NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(called "We", "Our", and "Us")

2 East Gilman Street, Madison, Wisconsin 53701

GROUP VISION CARE INSURANCE CERTIFICATE

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
Rancho Cordova, CA 95670

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Kimberly A. Shaul, Secretary **Mark Solverud, President**

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number: P.O. Box 967, Rancho Cordova, CA 95741 • 1-800-507-3800.

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at P.O. Box 1157, 1300 E. Main Street, Richmond, VA 23219. You may also call the Bureau at (804) 371-9691 (local), (800) 552-7945 (VA toll-free) or (877) 310-6560 (out-of-state toll-free).

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

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PART I. CERTIFICATE SCHEDULE

Policyholder:	Westmoreland County Public Schools
Group Policy Number:	35229
Effective Date:	October 1, 2016
Initial Term:	48 Months
Eligible Classes	All employees working at least 20 hours per week
Waiting Period:	1st of the month following date of hire
Mode of Premium Payment:	MONTHLY
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Rolling Benefit Plan Basis	
Vision Exam:	Once every 12 Months
Eyeglass Lenses:	Once every 12 Months
Frames:	Once every 12 Months
Contact Lenses:	Once every 12 Months
Contact Lens Fit:	Once every 12 Months

CO-PAY (PER INSURED)		
	In-Network Providers:	Out-of-Network Provider:
Vision Exam:	$10	$10
Eyeglass Lenses/Frames:	$25	$25
Contact Lens Fit:	$25	Not Covered

BENEFITS AND ALLOWANCES [1]		
	In-Network Providers: [2]	Out-of-Network Provider:
Vision Exam:		
Ophthalmologist (M.D.)	Covered in Full	$34 Allowance
Optometrist (O.D.)	Covered in Full	$26 Allowance
Materials- Eyeglass Lenses: [3]		
Single Vision	Covered in Full	$29 Allowance
Progressive	Covered up to the providers retail trifocal amount	$53 Allowance
Bifocals	Covered in Full	$42 Allowance
Trifocals	Covered in Full	$53 Allowance
Lenticular	Covered in Full	$84 Allowance
Materials – Frames: [3]	$150 Allowance	$70 Allowance
Materials – Contact Lenses: [4]		
Non-Elective	Covered in Full	$210 Allowance
Elective	$150 Allowance	$100 Allowance
Contact Lens Fit:		
Standard	Covered in Full	Not Covered
Specialty	$50 Allowance	Not Covered

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

[2] If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network allowance.

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

[4] The Contact Lenses Benefit is paid in lieu of Eyeglass Lenses and Frames.

PART III. DEFINITIONS

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

Claim - A request for payment of benefits under this Certificate.

Co-Pay – An Insured's share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. If an Out-of-Network Provider is used, the Co-Pay will be deducted from the Out-of-Network Allowance at the time We pay benefits. Co-Pay amounts are listed in the Schedule of Benefits.

Contact Lenses, Elective – Elective contact lenses refer to contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

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

1. Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective Contact Lenses for this condition.
2. When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
4. Keratoconus.

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of an In-Network Provider. This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Services or Materials – Means the Vision Exam services and Materials that qualify for benefits under the Group Policy. Covered Services or Materials are shown in the Schedule of Benefits.

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Waiting Period, if any.

Eligible Dependent - Means a person listed below:

1. Your spouse;
2. Your unmarried dependent child under age 19, who is Your natural or adopted child, step-child, foster child, or child for whom You are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child age 19 or older but less than age 26 who is:
   a. Not regularly employed on a full-time basis;
   b. Primarily dependent upon You for support and maintenance; and
      (i) Enrolled as a full-time student in an accredited educational institution or licensed trade school; or
      (ii) Enrolled as a full-time student in an accredited educational institution or licensed trade school and is unable to continue school as a full-time student because of a medical condition. This coverage shall end 12 months from the date child ceases to be a full-time student or until child attains age 26, whichever occurs first. Child's treating physician must certify that the absence is medically necessary.

4. Your unmarried child who is age 19 or older and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.
   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

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

He, Him and His – Refers to the male or female gender.

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

Initial Term - The period following the group's initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period.

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

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

Insured – Means You (the Insured Member) and each Covered Dependent.

Insured Member– Means a person:
1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Waiting Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the section titled "Limitations."

Materials – Means corrective Eyeglass Lenses, Frames and Contact Lenses.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

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

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

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

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

Plano Lens - A lens that has no refractive power.

