



**NATIONAL GUARDIAN LIFE INSURANCE COMPANY
(We, Our and Us)**

VISION CARE

GROUP POLICY

POLICYHOLDER: North Dakota Public Employees Retirement System
(NDPERS)

GROUP POLICY NUMBER: 29854

EFFECTIVE DATE: January 1, 2011

ANNIVERSARY DATE: January 1

JURISDICTION: North Dakota

PREMIUM DUE DATE: 1st of every Month

COVERAGE PROVIDED: Employees working a minimum of 20 hours per week upon
the first day of the month following month of employment.

INITIAL TERM: 48 months

Underwritten by National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: 
Superior Vision Services, Inc.
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

Vision Benefit Manager: 
Superior Vision Services, Inc.
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

TABLE OF CONTENTS

DEFINITIONS	3
TERM AND TERMINATION	5
Insurance Provided	5
ELIGIBILITY DETERMINATION	6
Identification Card	6
Dependents	6
Coordination of Benefits	6
COVERED SERVICES AND MATERIALS	9
Vision Examination	9
Standard Eyeglass Lenses Benefit	9
Eyeglass Frame Benefit	9
Contact Lenses Benefit	10
CHOICE OF PROVIDERS	10
LIMITATIONS AND EXCLUSIONS	10
Limitations	10
Not Covered	11
GENERAL PROVISIONS	11
PREMIUMS	12
RENEWAL PROVISIONS	13
Termination of Policy - Services Being Rendered	13
Withdrawal From Elective Plans	13
Individual Continuation of Coverage	13
Basis for Terminating Policy	13
Cancellation	13
CLAIMS PROVISIONS	13
GRIEVANCE PROCEDURE	14

DEFINITIONS

Calendar Year Plan - means benefits begin anew on January 1 of each Calendar Year. For persons enrolled other than on January 1, of a given Calendar Year, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Calendar Year with full twelve (12) month benefits becoming effective January 1 of the next Calendar Year.

Claim Form - A form provided by Us for the purpose of determining eligibility and claim payment.

Copay Amount - An Insured's share of costs, paid to the Contracting Provider at the time the services are rendered. Copay Amounts that apply to the various vision benefits are listed in the Certificate of Coverage Benefits Summary.

Elective Plan - A plan in which individual Employees may elect whether they choose to participate.

Employee - The individual employed by the Policyholder.

Employer - The entity for whose Employees or Members vision care benefits are being provided.

Group - The aggregate of Employees which is eligible to be the recipient of benefits under the Policy.

Immediate Family Member - An Insured's parent, step-parent, spouse, child, step-child, brother or sister.

Initial Term - The forty-eight (48) month period following the group's initial effective date. Rates are guaranteed not to change during this period.

Insured - The Member and Insured Dependents if dependent coverage is provided by the Employer participating in the program.

Late Entrant - Is any active eligible employee or eligible dependent enrolling more than thirty-one (31) days after first becoming eligible for coverage. Benefits are limited for Late Entrants under Limitations.

Materials - Eyeglass lenses, frames, contact lenses.

Member - An Employee who became insured under the policy.

Network or Contracting Provider - An Ophthalmologist, Optician or Optometrist who has elected to enter into a contract with the Vision Benefit Manager and who is listed in the Provider Directory.

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, who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optical Necessity - Situation when a prescription or a change of prescription is required to correct visual function.

Optician - A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an Optometrist or an Ophthalmologist, who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optometrist - A person licensed to practice optometry as defined by the laws of the state in which his or her services are rendered, who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Orthoptics - The teaching and training process for the improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

Out-of-Network Provider - An Ophthalmologist, Optician or Optometrist who has elected not to enter into a contract with the Vision Manager and who is not listed in the Provider Directory.

Plan - The coverage and benefits provided by the Policy to the Insured.

Policyholder - The entity that contracts with Us on behalf of its Members.

Policy Year Plan - means benefits begin immediately on the Policyholder's effective date and renew twelve (12) months following the initial effective date. For persons enrolled on other than the Policyholder's initial effective date or a subsequent Plan anniversary, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Plan Year with full twelve (12) month benefits becoming effective on the next Plan anniversary of the next Calendar Year.

Professional Service - Examination, material selection, fitting of glasses, related adjustments, etc.

Re-enrollee - Any active Member or dependent who was covered under the policy, terminated his coverage, and then subsequently re-enrolled for coverage at a later date.

Standard Lenses - Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top thirty-five (35) for plastic bifocal and lenticular lenses, glass trifocals through flat top twenty-eight (28) plastic trifocals through flat top thirty-five (35).

