



**Combined Insurance Company of America**  
111 Wacker Drive, Suite 700 • Chicago, Illinois 60601  
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

### **GROUP VISION INSURANCE CERTIFICATE**

**POLICY NUMBER:** 1002767  
**POLICYHOLDER:** City of Jacksonville  
**POLICY ANNIVERSARY DATE:** January 1, 2017, and each January 1 thereafter

Combined Insurance Company of America represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

To make inquiries, request information or resolve complaints, call: 1-800-000-0000.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Carmine A. Giganti, Vice President and Secretary

**THIS IS A LIMITED BENEFIT CERTIFICATE**  
*Please read the Certificate carefully.*

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## DEFINITIONS

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Benefit Frequency** means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. 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 covered Vision Examination and 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". 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 cyclopegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

**Dependent** - means any of the following persons:

1. Your lawful spouse;
2. each child from birth to age 25 who meets all of the following: (a) the child is dependent upon You for support; and (b) the child is living in the household, or (c) the child is a full-time or part-time student; or
3. each unmarried child until the end of the calendar year in which the child reaches the age of 30 if the child meets all of the following: (a) the child is unmarried and does not have dependents; (b) the child is a resident of Florida or is a full-time or part-time student; and (c) the child is not provided coverage as a named subscriber under any health benefit plan or is not entitled to benefits under the Social Security Act; or
4. each child at least 25 years of age who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 25<sup>th</sup> birthday; and who has been continuously so incapacitated since his or her 25<sup>th</sup> birthday.

Child includes stepchild, legally adopted child, child legally placed in the Your home for adoption and child under Your legal guardianship. A full-time student is one who is enrolled the minimum number of hours of class a week the school considers as full-time status.

**Fundus Photography Examination** means the recording of a portion(s) or complete retina surface and structures.

**Insured** means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

**Insured Person** means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

**IntraLase Initiated LASIK** means a LASIK surgical procedure in which a special laser is used instead of a blade to create the stromal flap.

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

**LASEK** (Laser Assisted Epithelium Keratomileusis) means a surgical procedure that utilizes a trephine to create an epithelial flap and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

**Laser Vision Correction Procedures** means surgical procedures which permanently alter the focusing power of the eye(s) in order to change refractive errors.

**LASIK** (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to create a stromal flap of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the stromal flap is replaced and is adhered without stitches.

**Low Vision** means a severe visual problem that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription; or
2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

**Low Vision Aids** are classified as follows:

1. *Spectacle-mounted magnifiers* - A magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;
2. *Handheld or spectacle-mounted telescopes* - These miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;
3. *Hand-held and stand magnifiers* - These can serve as supplements to other specialized systems, and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types can be equipped with lights; or
4. *Video magnification* - Table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.]

**[Low Vision Supplemental Testing** means diagnostic evaluation beyond the Comprehensive Eye Examination, and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, travel vision, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken of the Insured Person's visual acuity using special low vision test charts, which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized refraction must be performed with each eye thoroughly examined. The eye care professional may prescribe various treatment options, including Low Vision Aids, as well as assist the Insured Person with identifying other resources for vision and lifestyle rehabilitation.

**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 the Policy issued to the Policyholder.

**Policyholder** means the Employer named as the Policyholder in the face page of the Policy.

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

**Preferred Provider Agreement** means an agreement between the PPO and a Provider that contains 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 that has 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 any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

**Vision Materials** means those materials shown in the Schedule of Benefits.

## EFFECTIVE DATES

**Effective Date of Insured's Insurance.** The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute towards the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided;
  - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
  - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

**Effective Date of Dependents' Insurance.** Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

**Newborn Infant Coverage** - A child born to an Insured is covered from the moment of birth. An adopted newborn child is covered from the moment of birth if You have entered into a written agreement to adopt prior to the child's birth whether or not the agreement is enforceable.

**Adopted Children Coverage** - A child You adopt, a foster child or child in Your custody by court order is covered as any other child. A child placed with You for adoption will be covered from the date of such placement. Coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

Coverage for the newborn or adopted child is effective from the moment of birth or placement for adoption. If You give Us notice within the first 45 days of birth or placement, We will not charge an additional premium for the first 45 days. Any additional premium required to continue coverage will begin from the 45th day after birth or placement. If notice is not given within the first 31 days We will charge an additional premium from date of birth or placement. However, coverage will not be denied because You failed to give Us timely notice.

With respect to a newborn child of Your insured Dependent child, coverage will terminate for such child 18 months after the birth of the newborn.

## BENEFITS

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

**Comprehensive Eye Examination.** An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

**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 at the time the covered service 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.

**Vision Materials.** If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frame(s)* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

## **LIMITATIONS**

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

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

## **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 and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or 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;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; and;
10. 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.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

## **TERMINATION OF INSURANCE**

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

**For All Insureds.** The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
  - a. does so without individual selection between Insureds; and
  - b. continues to pay any premium contribution for those individuals.

