after a Life Event.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.

2. The date you first acquire a Dependent.

You must apply for Insurance on your Dependents. The Insurance on your Dependents will become effective:

1. On the date they become eligible, if you apply for Insurance on your Dependents on or before or within 31 days after that date.

2. On the first day of the month following the Open Enrollment Period.

3. On the date of a Life Event.

We will not refuse:

1. To insure a child under the Group Policy on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.

2. To insure an otherwise eligible child under the Group Policy if the child is presumed to be the natural child of the insured.

A Dependent confined to a hospital or any other institution when that person's Insurance would normally begin will be insured on discharge. This limitation does not apply to a child at birth, an adopted child, or a child subject to court ordered child support

A newly born child, adopted child, grandchild, child placed in your home for adoption, or stepchild residing in your home is automatically covered from the date of birth, adoption, placement or residence for 31 days. In order to continue the child's coverage beyond this period you must apply for Insurance on the child and pay the required premium, if any, within 31 days of the date of birth, adoption, placement, or residence.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

Regardless of any other provision in the Group Policy, we will comply with any Qualified Medical Child Support Order (QMCSO) to the extent required by law. Upon receipt of a Medical Child Support Order we will promptly notify you and each Alternative Recipient that we have received the Medical Child Support Order and have adopted procedures for determining whether the Medical Child Support Order is, in fact, a QMSO. Those procedures include notifying you, and each Alternative Recipient, that each Alternative Recipient will have the right to designate a representative to receive all communications regarding the Alternative Recipient's rights to receive benefits under the Group Policy.

We will, within a reasonable period of time, determine whether the Medical Child Support Order is a QMCSO. If the Medical Child Support Order is a QMCSO, the Alternative Recipient designated in the order will be treated as the insured Member for purposes of payment of benefits under the Group Policy and the reporting and disclosure requirements under ERISA. For example, if benefits would otherwise be payable under the plan to you on account of Covered Expenses relating to an Alternate Recipient, those benefits would be paid directly to the Alternate Recipient or his or her custodial parent or legal guardian.

Any Alternate Recipient, not already Insured as a Dependent, who is the subject of a Medical Child Support Order will be eligible, and may be enrolled, for Insurance under the Group Policy on the date we determine the order is a QMCSO. On that date we will:

1. Permit the child's parent to enroll the child for Insurance without regard to any enrollment season restrictions;

2. Permit the child's other parent, the state department of social and health services, or other agency appointed by a court of competent jurisdiction pursuant to the order, to enroll the child for Insurance, if the child's parent is enrolled but fails to make application to obtain Insurance for the child; and

3. Not terminate the child's Insurance, unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled for comparable vision coverage through another carrier which will take effect not later than the effective date of the termination of the child's insurance, or the Employer has eliminated family vision coverage for all of its employees.

Nothing in the provisions of a QMCSO will require the Group Policy to provide any type or form of benefits, or any option, pursuant to the order that is not already provided under the Group Policy, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822).

The participant's Employer is authorized to withhold from the participant's salary or wages the cost of the coverage, if any, provided to the Alternative Recipient under the QMCSO.

Part 3. 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. 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.

A. FREQUENCY OF USE

Eye Examination	Once every calendar year.
Materials	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every calendar year and frame every other calendar year.

B. IN-NETWORK BENEFITS

	Copayment *
Eye Examination	$10.00
Materials	
Frames**	None
Spectacle Lenses	$10.00
Contact Lenses	
Single Tier Formulary	$0.00***
Contact Lens Eval/Fit Co-pay	$10.00****
Medically Necessary Contact Lenses	None

Note this benefit is subject to prior approval – the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be your responsibility.

* Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.

** Frames other than Davis Vision's Designer Collection will be paid up to a maximum of $130.00 plus a 20% discount on any amount over $130.00. (Discount does not apply to any frames purchased at Wal-Mart). The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Premier Collection there is an additional copayment; see "Optional In-Network Items" below.

*** Contact lenses other than Single Tier Formulary contact lenses will be paid up to a maximum of $130.00 plus a 15% discount on any amount over $130.00. (Discount does not apply to any contact lenses purchased at Wal-Mart). You may submit charges until the maximum allowance is met. The balance, if any, is the Covered Person's responsibility.