Sub-Normal Optical Correction - means vision is not correctable to better than twenty/seventy (20/70) in the better eye by the use of conventional lenses.

The Administrator - The entity which will provide complete claims service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Usual, Customary and Reasonable - means the lesser of: (a) the reasonable charges the provider charges for a vision service or supply; or (b) the customary charge for the vision service or supply. We will determine the customary charge from within the range of charges made for such vision service or supply by other providers of similar training and experience in that general geographic area.

Vision Benefit Manager - The entity which will provide a network of Network Providers and claims payment services as agreed to in a contract with The Administrator.

Vision Examination - An examination of principal vision functions. A Vision Examination 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 will be consistent with the community standards, rules and regulations of the jurisdiction in which the Contracting Provider practice is located.

GROUP VISION CARE POLICY

The Company providing this insurance designated in the Application herein is called the Company, We, Our and Us.

The Company shall arrange to provide a panel of Providers to perform services to the Insured, as described under "Eligibility Determination", subject to the terms and conditions of the Policy.

TERM AND TERMINATION

The Policy shall be effective commencing on the Effective Date for the Initial Term and continuing until terminated by either party giving the other sixty (60) days prior written notice. The Policy shall terminate at midnight, the last day of the month for which the notice has been given.

INSURANCE PROVIDED

In consideration of the payment of premium and the application, We agree to provide the insurance as specified in the Policy (including forms and endorsements made a part hereof) with respect to those coverages and to those premises designated in the Application.

The insurance provided is subject to all of the provisions of the Policy relating to the limits of Our liability, and to the exclusions, definitions, conditions, and other terms hereof.

All periods of insurance under the Policy will begin and end at midnight at the address of the Policyholder.

The Policy will be governed by and construed under the laws of the Jurisdiction shown on the cover page.

Signed for the Company:



Sherri Kliczak, Secretary



John Larson, President

ELIGIBILITY DETERMINATION

For purposes of the Policy, Eligible Employees shall be defined as all full-time Employees of the Employer who work at the Employer's normal place of business. Employees who work twenty (20) or more hours per week are able to participate in Elective Plans upon the first day of the month following month of employment.

IDENTIFICATION CARD

We will issue Eligible Employees an identification card showing Employee's name, Member I.D. number and other information about the Plan required to gain access to Network Provider discounts.

DEPENDENTS

Dependents: If dependent coverage is provided under the Policy, dependents eligible shall be covered who have not attained their 23rd birthday or their 26th birthday if attending an accredited college, university or at a vocational, technical, vocational-technical or trade school or institute or secondary school full-time. Dependents eligible for coverage shall be the Member's spouse and the Member's or spouse's unmarried dependent children, adopted (or in the process thereof) children when placed in the Member's home, and children for which the Employee or spouse are required to provide medical support by a valid order issued pursuant to state or federal law.

An unmarried child age 23 or over may continue to be eligible as a dependent if the child is:

1. Incapable of self-sustaining employment by reason of mental or physical handicap, and
2. Chiefly dependent upon the Member for support and maintenance.

PROVIDED, HOWEVER, proof of such incapacity and dependency is furnished to Us by the Member within thirty-one (31) days of the request for such information by Us, and subsequently as may be required by Us but not more frequently than annually.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to This Plan when an Insured Person has health care coverage under more than one (1) Plan. **Plan** and **This Plan** are defined below. This provision will only apply for the duration of Your employment with the Employer.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- a. Shall not be reduced when This Plan determines its benefits before another Plan; but
- b. May be reduced when another Plan determines its benefits first.

1. Definitions

- a. **Plan** is any of these which provides benefits or services for, or because of, medical or vision care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

- b. **This Plan** is the part of the Policy that provides benefits for health care expenses.
- c. **Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two (2) Plans covering the person, This Plan may be a Primary Plan as to one (1) or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- d. **Allowable Expense** means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one (1) or more Plans covering the Insured for whom claim is made.

When benefits are reduced under a Primary Plan because an Insured does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense.

- e. **Claim Determination Period** means a Policy Year. However, it does not include any part of a year during which an Insured has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

2. **Order of Benefit Determination Rules**

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- a. The other Plan has rules coordinating its benefits with those of This Plan; and
- b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-Dependent/Dependent - The benefits of the Plan which covers the Insured as an Employee, member or subscriber are determined before those of the Plan which covers the Insured as a Dependent; except that: if the Insured is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
 - (1) Secondary to the Plan covering the Insured as a Dependent and
 - (2) Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired Employee),

then the benefits of the Plan covering the Insured as a dependent are determined before those of the Plan covering that Insured Person as other than a Dependent.

