American Family Life Assurance Company of Columbus

CERTIFICATE OF INSURANCE FOR GROUP VISION INSURANCE

Underwritten by: American Family Life Assurance Company of Columbus
Worldwide Headquarters
1932 Wynnton Road
Columbus, Georgia 31999

Administrator: Aflac Benefits Solutions, Inc.
4211 West Boy Scout Blvd
Tampa, FL 33607

About Your Insurance – This Certificate explains the vision insurance coverage under the Policy issued to the Policyholder, which is underwritten by American Family Life Assurance Company of Columbus (a stock company hereinafter called: We, Our, Us, or Aflac). The Policy provides benefits for the Insured Persons (hereinafter called: You or Your). Read it closely to become familiar with Your plan.

Coverage is effective as of the Certificate Effective Date shown on Your ID card.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions sections and are capitalized in this Certificate.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice by Us to any Insured Person who claims rights or benefits under the Policy. The Policyholder is responsible for providing notice, if any, to the Insured Persons.

The Policy provides the benefits described in this Certificate for Insured Persons. This Certificate with any attached Riders, Endorsements, or Amendments, as well as the Application and Enrollment Form, make up the Certificate of Insurance. It replaces any prior Certificates of Insurance issued under the Policy.

In witness whereof, Aflac's president and secretary signed this Certificate in Columbus, Georgia, as of the Insured Member's effective date of coverage.

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

TABLE OF CONTENTS

Insert

PART I – SCHEDULE OF BENEFITS

PART II - GENERAL INSURANCE PROVISIONS

DEFINITIONS

Actively at Work: the performance of the normal duties of Your usual job on a Full-Time basis at Your usual place of work or at another place to which You are required to travel. You must be able to perform all the duties of Your regular occupation. You will be considered to be Actively at Work while on a paid vacation day or regular non-working day.

Administrator: the entity which will provide services and/or facilities for the writing and servicing of the Policy as agreed in a separate contract with Us.

Associated Company: any company listed on the list of Associated Companies in the Schedule of Benefits. These companies must be a subsidiary of or affiliated with the Policyholder.

Calendar Year Plan: the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Contact Lenses: contact lenses an Insured Person elects to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective: contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured Person from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

- Aphakia (after cataract surgery).
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Keratoconus.

Co-Pay: an Insured Person's share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.

Covered Services or Materials: the Materials that qualify for benefits under the Policy. Covered Services or Materials are shown in the Schedule of Benefits.

Eligibility Period: the period of time that an Eligible Member must wait before He is eligible for coverage. This period, if any, is specified in the Policyholder's Application and shown on the Schedule of Benefits.

Eligible Class: a group of people who are eligible for coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify to enroll for insurance on the date He completes the required Eligibility Period.

Eligible Dependent: someone who is residing in the United States and who is:

- Your legally married spouse or registered domestic partner; or
- Your or Your spouse's natural child, stepchild, legally adopted child, child in Your custodial care pursuant to a court order, or child for whom You have been appointed as legal guardian, who is under age 26.

Coverage will continue for any Eligible Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability, and who became so disabled prior to age 26 and while covered under this Certificate. You must furnish proof of such disability and dependency to Us within 31 days of the Eligible Dependent child's 26th birthday. You must furnish proof of continuing disability and dependency at Our request, but not more often than annually, after the two-year period following the Eligible Dependent child's 26th birthday.

Eligible Member: a person who belongs to an Eligible Class.

Eyeglass Lenses: a standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

Family Members: a unit consisting of You and each of Your Insured Dependents.

Full-Time: a regular workweek as shown in the description of Eligible Classes in the Schedule of Benefits. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.

Group: the employer, union, trust, association, or other eligible entity or organization to which the Policy is issued.

He, Him, His: refers to the male or female gender.

In-Network Provider: an Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide Covered Services or Materials at an agreed-to cost. When an In-Network Provider is used, the Insured Person will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory: a list of In-Network Providers and the services they are contracted for in Your area. The list will be updated periodically.

Initial Term: the period following the Group's initial Effective Date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

Insured Dependent: an Eligible Dependent of an Insured Member for whom insurance under the Policy has become effective.

Insured Member: a person who is an Eligible Member of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

Insured Person: an Insured Member and Insured Dependents.

Late Entrant: any Eligible Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits.

Limited Access Area: an area where there are no In-Network providers within a driving distance of 35 miles from Your primary residence.

Materials: corrective Eyeglass Lenses, Frames, and Contact Lenses.

Ophthalmologist: a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder.

Optician: a person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist: a person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder.

Out-of-Network Provider: an Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges. They are not listed in the In-Network Provider Directory.