**** For specialty contact lenses, an evaluation and fitting fee will be paid up to a maximum of $60.00 plus a 15% discount on any amount over $60.00. (Discount does not apply at Wal-Mart). The balance, if any, is the Covered Person's responsibility.

Plan Level

Designer Plan — Eyewear from Davis Vision's Designer Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Premier Collection. All Optional In-Network Items are subject to the applicable Copayment.

Optional In-Network Items	Copayment
Premier Frame	$25.00
Blended Segment Lenses	$20.00
Intermediate Vision Lenses	$30.00
Progressive Addition Lenses	
Standard Types	$50.00
Premium Types	$90.00
Photochromic Glass Lenses	$20.00
Plastic Photosensitive Lenses	$65.00
Polarized Lenses	$75.00
ARC (Anti-Reflective Coating)	
Standard Type	$35.00
Premium Type	$48.00
Ultra Type	$60.00
Hi-Index Lenses	$55.00

C. OUT-OF-NETWORK BENEFITS

A Covered Person may use the Provider of his or her choice for the following covered vision services. Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

	Allowance *
Eye Examination	$30.00
Materials:	
Frames	$30.00
Lenses:	
Single Vision	$25.00
Bifocal	$35.00
Trifocal	$45.00
Lenticular	$60.00
Contact Lenses	$75.00

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are your responsibility.

Medically Necessary Contact Lenses	$225.00

Note this benefit is subject to prior approval – the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)
Maximum per Evaluation	$300.00
Maximum per Follow-up Visit	$100.00
Low Vision Aids	
Maximum per Aid	$600.00
Lifetime Maximum for all Aids	$1200.00

Note this 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. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. 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 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while the you or your Dependents, if any, are insured for these benefits. The benefits payable under the Group Policy vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Case history - chief complaint, eye and vision history, medical history
2. Entrance distance acuities
3. External ocular evaluation including slit lamp examination
4. Internal ocular examination
5. Tonometry
6. Distance refraction - objective and subjective
7. Binocular coordination and ocular motility evaluation
8. Evaluation of pupillary function
9. Biomicroscopy
10. Gross visual fields
11. Assessment and plan
12. Advise a Covered Person on matters pertaining to vision care.
13. Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. Benefits under the Group Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Designer Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:

   a. Glass-Grey #3 Prescription Sunglasses
   b. Oversized Lenses
   c. Post-Cataract Lenses
   d. Contact Lenses
   e. Fashion and Gradient Tinting of Plastic Lenses
   f. Scratch Resistant Coating
   g. Ultraviolet Coating
   h. Polycarbonate lenses

   The above materials are subject to the Copayment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items. These materials are subject to the Copayment for Optional In-Network Items shown in Part 3:

   a. Premier Frames
   b. Hi-Index Lenses
   c. Blended Segment Lenses
   d. Intermediate Vision Lenses
   e. Standard Progressive Addition Lenses
   f. Premium Progressive Addition Lenses
   g. Standard ARC (Anti-Reflective Coating)
   h. Premium ARC (Anti-Reflective Coating)
   i. Ultra ARC (Anti-Reflective Coating)
   j. Photochromic Glass Lenses
   k. Plastic Photosensitive Lenses
   l. Polarized Lenses

Frames and lenses from an Out-of-Network Provider or from an In-Network Provider's own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in Part 3. Schedule of Benefits.

Medically necessary contact lenses prescribed for a Covered Person are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Benefits are payable up to the allowance, subject to the maximum shown in Part 3 for the Covered Expense. Covered Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
- Follow-up Visits
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be your responsibility.

Part 5. 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 3.
3. For eye examinations required by an 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 any medical treatment rendered outside the United States or Canada.
13. For services rendered by practitioners who do not meet the definition of Provider.
14. For expenses covered by:

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

15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.

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

17. 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 6. 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

1. This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

2. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

3. Definitions

   a. Allowable Expense - a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

      (1) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.

      (2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.