- b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph three (3) below, when This Plan and another Plan cover the same child as a dependent of different persons, called parents:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (2) If both parents have the same birthday, the benefits of the Plan which covered one (1) parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in “a.” immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. Dependent Child/Separated or Divorced - If two (2) or more Plans cover an Insured as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody;
- (3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall follow the order of benefit determination rules outlined in Paragraph two (2).
- e. Active/Inactive Employee - The benefits of a plan which covers an Insured as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Insured as a laid off or retired Employee. The same would hold true if an Insured is a Dependent of a person covered as a retiree and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. Continuation Coverage - If an Insured whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - (1) First, the benefits of a Plan covering the Insured as an Employee, member or subscriber (or as that Insured);
 - (2) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- g. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Insured for the shorter term.

3. **Effect On the Benefits of This Plan**

This Section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this Section.

The benefits of This Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

4. **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit Plan administrator with whom We coordinate benefits.

5. **Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. **Right to Recovery**

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one (1) or more of:

- a. The persons We have paid or for whom We have paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COVERED SERVICES AND MATERIALS

The amount of Vision Benefits payable hereunder and the manner of payment is determined by whether the Insured utilizes the services of a Network Provider or an Out-of-Network Provider.

The Insured will receive an identification card or cards for use while covered under this Policy. The Policyholder shall submit to the Administrator on a monthly basis, a list of all Insured. When the Insured incurs the services of a Network Provider, such Insured may be required to present the program on the identification card to the Network Provider. The Network Provider will submit the information on the identification card electronically and may: (1) verify eligibility; and (2) notify the Insured of any out-of-pocket expenses.

If the Insured incurs the services of an Out-of Network Provider, such Insured will be required to pay the full cost of such services at the time of the purchase.

Vision Examination Benefit. If an Insured incurs expenses for a Vision Examination, We will pay such expenses up to the applicable Vision Examination Maximum Benefit shown in the Certificate of Coverage, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Policy; and 2) the Insured has paid any applicable Copay Amount, as shown in the Certificate of Coverage. Benefits will be payable at the Vision Examination Benefit Frequency shown in the Certificate of Coverage.

Standard Lenses Benefit. If an Insured incurs expenses for Standard Lenses, We will pay such expenses up to the Standard Lenses Maximum Benefit shown in the Certificate of Coverage subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Policy; and 2) the Insured has paid any applicable Copay Amount, as shown in the Certificate of Coverage. Benefits will be payable at the Standard Lenses Benefit Frequency shown in the Certificate of Coverage.

Eyeglass Frame Benefit. If an Insured incurs expenses for eyeglass frames, We will pay such expenses up to the applicable Eyeglass Frame Maximum Benefit shown in the Certificate of Coverage, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Policy; and 2) the Insured has paid any applicable Copay Amount, as shown in the Certificate of Coverage. Benefits will be payable at the Eyeglass Frame Benefit Frequency shown in the Certificate of Coverage.

Contact Lenses Benefit. If an Insured incurs expenses for contact lenses, We will pay such expenses up to the applicable Contact Lenses Maximum Benefit shown in the Certificate of Coverage, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Policy; 2) the Insured has paid any applicable Copay Amount, as shown in the Certificate of Coverage; and 3) the Contact Lenses are due to an Optical Necessity.

In addition to the above, benefits will not be payable for expenses incurred for Sub Normal Optical Correction, unless: 1) the Network or Out-of-Network Provider of such services, makes a request, in writing, to the Vision Benefit Manager that a special contact lens or lenses is necessary to achieve the best possible correction for the Insured; and 2) the Vision Benefit Manager, upon review of such request, approves the request. Benefits will be payable at the Contact Lenses Benefit Frequency and amount shown in the Certificate of Coverage.

CHOICE OF PROVIDERS

The Policy provides an Insured with a choice of Providers. They may receive vision care services and Materials from a Network Provider or may choose an Out-of-Network Provider, in which case services may be secured from any Optometrist, Ophthalmologist and/or dispensing Optician. We will reimburse according to the Benefit Summary as specified in the Certificate of Coverage.

PROCEDURES FOR USING BENEFITS

1. The Insured presents their Identification Card when visiting a provider. Insured's may locate Network Providers in their area by calling the toll-free number listed on the Identification Card.
2. The Insured presents their Identification Card at the time of service and pay any Copay Amount and other charges not covered at the time of service. No paperwork is required at Network Providers.
3. If Insured selects an Out-of-Network Provider, full payment is given to the provider at the time of service. Original invoices including an itemized statement of charges and your prescription must be sent to The Administrator in order for the Insured to be reimbursed:

Superior Vision Services, Inc.
PO Box 967
Rancho Cordova, CA 95741

LIMITATIONS AND EXCLUSIONS

The Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and Eyeglass Frame Benefit. An Insured shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

The Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit is payable in lieu of the Contact Lenses Benefit. An Insured shall be eligible to receive benefits under the Contact Lenses Benefit only after the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit Frequency has ended.

