UNITED HEALTHCARE INSURANCE COMPANY

GROUP VISION CARE INSURANCE

CERTIFICATE OF COVERAGE

FOR

ST OF NC STATE RETIREMENT SERVICES

GROUP NUMBER - 708788

Effective Date: January 1, 2008

Offered and Underwritten by
UNITED HEALTHCARE INSURANCE COMPANY

UnitedHealthcare®
A UnitedHealth Group Company

Document ID: 659080

UNITED HEALTHCARE INSURANCE COMPANY

A Stock Company

450 Columbus Boulevard, Hartford, Connecticut

Customer Service Phone#: 1-800-980-2965

GROUP VISION CARE INSURANCE CERTIFICATE

EMPLOYEE	As on file with the Policyholder
CERTIFICATE NUMBER	As on file with the Policyholder
COVERAGE EFFECTIVE DATE	As on file with the Policyholder
POLICYHOLDER	St of NC State Retirement Services
POLICY NUMBER	708788
ISSUED STATE	North Carolina

This Certificate certifies that you are covered under the Group Policy. This Certificate is not the Group Policy. It is evidence of your coverage under the Group Policy. Your coverage is subject to the provisions, terms and conditions of the Group Policy. Only the Group Policy governs the terms of your coverage. You may inspect the Group Policy at the Policyholder's office during normal business hours.

PLEASE READ YOUR CERTIFICATE CAREFULLY

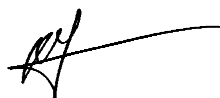
LIMITED BENEFIT COVERAGE

UNITED HEALTHCARE INSURANCE COMPANY

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

UNITED HEALTHCARE INSURANCE COMPANY



Michael J. McDonnell, Secretary

DEFINITIONS

Co-Payment - means the dollar amount You or Your Dependent is required to pay, if any, when a Service is rendered or Materials are purchased.

Dependent - means any of the following persons:

1. a legal spouse; and
2. any unmarried Child under the ages as shown on the Table of Benefits.

The term "Child" includes natural child, legally adopted child, stepchild, foster child, or any child who is under the custody of the Covered Person, and depends on the Covered Person for more than 50% of his support.

A child adopted or placed with You for adoption while the policy is in force shall be covered from:

1. the date of such adoption or placement, or
2. their date of birth, if the child is placed with You for adoption within 60 days of birth,

subject to the following requirements:

1. The child must be under age 18 at the time of adoption or placement.
2. "Placement" means physical placement in a covered person's care. If physical placement is prevented due to the medical needs of the child which requires placement in a medical facility, "placement" means when the covered person signs an agreement assuming financial obligation for the child.

Such coverage will continue, unless:

1. The child is removed permanently from that placement and the legal obligations ends; or
2. The covered person rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

A notice of adoption or of placement for adoption together with the additional premium must be submitted to Us. This must be done within 60 days after the date of such adoption or placement in order to continue coverage beyond the 60 day period.

To continue coverage for a disabled child, you must furnish proof of your child's disability no later than 31 days after the end of the Calendar Year in which the child turns age 19. To continue coverage each year, you must furnish proof to Us of your child's disability within 31 days after each successive birthday.

A full-time student means:

1. registered for day, non-correspondence courses;
2. school attendance at the rate of at least 36 weeks per academic year;
3. a subject load sufficient to attain the educational or training objective, when successfully completed; and
4. completion of the educational or training objective within the period generally accepted as a minimum for such objective.

Employee - means the person who:

1. meets all applicable eligibility requirements for vision care coverage; and
2. enrolls for vision care coverage; and
3. for whom the required premium has been received by Us.

Locations - means the offices of Network Providers.

Materials - means lenses, frames, low vision aids and contact lenses.

Network Provider - means any optometrist, ophthalmologist, optician or other person who may lawfully provide covered Services who has contracted, directly or indirectly with Us, to provide Services to You and Your Dependents of Our vision plans.

Policy - means the Group Vision Care Insurance Policy issued to the Policyholder.

Policyholder - means the person or entity to whom the Policy is issued.

Policy Term - means a period beginning on the Policy Effective Date and on each subsequent anniversary of such date.

Service - means an examination, Material selection, fitting of glasses and related adjustments.

We, Us, Our, the Company - means United HealthCare Insurance Company.

You, Your, Yours - means the Employee covered by the Policy.

ELIGIBILITY AND EFFECTIVE DATES

You will be eligible for coverage under the Policy when the following requirements have been met:

1. You have been continuously employed with the Policyholder beyond any applicable waiting period.

You will be eligible for Dependent coverage on the date You become eligible for coverage, or the date the Dependent is first acquired. If both persons are eligible employees under the Policy, only one (1) person will be considered eligible for Dependent coverage.

A child born to You or Your Dependent spouse is covered from the moment of birth for a period of 31 days. The child must be enrolled and any required additional Premium paid within the initial 31 days in order to continue coverage.

A child placed with You for adoption or foster care will be covered from the date of placement. To continue coverage, the child must be enrolled and any required additional Premium paid within 31 days after the date of placement.

TERMINATION PROVISIONS

TERMINATION BY US

We may terminate a Policyholder's coverage without notice when the Premium is delinquent and unpaid by the last day of the Grace Period.

TERMINATION BY POLICYHOLDER

A Policyholder may terminate their coverage by delivering written notice to Us at least 60 days prior to their Policy Renewal Date.