Policyholder - The entity stated on the front page of the Policy.

Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

Rolling Benefit Plan – Benefits begin anew twelve (12) months from the date of service.

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

You or Your – The Insured Member.

Waiting Period - The period of time a Member must wait before He is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

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

1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

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

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, enrollment will default to the Policyholder's rules.

B. ENROLLMENT

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

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

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year buy may, at the Policyholder's discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

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

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within thirty-one (31) days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;

4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the date specified by the Policyholder. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

PART VI. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date He is no longer an Eligible Dependent;
2. the date We receive Your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

Incontestability. Your coverage under the Policy will be incontestable, except for non-payment of premium, after it has been in force for two years. No statement made by You relating to Your insurability or the insurability of Your covered Dependents will be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and
2. Unless the statement is contained in a written instrument signed by such person.

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. We may require payment of any pro-rata premium for the time the insurance was in effect during the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a twelve (12) month period. We will give the Policyholder written notice at least forty-five (45) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

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

A. IN-NETWORK BENEFITS

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

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

Note Exception: If You use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that You pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

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

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

B. OUT-OF-NETWORK BENEFITS

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

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

C. COVERED SERVICES OR MATERIALS

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

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

In no event will coverage exceed the lesser of:

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

PART IX. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. An Insured is eligible to receive benefits under the Contact Lenses benefit only after the Eyeglass Lenses benefit Frequency has ended.

Coverage for a Late Entrant or Re-Enrollee is limited to the Vision Exam benefit during the first twenty-four (24) months after such person's effective date of coverage.

B. EXCLUSIONS

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

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;
11. Services for which benefits are paid by Worker's Compensation;
12. Benefits provided under the employee's medical insurance except in the case of Coordination of Benefits;
13. Blended bifocal lenses;
14. Groove, Drill or Notch, and Roll and Polish;
15. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
17. Cosmetic items;
18. Faceted lenses;
19. High-Index Lenses;
20. Laminated Lenses;

21. Oversize Lenses – any lens with an eye size of 61mm or greater;
22. Photochromic (Transition) lenses;
23. Polaroid lenses;
24. Polished bevel lenses;
25. Polycarbonate lenses;
26. Prism lenses;
27. Slab-off lenses;
28. Tints (except Pink tint #1 and #2);
29. Ultra-violet tint or coating;
30. Additional cost for contact lenses over the allowance;
31. Additional cost for a frame over the allowance;
32. Progressive Power Lenses*

*Progressive Power Lens Benefit. If this type of lens is not a covered benefit under Your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

PART X. CLAIM PROVISIONS

A. IN-NETWORK CLAIMS

When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator. (Note the exception under Part VIII.A, "In-Network Benefits.)

B. OUT-OF-NETWORK CLAIMS

In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

C. NOTICE OF CLAIM

Written notice of claim must be given to Us within 20 days after the loss starts or as soon as reasonably possible. Notice should be sent to Our Administrator at the following address:

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

D. CLAIM FORMS

When the Administrator receives notice of Claim that does not contain all necessary information, forms for filing proof of loss will be sent to You along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, You will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss within the time stated in the Proof of Loss provision.

E. PROOF OF LOSS

Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

F. PAYMENT OF BENEFITS

Benefits payable under the Policy will be paid directly to You. In the event of Your death, any benefits due and unpaid will be paid in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to Your estate. Any other benefits unpaid at death may be paid, at Our option, either to Your beneficiary or estate. If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to $1,000.00 to someone related to You or Your beneficiary by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any payment made in good faith.

G. TIME OF PAYMENT OF BENEFITS

Benefits payable under this Policy will be paid within 45 days of the date on which We receive proper proof of loss. If We require additional information to determine whether to approve or deny the claim, We will notify You of the additional information within 30 days after We receive Your claim. We will then either approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, We will pay the claim within 45 days after We receive the additional information.

If We fail to pay the claim within the required 45-day time period: (1) the value of the final settlement will bear interest at the rate of ten percent (10%) per annum from and after the expiration of the 45-day period; and (2) You will be entitled to be reimbursed for any reasonable attorney's fees incurred by You in connection with this claim. If We reimburse You for reasonable attorney fees, no part of such reimbursement will be charged against benefits otherwise due You.

H. OVERPAYMENTS

If we pay a benefit and it is later shown that a lesser amount should have been paid, We will be entitled to a refund of the excess. This applies to payments made to You, to a Covered Dependent, or to the provider of the Covered Services or Materials.