In no event will coverage exceed the lesser of:

1. the actual cost of insured Services or Materials; or
2. the limits of the coverage shown in the Certificate of Coverage Benefits Summary.

Materials paid for under the Policy that are lost or broken will only be replaced at normal intervals when other Services are available.

Vision – Late Entry Benefit: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first twenty-four (24) months after the Late Entrant's or Re-Enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents if enrolled.

NOT COVERED

THERE IS NO COVERAGE FOR PROFESSIONAL SERVICES OR MATERIALS CONNECTED WITH:

1. Professional Services and/or Materials in connection with:
 - a) blended bifocals, no line, or progressive addition lenses.
 - b) compensated or special multi-focal lenses.
 - c) plain (non-prescription) lenses.
 - d) anti-reflective, scratch, UV400, or any coating or lamination applied to lenses.
 - e) Subnormal Visual Aids.
 - f) tints other than solid.
 - g) Orthoptics, vision training and developmental vision procedures.
 - h) polycarbonate lenses.
2. Medical or surgical treatment of the eyes.
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses. Although no-line bifocals and blended lenses are not covered, an Insured may elect to apply the maximum allowance for Standard Lenses toward his or her cost of progressive lenses.
6. Sub-normal vision aids.
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a) the Member resides in the U.S. or Canada; and
 - b) the charges are incurred while on a business or pleasure trip.
8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials.
9. Experimental or non-conventional treatment or device.
10. Safety eyewear.
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary in the Certificate of Coverage.
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
13. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Policy, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured Person within thirty-one (31) days from the date of such order.
15. Services rendered or Materials ordered before the date coverage began under this Policy.

Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Certificate of Coverage.

GENERAL PROVISIONS

1. Under the provisions of the Policy, We act as a contracting agency to enable the Group and Insured to acquire professional vision care on a discounted basis. Under no circumstances shall We or the Policyholder be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with the Policy.
2. All notices provided hereunder shall be deemed to have been properly made upon depositing the same in the United States mail, postage prepaid, and addressing such notices to Us at Our main office, or to the Administrator, at least thirty (30) days prior to said action taking effect. Group agrees to cooperate with Us in disseminating to its Members those disclosure forms, plan summaries or other materials that may be required to be disseminated to the Members. It is understood that any such material required to be disseminated shall be delivered to the Policyholder by Us, and disseminated by Policyholder to Members no later than thirty (30) days after the receipt thereof.

3. If any provision of the Policy is declared invalid or unenforceable, the remaining provisions hereof shall remain in full force and effect. The failure of either party to protest any default or breach shall not constitute a waiver of such party's rights under the Policy, or such party's rights upon any subsequent default or breach.
4. The Policy is not assignable, except with Our prior consent.
5. Entire Contract. The Policy, all applications of the Insured and the application of the Policyholder, a copy of which is attached hereto, make up the entire contract between the parties. All statements made by the Policyholder or by the Insured are deemed representations and not warranties. No such statement will be used in any contest under the Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person or his beneficiary, if any.
6. Changes. None of the terms of the Policy may be modified or waived, except by an agreement in writing signed by an officer of the Company. We may amend the Policy or change it at any time, subject to the laws of the jurisdiction in which it is delivered. The consent of the Insured or other beneficiaries, if any, is not needed. No change in the Policy will be valid unless evidenced by amendment to the Policy signed by Us.
7. Our Right to Contest. 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 its effective date. No statement, except for a fraudulent misstatement, made by any Insured relating to his insurability will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two (2) years during such Insured's lifetime nor unless it is contained in written instrument, signed by him, and a copy of such instrument is or has been furnished to him or his beneficiary.
8. We will give a certificate to the Policyholder for delivery to each Member. It will contain the essential features of the insurance to which the Member is entitled and to whom benefits are payable.
9. The Policy is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.
10. We shall have the right at all reasonable times to inspect such records of the Policyholder as we deem necessary to determine the number and eligibility of the Insured, and the Policyholder agrees to make such records available at such times and upon such requests.
11. The Policy does not share in the Company's surplus earnings.
12. If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

PREMIUMS

Premium Payments: Premiums will be payable by the Policyholder to Us for the coverage provided under the Policy. Premium payments are due on the first day of each consecutive calendar month.

