UNITED HEALTHCARE INSURANCE COMPANY

GROUP VISION CARE INSURANCE

CERTIFICATE OF COVERAGE

FOR

MIAMI-DADE COUNTY PUBLIC SCHOOLS

GROUP NUMBER - 718223

Effective Date: January 1, 2010

Offered and Underwritten by
UNITED HEALTHCARE INSURANCE COMPANY

UnitedHealthcare®
A UnitedHealth Group Company

UNITED HEALTHCARE INSURANCE COMPANY

A Stock Company

450 Columbus Boulevard, Hartford, Connecticut

Phone: 1-800-638-3120

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	Miami-Dade County Public Schools
POLICY NUMBER	718223
ISSUED STATE	Florida

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

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-800-638-3120

If you need information about your insurance, or should any dispute arise about your premium or about a claim that you have filed, call Us at the toll-free number listed above.

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 (shall also include Domestic Partner); and
2. any 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. A Child can be either a full-time or a part-time student or living in the household of the Employee.

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.

The term "Domestic Partner" means a person of the opposite or same sex with whom the Covered Person has established a Domestic Partnership.

The term "Domestic Partnership" means a relationship between a Covered Person and one other person of the opposite or same sex. All of the following requirements apply to both persons:

1. they must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
2. they must not be currently married to, or a Domestic Partner of another person under either statutory or common law.
3. they must share the same permanent residence and the common necessities of life.
4. they must be at least 18 years of age.
5. they must be mentally competent to consent to contract.
6. they must be financially interdependent and have furnished documents to support at least three of the following conditions of such financial interdependence:
    a. they have a single dedicated relationship of at least six months duration.
    b. they have joint ownership of a residence.

c. they have at least two of the following:

- a joint ownership of an automobile;
- a joint checking, bank or investment account;
- a joint credit account;
- a lease for a residence identifying both partners as tenants; or
- a will and/or life insurance policies, which designates the other as primary beneficiary.

7. the Covered Person and the Domestic Partner must jointly sign the required Affidavit of Domestic Partnership.

To continue coverage for a disabled child beyond the limiting age for children as specified in the Table of Benefits, the child must be incapable of self-sustaining employment by reason of mental retardation or physical handicap and be chiefly dependent upon You for support and maintenance.

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 must customarily work at least the number of hours per week shown on the Table of Benefits.
2. If You are not actively at work on the Effective Date of coverage, coverage will become effective on the first day of the month following Your return to active employment.
3. You have been continuously employed with the Policyholder beyond any applicable waiting period as shown on the Table of Benefits.

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 or a child born to a covered family member is covered from the moment of birth for a period of 60 days. To continue coverage, the child must be enrolled within 60 days after the date of birth.

A child placed with You for adoption, foster care or children in custody will be covered from the date of placement. Also, a child placed with You for adoption will be covered from birth provided You have a written agreement to adopt such child prior to the birth of such child. To continue coverage, the child must be enrolled within 60 days after the date of placement or birth.

TERMINATION PROVISIONS

TERMINATION BY US

We will mail a written notice within 45 days of the premium due date in order for Us to terminate coverage retroactive to the premium due date, when 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 end of the month 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 end of the month 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 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 applicable statute of limitations 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.

All statements made by the Policyholder and by You are representations and not warranties. No statement made by You will be used to contest the coverage provided by the Policy; unless:

1. It is contained in a written statement signed by You and
2. A copy of the statement is furnished to You or a beneficiary.

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.

PROOF OF LOSS

If the Policy provides for periodic payment of a continuing loss, written proof of loss must be given the insurer within 365 days after the end of each period for which We are liable. For any other loss, written proof must be given within 365 days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

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.

We will pay immediately all benefits due under this Policy. If We fail to respond to Your claim within 45 working days of receipt of proof of loss, We must mail You a letter or notice explaining why your claim or any part has not been paid. If we requested additional information to pay the claim, We have 60 working days to either pay or deny the claim. If We do not meet the above conditions, We must pay you 10% interest per year. This applies only to benefits for which the above time limits have not been met.

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 is paid under Worker's Compensation Law, or other similar employer liability law;
5. Services or Materials which the patient, without cost, obtains from any governmental organization or program;
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

Class of Employees: Employees must customarily work at least 20 hours per week to be eligible for coverage.

Employee Waiting Period: Active employees - Date of hire; Temporary teachers - First day following 30 days of employment.

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Dependent Eligibility:

Spouse or Domestic Partner

Children: birth to the end of the calendar year in which the child attains 30 years of age

Service	Frequency of Service	Network Provider Co-payment *	Out of Network Maximum Benefit
Vision Exam	Once every 12 months	$0.00	$40.00
Frames **	Once every 12 months	$10.00	$45.00
Lenses (Any one type)	Once every 12 months		
Single Vision		$10.00	$40.00
Bifocal Vision		$10.00	$60.00
Trifocal Vision		$10.00	$80.00
Lenticular Vision		$10.00	$80.00

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*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 Covered Frame 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.

Cosmetic Lens Extras: The following cosmetic lens extras are covered in full:

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Scratch-resistant coating

Polycarbonate lenses

Contact Lenses at a Network Provider: In lieu of lenses and a frame, you may select contact lenses after a Co-payment of $10.00. You will receive from a 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 a Covered Contact Lens Selection, the Co-payment does not apply. However, you will receive a $105.00 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 $105.00 for elective contact lenses and $175.00 for necessary contact lenses. If your contact lenses are necessary the provider must submit to Us for approval prior to dispensing the contact lenses.

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