I. PAYOR OF LAST RESORT

It is understood and agreed that the Virginia Department of Medical Assistance is the payor of last resort with respect to benefits for those persons eligible for medical assistance in the Commonwealth of Virginia. This means that if the You are eligible for medical assistance from the Virginia Department of Medical Assistance, no benefit payable under the Policy will be denied or reduced because of such assistance.

PART XI. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has vision coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or services for vision services on a group basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan**: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately.
Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
   a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
   b. **Dependent Child/Parents Not Separated or Divorced**. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.
   c. **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
      ii. The Plan of the parent with custody of the child;
      iii. The Plan of the spouse of the parent with custody; and
      iv. The Plan of the parent without custody of the child.
   d. **Dependent Child/Joint Custody**: If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
   e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
   f. **Longer/Shorter Length of Coverage**. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made. In the absence of fraud, this right will be limited to a period not to exceed 24 months following the date of any overpayment made by Us.

PART XII. CLAIM NOTICE AND APPEAL PROCESS AND PROCEDURES

Your provider or other authorized representative may file a Claim or an Appeal on the Insured's behalf. We may require proof that a person is authorized to represent the Insured.

A. DEFINITIONS

Adverse Decision - means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a vision care service, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of You or Your dependent's eligibility to participate in a plan.

Appeal - a protest filed by a Claimant regarding an Adverse Decision.

Appeal Decision - the final decision made by Us regarding an Appeal.

Claimant - the Insured or a vision provider filing on the Insured's behalf.

Complaint – a written communication from You primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including Claims payments, the handling or reimbursement for such services, or any other matter pertaining to the Insured's contractual relationship with Us.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Peer of the Treating Eye Care Provider - means a physician or other eye care professional who holds a non-restricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

B. INITIAL NOTICE OF BENEFIT DECISIONS

1. **Eligibility and Benefits Coverage Verification:** Insured or provider may contact Us prior to services being rendered in order to verify the applicable benefits coverage and reimbursement schedule. Based on the plan benefits available, this allows the Insured and Provider to know what coverage would be available and the potential out of pocket cost to the Insured.

2. **Notice of Claim Decisions:** We will notify a Claimant in writing if a Claim is denied, in whole or in part, within 30 days after receipt of the Claim. This period may be extended by one 15-day period, if additional time is needed to process the Claim due to circumstances beyond Our control. If an extension is needed, We will notify the Claimant prior to the end of the initial 30-day period why the extension is needed and the date by which We expect to reach a decision.

   If the Claimant submitted an incomplete Claim, We will notify the Claimant of the specific information needed to make a decision. Notice may be oral, unless written notice is requested. If the information is not received We will, within 30 days after receipt of the Claim, either:
   a. Deny the Claim and send written notice of the Adverse Decision as described below; or
   b. Notify the Claimant in writing that an extension is needed, the specific reason for the extension, and the date by which We expect to reach a decision.

   The Claimant will have 60 days after receiving notice of an extension to provide the specified information. The period for making the benefit decision will be suspended from the date the notice was sent, until the earlier of the date the Claimant responds to the request for additional information, or the end of the 60-day period. If the Claimant fails to provide the additional

information prior to the end of the 60-day period, the Claim will be automatically denied at the end of the 60-day period.

3. **Content of Notice of Adverse Decision:** When a Claim is denied, in whole or in part, the oral or written notice will include the following:
   - The specific factual basis why the vision service was denied;
   - The specific plan provision on which the decision is based;
   - A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;
   - Instructions for the provider on behalf of the Insured to seek a reconsideration of the adverse decision, including the contact name, address, and telephone number of the person responsible for making the adverse decision;
   - To bring a civil action under section 502(a) of ERISA following an Appeal Decision by Us;
   - In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a Claim decision.

C. RIGHT TO REQUEST RECONSIDERATION OF AN ADVERSE DECISION

A treating provider may request reconsideration within 180 days after the date of receipt of notice of an Adverse Decision by contacting Our member services department to discuss the specific reasons for the Adverse Decision. The provider may submit additional documentation to support the Claim.

A decision on reconsideration will be reviewed by a Peer of the Treating Eye Care Provider, or a panel of other appropriate health care providers with at least one Peer of the Treating Eye Care Provider on the panel.

We will notify the treating provider of its reconsideration decision, in writing, within 10 business days (excluding legal holidays) of the request for reconsideration. The notice will include the factual basis and specific plan provision on which the adverse decision was based, and the opportunity to file an Appeal.