**For Dependents.** A Dependent's insurance will cease on the earlier of:

1. on the date the Insured's coverage ends;
2. the date on which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

## CLAIMS

**Notice of Claim.** Written notice of claim must be given to the Company within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

**Claim Forms.** The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

**Proof of Loss.** Written proof of loss must be furnished to the Company at the Company's home office 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 the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

**Right of Recovery.** If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

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

**Crime Victims Provision.** If the Insured Person is a victim of a violent crime and it is determined that the Insured Person is eligible under the Florida Crimes Compensation Act, any Co-payment provision required under this Policy will not apply. The Insured Person must provide the Company with a copy of the written notification concerning his or her status received from the Office of the Attorney General, Division of Victim Services, State of Florida.

## GENERAL PROVISIONS

**Clerical Error.** Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

**Conformity to Law.** Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

## SCHEDULE OF BENEFITS

Policyholder: City of Jacksonville

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

<b><u>Benefit</u></b>	<b><u>In-Network Cost Benefit Amount</u></b>	<b><u>Out-of-Network Reimbursement Benefit Amount</u></b>	<b><u>Benefit Frequency</u></b>
<b>VISION EXAMINATION</b>			
<b>Comprehensive Eye Examination</b>	\$10 Co-payment	up to \$50	12 months
<b>Low Vision Supplemental Testing</b>	Covered in Full	up to \$125	24 months
<b>Low Vision Aids</b>	25% Co-payment up to \$1,000	25% Co-payment up to \$1,000	
<b>VISION MATERIALS</b>			
<b><i>Standard Plastic Lenses</i></b>			24 months
Single Vision	\$20 Co-payment	up to \$50	
Bifocal	\$20 Co-payment	up to \$75	
Trifocal	\$20 Co-payment	up to \$100	
Lenticular	\$20 Co-payment	up to \$125	
<b><i>Frames</i></b>	\$110 retail allowance	up to \$70	24 months
<b><i>Contact Lenses (only one option available per Benefit Frequency)</i></b>			24 months
Conventional	\$0 Co-payment up to \$110 allowance	up to \$105	
Disposable	\$0 Co-payment up to \$110 allowance	up to \$105	
Medically Necessary	\$0 Co-payment Paid in full	up to \$210	
<b><i>Lens Options</i></b>			24 months
Standard Polycarbonate - Adults	\$0 Co-payment	up to \$20	
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	\$0 Co-payment	up to \$20	
UV Treatment	\$0 Co-payment	up to \$8	
Tint: Solid or Gradient	\$0 Co-payment	up to \$8	
Standard Plastic Scratch Coating	\$0 Co-payment	up to \$8	
Standard Progressive Lenses (add on to Bifocal) "Brand Names"	\$80 Co-payment	up to \$75	
Premium Progressive Lenses (add on to Bifocal) "Brand Names"	Tier 1 - \$100 Co-payment Tier 2 - \$110 Co-payment Tier 3 - \$125 Co-payment Tier 4 - \$80 Co-payment, less \$120 allowance	up to \$75	
Standard Anti-Reflective Coating "Brand Names"	\$39 Co-payment	up to \$3	
Premium Anti-Reflective Coating "Brand Names"	Tier 1 - \$51 Co-payment Tier 2 - \$62 Co-payment	up to \$3	

## SCHEDULE OF BENEFITS

Policyholder: City of Jacksonville

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

<b><u>Benefit</u></b>	<b><u>In-Network Cost Benefit Amount</u></b>	<b><u>Out-of-Network Reimbursement Benefit Amount</u></b>	<b><u>Benefit Frequency</u></b>
<b>VISION EXAMINATION</b>			
<b>Comprehensive Eye Examination</b>	\$10 Co-payment	up to \$53	12 months
<b>Low Vision Supplemental Testing</b>	Covered in Full	up to \$125	24 months
<b>Low Vision Aids</b>	25% Co-payment up to \$1,000	25% Co-payment up to \$1,000	
<b>VISION MATERIALS</b>			
<b><i>Standard Plastic Lenses</i></b>			12 months
Single Vision	\$20 Co-payment	up to \$50	
Bifocal	\$20 Co-payment	up to \$75	
Trifocal	\$20 Co-payment	up to \$100	
Lenticular	\$20 Co-payment	up to \$125	
<b><i>Frames</i></b>	\$130 retail allowance	up to \$70	24 months
<b><i>Contact Lenses (only one option available per Benefit Frequency)</i></b>			12 months
Conventional	\$0 Co-payment up to \$130 allowance	up to \$105	
Disposable	\$0 Co-payment up to \$130 allowance	up to \$105	
Medically Necessary	\$0 Co-payment Paid in full	up to \$210	
<b><i>Lens Options</i></b>			12 months
Standard Polycarbonate - Adults	\$0 Co-payment	up to \$20	
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	\$0 Co-payment	up to \$20	
UV Treatment	\$0 Co-payment	up to \$8	
Tint: Solid or Gradient	\$0 Co-payment	up to \$8	
Standard Plastic Scratch Coating	\$0 Co-payment	up to \$8	
Standard Progressive Lenses (add on to Bifocal) "Brand Names"	\$20 Co-payment	up to \$75	
Premium Progressive Lenses (add on to Bifocal) "Brand Names"	Tier 1 - \$20 Co-payment Tier 2 - \$20 Co-payment Tier 3 - \$20 Co-payment Tier 4 - \$20 Co-payment	up to \$75	
Standard Anti-Reflective Coating "Brand Names"	\$39 Co-payment	up to \$3	
Premium Anti-Reflective Coating "Brand Names"	Tier 1 - \$51 Co-payment Tier 2 - \$62 Co-payment	up to \$3	