(5) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

b. Claim Determination Period - a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

c. Closed Panel Plan - a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

d. Custodial Parent - a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

e. Plan - any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes:

(a) group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
(b) hospital indemnity benefits in excess of $300 per day; medical care components of group long-term care contracts, such as skilled nursing care;
(c) medical benefits under group or individual automobile contracts; and
(d) Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include:

(a) individual or family insurance;
(b) closed panel or other individual coverage (except for group-type coverage);
(c) amounts of hospital indemnity insurance of $300 or less per day; school accident type coverage, benefits for nonmedical components of group long-term care policies;
(d) Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

(3) Each contract for coverage under "i" or "ii" is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(4) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

(5) When this plan is primary its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

4. Order of Benefit Determination Rules

a. When two or more plans pay benefits, the rules for determining the order of payment are as follows.

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: (i) coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(a) Nondependent or Dependent

The plan that covers the person other than as a dependent, (for example, as an employee, member, subscriber, or retiree) is primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

(b) Child Covered Under More Than One Plan

The order of benefits when a child is covered by more than one plan is:

i. the primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) the parents are married;
(ii) the parents are not separated (whether or not they ever have been married); or
(iii) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

ii. if both parents have the same birthday, the plan that covered either of the parents longer is primary;

iii. if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree;

iv. if the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(i) the plan of the custodial parent;
(ii) the plan of the spouse of the custodial parent;
(iii) the plan of the noncustodial parent; and then
(iv) the plan of the spouse of the noncustodial parent.

b. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under 4.a.(4)(b)iv.(i) above.

c. Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

d. Longer or Shorter Length of Coverage

The plan that covered the person as an employee, member, subscriber, or retiree longer is primary.

e. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

5. Effect on the Benefits of this Plan

a. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(1) determine its obligation to pay or provide benefits under its contract;

(2) determine whether a benefit reserve has been recorded for the covered person; a and

(3) determine whether there are any unpaid allowable expenses during that claims determination period.

b. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

c. If a covered person is enrolled in two or more closed panel plans, and if for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

6. Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Organization responsible for COB administration may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Organization responsible for COB administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give organization responsible for COB administration any facts it needs to apply those rules and determine benefits payable.

7. Facility of Payment

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

8. Right of Recovery

If the amount of the payments made by organization responsible for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes 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.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

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

1. The last day of the calendar month in which you cease to be a Member as defined in Part 1A.

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.

5. The last day of the calendar month in which you cease to be Actively at Work for the Employer on your regular work days for any reason, including the elimination of your job. However, your Insurance will be continued (unless it ends under any of the above items) during the following periods while you are absent from Active Work:

   a. While you are receiving full salary (including sick pay and vacation pay) from the Employer, but not beyond the date your job is eliminated, the effective date of a severance agreement, or the date your job is terminated by you or the Employer.

   b. For up to twelve weeks during a period of family or medical leave approved by the Employer in accordance with the Employer's uniform family and medical leave policy patterned after the federal Family and Medical Leave Act of 1993 or applicable state law.

   c. While you are unable to be Actively At Work as a result of your sickness, accidental bodily injury, or pregnancy, but not beyond the date your employment is terminated by you or the Employer.

   d. During a leave of absence or a temporary layoff, but not beyond the date approved by the Employer.

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 subject to the following:

1. If your Insurance is Contributory or Voluntary, 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 be deducted from your compensation if you were Actively At Work for the Employer.

2. If your Insurance is Non-Contributory your coverage will be continued automatically while you remain on active duty.

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 8. 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 last day of the calendar month in which the person ceases to be your Dependent, as defined in Part 2A.

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.

5. With respect to a student dependent, the date the student dependent ceases to be a registered student in regular full time attendance at an accredited college or university, or a vocational, technical, vocational-technical, or trade school or institute, or secondary school, except when coverage continues beyond that date for a student who, in the opinion of a qualified psychiatrist, developed a mental or nervous condition, problem, or disorder.

Continued Coverage For A Handicapped Child:

Insurance on a Dependent child or student will not end solely because the child or student ceases to be a Dependent as defined in Part 2 if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. This proof must be furnished to us on our forms within 31 days after the child or student ceases to be a Dependent as defined, and thereafter as required by us, but not more often than once a year after the two year period following the child's attainment of the limiting age. We have the right, at our expense, to have your child examined at reasonable intervals while you are claiming continued coverage under this provision.

Insurance on a Handicapped Child will end automatically on the earliest of the following dates:

1. The date the child or student becomes capable of self-sustaining employment.

2. The date the child or student ceases to be chiefly dependent upon you for support and maintenance.

3. 90 days after the date we mail you a request for proof that the child or student continues to qualify as a Handicapped Child, unless you provide us with the required proof within that 90 day period.