Plan Year: the 12-month period of time shown on the Schedule of Benefits as a Calendar Year Plan or Policy Year Plan. The type of Plan Year issued is shown in the Schedule of Benefits.

Plano Lens: a lens that has no refractive power.

Policy: the entire contract. It consists of:

- the Policy;
- the Policyholder's Application;
- any Riders, Endorsements and Amendments;
- the Certificate of Insurance; and
- the Enrollment Form, if any.

Premium: the amount of money paid on a recurring basis to purchase the insurance benefits provided by the Policy.

Policy Anniversary: the month and day as shown on the Policy as the Policy Anniversary.

Policy Year Plan: for the first year, the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.

Policyholder: the Group listed in the Schedule of Benefits to which the Group Master Policy has been issued.

Vision Exam: an examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

We, Us, Our, Aflac: American Family Life Assurance Company of Columbus.

You, Your: an Insured Member.

ELIGIBILITY PROVISIONS

To be eligible for coverage under the Policy, an individual must:

- be a person of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
- satisfy the Eligibility Period, if any.

The Eligible Member's Eligible Dependents are also eligible for coverage, provided that the Eligible Member becomes insured under the Policy and Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Member and His spouse or registered domestic partner are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse or registered domestic partner carrying Dependent coverage ceases to be eligible, Dependent coverage will become effective under the other spouse's or registered domestic partner's coverage upon Our receipt of a request for such change.

ENROLLMENT PROVISIONS

The term "Enrollment" means written or electronic enrollment in the coverage by an Eligible Member on an Enrollment Form furnished or approved by Us. Coverage will not become effective until the Eligible Members have enrolled themselves and, if applicable, their Eligible Dependents, and paid the required Premium, if any.

Initial Enrollment: Eligible Members who enroll themselves and, if applicable, their Eligible Dependents within 31 days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an Open Enrollment period.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a Permitted Change in Election Event, as described below.

Permitted Change in Election Event: Members may enroll in or change their coverage outside of a designated Enrollment period if a permitted change in election event occurs, provided the Insured Member makes written application to enroll within 31 days of the event. A permitted change in election event means any of the following:

- marriage or registered domestic partnership,
- divorce or legal separation,
- birth or adoption of a child,
- placement of a child in Your custodial care pursuant to a court order,
- You being appointed legal guardian of a child,
- death of a spouse or registered domestic partner or child, or
- other changes as permitted by Us and the Policyholder.

EFFECTIVE DATE PROVISIONS

Eligible Members and Eligible Dependents
Coverage takes effect on the Certificate Effective Date shown on Your ID card.

Additional Dependents
The Effective Date of any newly acquired Eligible Dependent will be governed by the same rules as described above under the heading “Eligible Members and Eligible Dependents.” You must first complete, sign and submit to Us a new Enrollment Form for all Your Additional Dependents, including newborn and adoptive children, and submit the additional Premium, if any. However, newborn and adoptive children will be covered immediately from birth or date of placement for purposes of adoption for the first 90 days following their birth. To continue coverage beyond that 90-day period, You must notify Us in writing of the child’s date of birth at any time during the 90-day period.

TERMINATION PROVISIONS

Insured Members
All of Your insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

- the date the Policy terminates;
- the last day of the month in which You cease to be an Eligible Member;
- the date You die; or
- on any Premium Due Date, when full payment for insurance is not made within the Grace Period.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

Insured Dependents
Your Dependent's insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

- the date the Policy terminates;
- the last day of the month in which You cease to be an Eligible Member;
- the date the Insured Dependent ceases to be an Eligible Dependent;
- the date You die;
- the date the Insured Dependent dies;
- on any Premium Due Date, when full payment for insurance is not made within the Grace Period; or
- the date We receive Your request to terminate Dependent coverage subject to any limitation imposed by the Policyholder.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

Notice Required When Your Coverage Terminates
We must be informed promptly, by You or the Policyholder, when Your status as an Eligible Member terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event Premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of three Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits for Your Covered Services or Materials incurred after the date Your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to Us.

PREMIUM PROVISIONS

Payment of Premiums
Insured Persons may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. If required, You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us.

Physical Examination and Autopsy
We shall have the right and opportunity at our own expense, to examine the Insured Person when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Grace Period
A Grace Period of 31 days following the Premium Due Date is granted for the payment of each Premium Due Date after the first. The coverage stays in force if the Premium is paid during this Grace Period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums
We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Policy Anniversary Date, We will not increase the Premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 60 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

CLAIM PROVISIONS

Notice of Claim
Written Notice of Claim must be provided to the Administrator within 60 days from the date of loss. We will not deny or reduce any claim filed after 60 days from the date of loss if it was not reasonably possible to file the claim within that 60-day period, and the claim is filed as soon as it is reasonably possible.