**Combined Insurance Company of America**  
111 Wacker Drive, Suite 700 • Chicago, Illinois 60601  
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

## **DIABETIC EYE CARE SERVICES BENEFIT RIDER**

The rider is attached to and made part of Policy No. 1002767 issued by **Combined Insurance Company of America** to **City of Jacksonville**.

Effective **January 1, 2016**, this Policy and Certificate as issued is amended as follows:

An Insured Person who has been diagnosed with Type 1 or Type 2 Diabetes is eligible for Diabetic Eye Care Services described below. The Diabetic Eye Care Services allow an Insured Person to obtain the Diabetic Eye Care Services described below from his or her eye care provider. This Rider does not cover medical treatment for an Insured Person's diabetic or other medical conditions.

<b><u>Benefit</u></b>	<b><u>In-Network Benefit Amount</u></b>	<b><u>Out-of-Network Benefit Amount</u></b>	<b><u>Benefit Frequency</u></b>
Medical Follow Up Eye Examination	Covered in full \$0 Co-payment	Up to \$77	2 per year
Gonioscopy	Covered in full \$0 Co-payment	Up to \$15	2 per year
Extended Ophthalmoscopy	Covered in full \$0 Co-payment	Up to \$15	2 per year
Fundus Photography	Covered in full \$0 Co-payment	Up to \$50	2 per year
Scanning Laser	Covered in full \$0 Co-payment	Up to \$33	2 per year

Diabetic Eye Care Expense Benefits are not payable for any of the following:

1. costs associated with securing frames, lenses or any other materials;
2. orthoptics or vision training and any associated supplemental testing;
3. surgical procedures, including laser or any other refractive surgery, and any pre- or post- operative services;
4. pathological treatment of any type for any condition;
5. any eye examination required by an employer as a condition of employment;
6. insulin or any medications or supplies of any type; and
7. services and/or supplies not included in this Rider as covered Benefits.

### **Definitions:**

**Diabetes** means a disease where the pancreas is either insulin deficient or is unable to use insulin.

**Diabetic Retinopathy** means retinal damage caused by complications of diabetes.

**Extended Ophthalmoscopy** means an examination of the interior of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report.

**Fundus Photography** means the recording of a portion(s) of complete retina surface and structures.

**Gonioscopy** means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

**Medical Follow Up Eye Examination** means a vision examination for diabetic vision care.

**Scanning Laser** means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral.

**Type 1 Diabetes** means a disease in which the pancreas produces little or no insulin.

**Type 2 Diabetes** means a disease in which the pancreas produces insufficient insulin or the pancreas cannot use insulin efficiently.

**Benefits:**

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

**Extended Ophthalmoscopy.** An Insured Person is eligible for one initial Extended Ophthalmoscopy examination and one subsequent Extended Ophthalmoscopy examination for diabetic vision care in each Benefit Frequency. The Extended Ophthalmoscopy must provide information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. The Extended Ophthalmoscopy is not covered if a retinal imaging examination was provided within the previous 6-month period.

**Fundus Photography.** An Insured Person is eligible for two retinal imaging examinations for diabetic vision care in each Benefit Frequency. The retinal imaging examination is not covered if an Extended Ophthalmoscopy was provided within the previous 6-month period.

**Gonioscopy.** An Insured Person is eligible for two Gonioscopies for diabetic vision care in each Benefit Frequency.

**Medical Follow Up Eye Examination.** An Insured Person is eligible for two Medical Follow Up Eye Examinations for diabetic vision care in each Benefit Frequency.

**Scanning Laser.** An Insured Person is eligible for two Scanning Lasers for diabetic vision care in each Benefit Frequency.

This rider takes effect and expires concurrently with the Policy/Certificate to which it is attached and is subject to all the terms and conditions of the Policy.

Signed for **Combined Insurance Company of America**



Brad Bennett, President



Rebecca L. Collins, Secretary