D. RIGHT TO APPEAL AN ADVERSE DECISION

If Claim reconsideration has been reviewed and denied, and the Claimant does not agree with an Adverse Decision, the Claimant may file a written Appeal within 180 days after the date of receipt of notice of the reconsideration denial based on the Adverse Decision. An expedited process is available for decisions needed on a more urgent basis as the circumstances may warrant.

The Appeal should include written comments, documents, records and other information relating to the Claim to support the Appeal, and must be sent to the following address:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
PO Box 967
Rancho Cordova, CA 95741
1-800-507-3800

The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. At any time the Claimant may submit additional documentation to support the Claim.

Any case under appeal shall be reviewed by a Peer of the Treating Eye Care Provider who provided or was primarily responsible for the care under review. With the exception of expedited appeals, a provider who reviews cases under appeal shall be a Peer of the Treating Eye Care Provider, shall be board certified or board eligible, and shall be specialized in a discipline pertinent to the issue under review.

The review will take into account all documents and comments that support the Claimant's position, even if the information was not submitted or considered in making the initial Adverse Decision.

E. APPEAL DECISIONS

We will notify a Claimant in writing of an Appeal Decision for a Claim, within a reasonable time, but not more than 60 days after the date the Appeal was received.

1. **Content of Notice of Adverse Decision on Appeal:** When a Claim is denied on Appeal, in whole or in part, written notice will include the following in clear understandable language:
   - The specific factual basis for the decision;
   - The specific plan provision on which the decision is based;
   - The identification of the expert whose advice was obtained for the review, if any, without regard to whether the advice was relied upon in making the Appeal Decision;
   - A clear and understandable statement of the Claimant's right:
     - To file an Appeal with the Virginia Bureau of Insurance within 30 days after receipt of the Our Appeal Decision of a Claim that involves a utilization review decision, the procedures for making such an appeal; the binding nature and effect of such an appeal; all necessary forms; and the mailing address, telephone number and electronic mail address of the Office of the Managed Care Ombudsman; and/or
     - To bring a civil action under section 502(a) of ERISA following an Appeal Decision by the Vision plan

   In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a Claim determination.

2. **Voluntary Appeals Process and Right to File Under ERISA:** If the Claimant does not agree with an Appeal Decision, the Claimant may choose:
   a. To file an Appeal to the Bureau of Insurance for certain Claims as described below; or
   b. To file a civil action under §502(a) of ERISA.

   Complete instructions and the forms for filing an appeal will be attached to each eligible notice of final Appeal Decision by Us. Except in the instance of fraud, any such Appeal may preclude Your exercise of any other right or remedy relating to such Appeal Decision.

F. COMPLAINTS-EXTERNAL REVIEW

1. **Voluntary Right to File an Appeal to the Bureau of Insurance:** You, Your or Your dependent's authorized representative, or a treating provider with the consent of You or Your dependent's authorized representative, may appeal to the Virginia Bureau of Insurance for review of any final Appeal Decision, if the following criteria is met:
   - The Claim must be based on a utilization review decision
   - The cost of service in question must exceed $300;
   - The appeal must be filed within 30 days of the final Appeal Decision by Us (the MCHIP);
   - The MCHIP's internal appeal process must have been exhausted (except for expedited reviews); and
   - A $50 filing fee must be submitted with this form by check or money order made payable to the Treasurer of Virginia. This fee may be waived or refunded if it can be demonstrated that paying the fee constitutes a financial hardship to You; and is refundable if the appeal is not accepted for review.

2. **Assistance from the Managed Care Ombudsman:** If You have any questions regarding an appeal or grievance concerning the health care services that You have been provided which have not been satisfactorily addressed by Us, You may contact the Office of the Managed Care Ombudsman for assistance.

   Mailing Address: Bureau of Insurance
   P.O. Box 1157
   Richmond, Virginia 23218

   Telephone: 877-310-6560 (Toll-Free)

804- 371-9032 (Richmond Metropolitan Area)

E-mail: ombudsman@scc.virginia.gov

3. **Assistance from the Office of Licensure and Certification:** Members may also contact the Office of Licensure and Certification Complaint Unit for assistance with quality of care complaints.