Grace Period: If the Policyholder has not given written notice to Us that the coverage under the Policy is to be terminated at least sixty (60) days prior to the premium due date, a grace period of thirty-one (31) days will be allowed for any premium due after the first premium. If the Policyholder fails to pay such premium before the end of the grace period all coverage will lapse as of the last date of the grace period. The policyholder will be liable to Us for payment of the pro-rata premium for the time the policy was in force during such grace period.

Change in Premiums: We have the right to change the premium rates after the Initial Term shown on the face page of this Policy and not more than once in any six (6) month period following the Initial Term. We will notify the policyholder in writing at least forty-five (45) days before any increase in policy rates.

Misstatement of Age: If the age of any Insured has been misstated and the amount of insurance would be affected by such misstated age, the amount of insurance will be adjusted to amount which the Insured would have been entitled at his correct age and the premiums will be based on the adjusted amount.

RENEWAL PROVISIONS

TERM AND TERMINATION CONDITIONS OF THE POLICY ARE SHOWN ON PAGE FIVE (5) OF THE POLICY.

After the Initial Term of the Policy, the Policy shall continue on a "month-to-month" basis automatically renewing the first day of each month unless proper notice has been given in accordance with the cancellation conditions shown on page five (5) of the Policy.

When We initiate a premium increase, the date said premium increase is to take effect shall become the Policy renewal date.

TERMINATION OF POLICY - SERVICES BEING RENDERED

If service for an Insured hereunder is being rendered as of the termination date of the Policy, coverage shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

WITHDRAWAL FROM ELECTIVE PLANS

Once a Member and/or dependent elects to participate in the Plan, withdrawal from the Plan typically is during open enrollment periods. However, a Member may withdraw his application prior to open enrollment. If a Member enrolls in the program and then withdraws and then subsequently reenrolls, the Member will be subject to late enrollment benefits in accordance with the late entry benefit shown on page ten (10).

INDIVIDUAL CONTINUATION OF COVERAGE

The Group Vision Care Policy is available to voluntary groups of a minimum of two hundred fifty (250) Employees and employer-funded groups of ten (10) and is, therefore, not available on an individual basis. When a Policyholder terminates coverage, individual coverage is not available for Members who may desire to retain same.

BASIS FOR TERMINATION OF POLICY

1. Failure of the Policyholder to make payment to Us as outlined under the "Premiums" section of the Policy, or
2. The Policyholder falls below minimum size requirement. However, in the event the Policyholder falls below the minimum size, the Group may continue receiving benefits under this Policy by making premium payment to the Company at the minimum Group size.

Terminating Members are dropped as reported by their Employer with thirty (30) days notice to Us.

CANCELLATION

In the event of cancellation of the Policy by Us or the Policyholder, We shall within thirty (30) days return to Policyholder the pro rata portion of the money paid to Us which corresponds to any unexpired period for which payment has been received, if any, less any amounts due to Us.

CLAIMS PROVISIONS

Notice of Claim: Written notice of claim must be given to Us within twenty (20) days of the date such loss begins. Notice must be given to Us with enough information to identify the Insured. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give notice within such time. However, the notice must be given as soon as reasonably possible.

Claim Forms: We will provide Claim Forms upon request of the Insured, or when We receive notice of a claim. If the forms are not given within fifteen (15) days, the Insured can submit written proof covering the occurrence, character and extent of loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us not later than ninety (90) days after the date of such loss. Failure to give such proof within such time will not invalidate nor 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, but in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the date of time such proof is otherwise required.

Physical Exam: We, at Our own expense, will have the right and opportunity to examine the person whose loss is the basis of a claim under the Policy when and so often as may be reasonably required while the claim is pending.

Time of Payment of Claim: Subject to due proof of loss, benefits provided by the Policy will be paid immediately, but not more than fifteen (15) days after receipt of such due written proof. After receipt of written proof of loss form, We shall, within fifteen (15) business days, pay the claim or that portion of the claim that is not contested, deny the claim, or make an initial request for additional information. If a claim or a portion of a claim is contested, the Insured Person or the Insured Person's assignee shall be notified in writing that the claim is contested and the reasons for the contest.

Legal Proceedings: No action at law or in equity may be brought to recover on the Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of one (1) year after the time proofs of loss are required to be filed.

Grievance Procedure

If a claim for benefits is wholly or partially denied, the Member will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice a Member may file a grievance and make a written request for review to:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
PO Box 967
Rancho Cordova, CA 95741

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Member or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Member will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of a Member regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Member.

In situations requiring urgent care, grievances will be resolved within seventy-two (72) hours of receiving the grievance.