Fidelity Security Life Insurance Company® of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101A
Brewster, New York 10509-2374

Administrative Office:
3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624

POLICY NUMBER:	VCN-19
POLICYHOLDER:	CASEBP - Edmeston Central School
POLICY EFFECTIVE DATE:	July 1, 2018
POLICY ANNIVERSARY DATE:	July 1 of the following year and each July 1 thereafter

Fidelity Security Life Insurance Company of New York represents that the Insured Person is insured for the benefits described in 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 Fidelity Security Life Insurance Company of New York at Brewster, New York on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Bradford R. Jones — President

Martha E. Madden — Secretary

The insurance evidenced by this Certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only or nursing home and home care insurance as defined by the New York State Department of Financial Services.

GROUP VISION INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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SCHEDULE OF BENEFITS ..... Attached (1A)

DEFINITIONS

Allowance means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the 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.

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

Comprehensive Eye Examination means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse, which includes a same sex partner to whom the Insured is legally married;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. each unmarried child at least 26 years of age who is chiefly dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap. Proof of such incapacity and dependency must be furnished to the Company within 31 days of the date the Dependent child would otherwise cease to be covered. The Company may require the same proof again but will not request it more than once a year after this coverage has been continued for two years.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

Formulary means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

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.

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

Medically Necessary Contact Lenses means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Out-of-Network Provider means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

Policy means the Vision Insurance 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 the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

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

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

Refraction means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials provided for visual health and welfare 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 toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes 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 becomes 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 becomes 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 Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force or if the Insured takes physical custody of a newborn child upon such child's release from the hospital and files a petition for adoption within 30 days, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. A proposed adopted child is eligible for coverage on the same basis as any natural child during any waiting period prior to the finalization of the child's adoption. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

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

In-Network Provider Benefits. The Insured Person must pay any Copayment 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 on behalf of the Insured Person.

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, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

LIMITATIONS

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

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 services provided as a result of any state or Federal workers' compensation, employers' liability or occupational disease law.

SERVICES AND MATERIALS NOT COVERED

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses;
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices;
12. 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; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

For All Insureds. The Insureds' insurance will cease on the earlier of:

1. the date the Policy is terminated. If the Company decides to stop offering a particular class of group policies, without regard to claims experience, to which the Certificate belongs, the Company will provide the Policyholder and Insureds at least 30 days' prior written notice;
2. the Policyholder has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid;
3. the date the Insured ceases to meet the eligibility requirements as defined by the Policyholder;
4. the Insured's death;
5. the end of the month during which the Policyholder or Insured provides written notice to the Company requesting termination of coverage, or on such later date requested for such termination by the notice;
6. if the Insured has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on the Insured's enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Company to the Insured;
7. the Policyholder has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage;
8. the Policyholder has failed to comply with a material plan provision relating to group participation rules. The Company will provide written notice to the Policyholder at least 30 days prior to when the coverage will cease;
9. the Policyholder ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. The Company will provide written notice to the Policyholder and Insured at least 30 days prior to when the coverage will cease; or
10. the date there is no longer any enrollee who lives, resides, or works in the PPO Service Area.

Termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination.

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

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application;
3. the end of the last period for which any required premium contribution has been made;
4. for Dependent spouses in cases of divorce, the date of the divorce;
5. upon the Insured's death, the last day of the month for which the premium has been paid; or
6. If the Insured has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on the Insured's enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Company to the Insured. If termination is a result of the Insured's action, coverage will terminate for the Insured and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

Extension of Benefits. Upon termination of insurance, whether due to termination of eligibility, or termination of the Policy or Certificate, an extension of benefits will be provided for Vision Materials ordered before the date of termination and received within 31 days of the date of termination.

Consolidated Omnibus Reconciliation Act Of 1985 (COBRA). The Company will continue coverage under the Policy for COBRA beneficiaries as requested by the Policyholder. An Insured or Insured Person who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the Insured is sent notice by first class mail of the right to continuation by the Policyholder.

Continuation of Coverage for Service in the Uniformed Services (USERRA). The Company will continue coverage under the Policy for Service in the Uniformed Services (USERRA) as requested by the Policyholder. The temporary continuation benefits terminate upon the earlier of 24 months from when the absence begins or the day after the date on which the Insured or Insured Person fails to apply for or return to a position of employment.

Provided the Insured or Insured Person serves more than 31 days the group can charge up to 102% of the group premium for the continued coverage.

No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

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

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

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Failure to give notice within such time will not invalidate or reduce any claim if it was not reasonably possible to give such notice and notice is given as soon as it 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 120 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.

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.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

Assignment. Benefits under the Policy may be assigned.

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

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 with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal

representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended with a minimum of 30 days prior written notice by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums or material misrepresentations. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest to void the insurance or reduce benefits unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

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

Translation Services. Translation services are available free of charge for non-English speaking Insured Persons. Please contact the Company at 1-888-249-5194 to access these services.

SCHEDULE OF BENEFITS

CASEBP - Edmeston Central School

BENEFIT FREQUENCY		
Vision Examination		
Comprehensive Eye Examination	once every 12 months	Insured Person
Vision Materials		
Frame	once every 12 months	Insured Person
Lenses	once every 12 months	Insured Person
Contact Lenses	once every 12 months	Insured Person

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** ***(Reimbursement up to)***
Vision Examination		
Comprehensive Eye Examination	$10 Copayment	$40
Vision Materials		
Frame	$0 Copayment up to $130 Allowance	$91
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses.		
Conventional	$0 Copayment up to $130 Allowance	$130
Disposable	$0 Copayment up to $130 Allowance	$130
Medically Necessary	Paid in Full	$300
Standard Plastic Lenses		
Single Vision	$10 Copayment	$30
Bifocal	$10 Copayment	$50
Trifocal	$10 Copayment	$70
Lenticular	$10 Copayment	$70
Progressive – Standard	$75 Copayment	$50
Progressive – Premium Tier 1	$95 Copayment	$50
Progressive – Premium Tier 2	$105 Copayment	$50
Progressive – Premium Tier 3	$120 Copayment	$50
Progressive – Premium Tier 4	$75 Copayment up to $120 Allowance	$50

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LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-28

The Policy provides limited benefits health insurance ONLY. The Policy does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

BENEFITS

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

In-Network Provider Benefits. The Insured Person must pay any Copayment 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 on behalf of the Insured Person.

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, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

LIMITATIONS

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

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 services provided as a result of any state or Federal workers' compensation, employers' liability or occupational disease law.

SERVICES AND MATERIALS NOT COVERED

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses;
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices;
12. 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; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

This disclosure statement is a very brief summary of the Insured Person's coverage under the group Policy.

The Certificate of Insurance sets forth the rights and obligations of both the Insured Person and the Company. It is therefore important that you READ YOUR CERTIFICATE carefully.

The expected benefit ratio for this coverage is 65%. This ratio is the portion of future premiums that the Company expects to return as benefits, when averaged over all people with this coverage.

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LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-28

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THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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7. non-prescription sunglasses;
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9. plano (non-prescription) contact lenses;
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12. 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; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

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The expected benefit ratio for this coverage is 65%. This ratio is the portion of future premiums that the Company expects to return as benefits, when averaged over all people with this coverage.