4. The date the Handicapped child or student marries.

5. The date coverage would end under this Part 8 for any reason other than the child's attainment of the limiting age.

Part 9. 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 Member, 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 a Member, you and your Dependents, if any, will be immediately eligible for Insurance if you become a Member 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 1B again if you qualify as a Member and return to Active 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 10. PAYMENT OF CLAIMS

A. 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.

B. PAYMENT OF BENEFITS

All in-network benefits will be paid directly to the Provider. Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any covered expense accrued benefits unpaid at the time of your death will 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.

C. NOTICE OF CLAIM

Written notice of a claim must be given to us within 90 days after the incurred date of the Covered Expense or as soon thereafter as reasonable possible. Notice given to us by or on behalf of a Covered Person with information sufficient to identify the Covered Person, will be deemed notice to us. 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.

D. 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 Policyholder 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:

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

2. 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.

E. 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:

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

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

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

4. 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 and, in any case, within one year after the end of the 90 day period.

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.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

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, or our initial notice of decision of claim (see L. NOTICE OF DECISION OF CLAIM), if later.

G. INDEPENDENT EXAMINATION AND AUTOPSY

We have the right to have a Provider of our choice examine you or your covered Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your covered Dependent fail to permit or cooperate with a review by the Provider of our choice. In the event of accidental death, we also have the right to have an autopsy performed unless forbidden by law.

H. 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.

I. 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) following a decision on appeal.

J. 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 judgement.

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 receive 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 receive 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) 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 local U.S. Department of Labor Office and your state insurance regulatory agency.

K. 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.

L. 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.

M. 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 three years after the time written proof of loss is required to be furnished.

Part 11. 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 a Member, (2) submit and have approved an Enrollment Form, and (3) meet the Active Work requirement.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder 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.

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 12. CLERICAL ERROR

Clerical error by the Employer will not:

1. Cause you to become insured or to not become insured if otherwise eligible.

2. Invalidate Insurance otherwise validly in force.

3. Continue Insurance otherwise validly terminated.

Part 13. 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 14. GENERAL DEFINITIONS

ACTIVELY AT WORK This term means the performance of all the duties that pertain to your work at the place where it is normally done, or where it is required to be done by your Employer.

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Group Policy as the participant's eligible Dependent. For purposes of the benefits provided under the Group Policy, an Alternate Recipient will be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a participant.

ALLOWANCE 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.

APPLICATION 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.

COPAYMENT 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 3. Schedule of Benefits.

COVERED DEPENDENT means a Member's Dependent insured under the Group Policy.

COVERED EXPENSE 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 a Member insured under the Group Policy or a Member's Dependent insured under the Group Policy.

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

EMPLOYER means Amerisafe, Inc.

ENROLLMENT, ENROLLMENT FORM 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 503949 issued to the Policyholder.

IN-NETWORK PROVIDER Providers who have 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 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 Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

MEDICAL CHILD SUPPORT ORDER This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act Sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822) with respect to a group health plan.

NONCONTRIBUTORY means your Employer pays the entire cost of your Insurance. The Insurance on your Dependents is Noncontributory if your Employer pays the entire cost of the Insurance on your Dependents.

OPTIONAL IN-NETWORK ITEMS 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 3. Schedule of Benefits.

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

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

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of his or her 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.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or eligible Dependent is entitled under the Group Policy. In order for such an order to be a QMCSO, it must clearly specify:

1. the name and last known mailing address (if any) of the participant and the name and mailing address of each the Alternate Recipient covered by the order;
2. a reasonable description of the type of coverage to be provided under the Group Policy to each Alternate Recipient, or the manner in which that type of coverage is to be determined;
3. the period of coverage to which the order applies; and
4. each plan to which the order applies.

SCHEDULED FEE 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 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.

VOLUNTARY means you pay any part of the cost of your Insurance. Your Dependent's Insurance is Voluntary if you pay any part of the cost of the Insurance on your Dependents. If your Insurance or your Dependents Insurance is Voluntary, your Employer determines the amount of your contribution toward the cost of the Insurance. You must enroll for both your and your Dependent's Insurance.

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