   Mailing Address: Office of Licensure and Certification
   9960 Mayland Drive, Suite 401
   Richmond, VA 23233

   Telephone: 800-955-1819 (Toll-Free)
   804-367-2106 (Richmond Metropolitan Area)

   Fax: 804-527-2104

   E-mail: mchip@vdh.virginia.gov

G. OTHER COMPLAINTS/GRIEVANCES

Members or their representatives have the right to file a grievance whenever there is any dissatisfaction with the provision of services or Claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer. These may be expressed either by contacting Our member services department at 1-800-507-3800 or submitting a formal grievance in writing. No covered person who exercises the right to file a complaint or appeal shall be subject to disenrollment or otherwise penalized due to the filing of a complaint or appeal.

Insureds or their representatives and providers may initiate a grievance by contacting Superior Vision Services, Inc., the Third Party Administrator of the vision benefit plan, in writing or by telephone at the following address:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
PO Box 967
Rancho Cordova, CA 95741
1-800-507-3800

Information obtained on the Grievance form includes date received, name of complainant, provider name, date of service, nature of complaint, desired resolution, billing records, etc. Upon receipt of a grievance related to a health benefit plan, the Insured will be notified that the grievance has been received within 72 hours of receipt (excluding legal holidays).

Superior Vision Services, Inc. will investigate the grievance and obtain any documentation necessary to make a final determination for benefits.

The final determination shall be made no later than 30 calendar days after the grievance is submitted in writing by the Insured unless Superior Vision Services, Inc. requires an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension shall not exceed 30 days from the end of the initial period unless the initial period is extended due to the Insured's failure to submit information necessary to decide the Claim on appeal. If the extension is due to an Insured's failure to submit information, the period for making the determination shall be tolled until the date the Insured responds to the request for additional information.

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

The Grievance Committee is established in accordance with applicable state requirements and does not include the person responsible for the initial determination.

- The Grievance Committee may consult with the initial decision-maker
- Any case under appeal shall be reviewed by Superior Vision Services, Inc. Chief Operating Officer or their designee

Superior Vision Services, Inc. shall notify the Insured of the results of the Committee's investigation within one business day of making the final determination.

H. IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
PO Box 967
Rancho Cordova, CA 95741
1-800-507-3800

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at P.O. Box 1157, Richmond, VA 23209, at (804) 371-9691 or toll-free at (800) 552-7945. Out of state residents may contact the Bureau toll-free at (877) 310-6560.

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

I. NOTICE OF YOUR RIGHT TO PROVIDER PAYMENT INFORMATION

You have the right to obtain information on the types of provider payment arrangements used to compensate providers that participate in this plan for the vision care services provided to You, including, but not limited to, fee-for-service discounts. To obtain this information, call Our member services department at 1-800-507-3800.

J. STATEMENT OF MEMBERS' RIGHTS AND RESPONSIBILITIES

We are committed to treating members in a manner that respects their rights.

You have the right to:

- Be provided with information about Our covered services and participating providers;
- Participate in decisions made regarding Your care;
- Be treated with respect and dignity by Our personnel and network;
- Privacy and confidentiality for treatments, tests, or procedures You receive;
- Voice concerns about the service and care You receive and to register complaints and appeals concerning Your Plan or the care provided to You;
- Receive timely response to Your concerns;
- Participate in a candid discussion with Your provider of appropriate and medically necessary treatment options for Your conditions, regardless of cost or benefit coverage;
- Be provided with reasonable access to providers; and
- Have coverage decisions and Claims processed according to regulatory standards.

You have the responsibility to:

- Know and confirm Your benefits when receiving treatment;
- Contact an appropriate provider when You have a service need or concern;
- Verify that the provider You receive services from is in the plan network;
- Pay any necessary co-payment at the time You receive treatment;
- Use emergency services only for injury or illness that, if not treated immediately, could pose serious threat to life or health;

- Keep scheduled appointments;
- Provide information needed for Your care;
- Follow the agreed-upon instructions and guidelines of providers;
- Notify Our member services department of any changes in address or family status; and
- Contact Our member services department when You have a question about Your benefits or coverage.

K. NOTICE OF GOVERNING LAW

The plan is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

PART XIII. GENERAL PROVISIONS

Entire Contract: The entire contract consists of:

1. the Policy;
2. the application of the Policyholder;
3. the provisions shown in this Certificate;
4. the Insured enrollment forms; and
5. riders and endorsements, if any, adding or changing the provisions of the Policy or Certificate.

A copy of the Policyholder's application is attached to the Policy on the date it is signed. All statements made in the applications, in the absence of fraud, are representations and not warranties. No statement made by an Insured under the Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured or to His Beneficiary or personal representative.

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.