Claims should be sent to Our Administrator at:

American Family Life Assurance Company of Columbus
Aflac Benefit Solutions, Inc.
c/o Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Proof of Loss
Written Proof of Loss (claim forms, medical bills, medical authorizations, or other reasonable evidence of the claim that is ordinarily required) must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Claim Forms
When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within 15 days, the claimant will meet the Proof of Loss requirements if We are given written proof of the nature and extent of the loss. Proof of Loss must be given within one year after it is due, unless You are legally incapable of doing so.

Payment of Claims
All benefits will be payable to You, unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

Time of Payment of Claims
All benefits under the Policy will be paid as soon as practicable, but no later than 30 working days after receipt of Your Notice of Claim unless the claim or portion thereof is contested by Us, in which case You will be notified, in writing, that the claim is contested or denied. However, no benefits will be paid until the required Proof of Loss has been submitted to Us.

Recovery of Overpayments
We reserve the right to deduct from any benefits properly payable under the Policy the amount of any payment that has been made:

- in error; or
- pursuant to a misstatement contained in a Proof of Loss; or
- pursuant to fraud or misrepresentation made to obtain coverage under the Policy within two years after the date such coverage commences; or
- with respect to an ineligible person; or
- pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person if claim payments previously were made with respect to an Insured Person.

PART III - VISION INSURANCE COVERAGE PROVISIONS

COVERAGE PROVISIONS

We pay a benefit if an Insured Person receives Covered Services or Materials at the allowable Frequency, as shown in the Schedule of Benefits, while His coverage under this Certificate is in force. An Insured Person may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured Person will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

In-Network Benefits
When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A Provider's status may occasionally change. We recommend that You call Us to verify the Provider's participation status in the network. You may change Providers at any time without notice to Us.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured Person pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Schedule of Benefits.

The Co-Pay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

Out-of-Network Benefits
If an Insured Person chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is Your responsibility to send us a claim by submitting the itemized invoice or receipt to Us. (See the "Notice of Claim" provision.) Any Co-Pay that applies should not be paid to the Out-of-Network Providers, as it will be deducted by Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any Co-Pay.

Covered Services or Materials
Covered Services or Materials are shown in the Schedule of Benefits. In order to be a Covered Service or Material, the services or materials must be provided to an Insured Person:

- To check or improve their vision condition;
- Within the allowable Frequency shown in the Schedule of Benefits; and
- By an Ophthalmologist, Optometrist, or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

- the actual cost incurred of the Covered Services or Materials; or
- the limits of coverage shown in the Schedule of Benefits.

Limited Access Area
If You live in a Limited Access Area and You receive Covered Services from an Out-of-Network provider, We will pay the same plan allowances as if You utilized an In-Network provider. It is important to note that You will be responsible for the difference between the billed amount and Our payment. Limited Access Area does not apply outside of the United States.

LIMITATIONS AND EXCLUSIONS

Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

Contact Lenses are payable in lieu of Eyeglass Lenses and Frames.

Dilation is covered in full under the Vision Exam benefit ONLY if required by state law or done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

Exclusions
No benefits are payable for any of the following conditions, services, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

- Replacement frames and/or lenses, except at normal intervals when Covered Services or Materials are otherwise available;
- Plano lens or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Frame cases;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Charges incurred after (a) the Policy ends; or (b) the Insured Person's coverage under the Policy ends, except as stated in the Policy;
- Any eye examination or corrective eyewear required by an Employer as a condition of employment;
- Services for which benefits are paid by Worker's Compensation;
- Blended bifocal lenses;
- Groove, Drill or Notch, and Roll and Polish;
- Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
- Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
- Cosmetic items;
- Faceted lenses;
- High-Index lenses;

- Laminated lenses;
- Oversize lenses – any lens with an eye size of 61mm or greater;
- Photochromic (Transition) lenses;
- Polaroid lenses;
- Polished bevel lenses;
- Polycarbonate lenses, except for Insured Members under 19;
- Prism lenses;
- Slab-off lenses;
- Tints (except Pink tint #1 and #2);
- Ultra-violet tint or coating;
- Additional cost for contact lenses over the allowance;
- Additional cost for a frame over the allowance;
- Progressive power lenses

No benefits are payable for services performed by a member of the Insured Person's family. Insured Person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents.

REVIEW OF CLAIM

If We send You a written statement denying Your claim in whole or in part, You may, within 60 days after Your receipt of such written statement, submit a written appeal to Us. A written decision with respect to the appeal shall be sent to You within 30 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.