INDIVIDUAL TERMINATION AND CONTINUATION

Your coverage under the Policy will end on the earliest of the following:

1. The date You no longer comply with the eligibility requirements as set forth in the Eligibility section;
2. The date You fail to pay any required premium contribution to the Policyholder;
3. The last day when Premiums are delinquent and unpaid by the Policyholder; or
4. The last day of any time period during which written notice of termination has been provided Us by the Policyholder.

A Dependent shall no longer be covered by the Policy on the earliest of the following:

1. The date the Dependent no longer complies with the requirements of the Eligibility section of the Policy;
2. The date Your coverage is terminated.

If covered Services are in progress on the date which coverage terminates, such Services shall be completed. This provision will not apply if termination is the result of non-payment of Premiums.

BENEFITS

GENERAL INFORMATION

You will be provided with benefits for each of the listed Services and Materials at the frequency stated in the Table of Benefits. Your rights to Benefits are subject to the terms, conditions, exclusions of the Policy, including this Certificate, and any attached Amendments.

EXAMINATIONS

Coverage shall include a vision survey examination of the condition of the eyes and principal vision functions, to include:

1. a case history; and
2. examination for eye pathology and abnormalities.

Post examination procedures shall only be performed when Materials are required.

CONTACT LENSES

In lieu of eyeglasses, You may receive contact lens Services. The Services and Materials include contact lenses, fitting and examination as shown in the Table of Benefits.

Contact lenses are medically necessary if You or Your Dependent has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post cataract surgery without intraocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

NETWORK PROVIDERS LOCATIONS

To find a Network Provider, call the Provider Locator Service at 1-800-839-3242, enter Your postal zip code and a list of Network Providers will be provided. You may also access a listing of Network Providers on the Internet at www.myuhcvision.com.

LASER SURGERY

The benefit as shown in the Table of Benefits, which includes a complimentary eye evaluation and consultation to determine whether You or Your Dependent is a candidate for laser eye surgery.

GENERAL PROVISIONS

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. No such action shall be brought more than 3 years after the claim is required to be filed.

INCONTESTABILITY

The validity of the Policy cannot be contested, except for non-payment of premiums, after it has been in force for two (2) years from the effective date.

ASSIGNMENT

No assignment of the Policy is binding unless agreed to in writing. Such agreement is not valid until approved by Us.

CLAIMS

NOTICE OF CLAIM

Notice of claim as determined by Us must be given to Us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the patient. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

PAYMENT OF CLAIMS

Network Providers will accept Your Co-payment for covered Services and Materials at the time of appointment. Network Providers will not bill You for covered Services in excess of Co-payment.

Reimbursement for Services or Materials received from providers who are not Network Providers will be made directly to You.

EXCLUSIONS

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses;
2. Non-prescription items;
3. Medical or surgical treatment for eye disease, which requires the services of a physician;
4. Services or Materials for which the patient may be compensated under Worker's Compensation Law, or other similar employer liability law;
5. Services or Materials for the treatment of an Occupational Injury or Sickness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such Services or Materials are the liability of the Employee, employer or workers' compensation insurance carrier according to final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
6. Services and Materials which are not specifically covered by the Policy;
7. Replacement or repair of lenses and/or frames which have been lost or broken;

8. Cosmetic extras, except as stated in the Table of Benefits.

TABLE OF BENEFITS

Third Party Administrator: Spectera, Inc.

Claim Administrator: Spectera, Inc., Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Telephone No. 1-800-839-3242. Fax No. 1-248-733-6060.

THE EMPLOYEE AND DEPENDENT INSURANCE INCLUDED IN THIS CERTIFICATE APPLIES ONLY TO YOU AND YOUR DEPENDENTS IF YOU HAVE ELECTED, PAID PREMIUMS AND ARE INSURED FOR EMPLOYEE AND DEPENDENT INSURANCE

Dependent Eligibility:

Spouse

Children: from birth to age 19; from birth to age 25 if full-time student

Service	Frequency of Service	Network Provider Co-payment *	Out of Network Maximum Benefit
Vision Exam	Once every 12 months	$20.00	$64.00
Frames **	Once every 24 months	$20.00	$50.00
Lenses (Any one type)	Once every 12 months		
Single Vision		$20.00	$40.00
Bifocal Vision		$20.00	$60.00
Trifocal Vision		$20.00	$80.00
Lenticular Vision		$20.00	$80.00

*The Network Provider Co-payment will apply once if frames and lenses are purchased at the same time.

**Frames purchased from Network private practice Providers and Network retail optical Providers that are outside the covered eyeglass frames selection will have a frame allowance. The frame allowance for a private practice provider is $50.00 wholesale and for a retail optical provider is $130.00 retail.

Contact Lenses at a Network Provider: In lieu of lenses and a frame, you may select contact lenses after a Co-payment of $20.00. You will receive from the covered contact lens selection either one (1) pair of standard contact lenses or four (4) boxes of covered disposables when obtained from a Network Provider. When you elect contact lenses from a Network Provider that are not from the covered contact lens selection, the Co-payment does not apply. However, you will receive a $125.00 allowance that will be applied toward the evaluation, fitting and purchase of contact lenses once every 12 months. In order to receive the full allowance, you must receive your exam, fitting and evaluation at the same Network Provider.

Contact Lenses at an Out-of-Network Provider: In lieu of lenses and a frame, you may select contact lenses from an Out-of-Network Provider. We will pay a maximum benefit of $125.00 for elective contact lenses and $210.00 for necessary contact lenses. If your contact lenses are necessary the provider must submit for approval prior to dispensing the contact lenses.

Laser Eye Surgery: Access to discounted refractive eye surgery procedures from a Laser Network Provider.