



# 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**

**THIS IS A LEGAL CONTRACT- PLEASE READ YOUR CERTIFICATE CAREFULLY**

**IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE PROVISION ENTITLED "TERMINATION" BEGINNING ON PAGE 7**

**THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.**

**THIS CERTIFICATE PROVIDES LIMITED VISION BENEFITS**

**NON-PARTICIPATING**

## TABLE OF CONTENTS

PART I.	CERTIFICATE SCHEDULE .....	Page 3
PART II.	SCHEDULE OF BENEFITS .....	Page 4
PART III.	DEFINITIONS.....	Page 5
PART IV.	ELIGIBILITY AND ENROLLMENT.....	Page 7
	A. Eligibility .....	Page 7
	B. Enrollment .....	Page 7
PART V.	INDIVIDUAL EFFECTIVE DATES .....	Page 7
PART VI.	INDIVIDUAL TERMINATION DATES.....	Page 8
PART VII.	INDIVIDUAL PREMIUMS .....	Page 8
PART VIII.	DESCRIPTION OF COVERAGE.....	Page 8
	A. In-Network Benefits .....	Page 8
	B. Out-of-Network Benefits .....	Page 9
	C. Covered Services or Materials .....	Page 9
PART IX.	LIMITATIONS AND EXCLUSIONS.....	Page 9
	A. Limitations .....	Page 9
	B. Exclusions.....	Page 9
PART X.	CLAIM PROVISIONS .....	Page 10
	A. In-Network Claims.....	Page 10
	B. Out-of-Network Claims .....	Page 10
PART XI.	COORDINATION OF BENEFITS .....	Page 11
PART XII.	GRIEVANCE PROCEDURE.....	Page 12
PART XIII.	GENERAL PROVISIONS.....	Page 13

## PART I. CERTIFICATE SCHEDULE

**Policyholder:** Bladen County Schools

**Group Policy Number:** 27686

**Effective Date:** Initial – January 1, 2006; Current Renewal – January 1, 2016

**Initial Term:** 12 Months from Initial Effective Date

**Eligible Classes:** All full-time employees working at least 30 hours per week

**Waiting Period:** Must sign within 30 days of hire

**Mode of Premium Payment:** MONTHLY

**Method of Premium Payment:** Remitted by Policyholder

**Premium Due Date:** 1<sup>st</sup> of every month

## PART II. SCHEDULE OF BENEFITS

<b>FREQUENCY OF SERVICES</b>	
<b>Your Certificate is on a Rolling Benefit Plan Basis</b>	
<b>Vision Exam:</b>	Once every 12 Months
<b>Eyeglass Lenses:</b>	Once every 12 Months
<b>Frames:</b>	Once every 24 Months
<b>Contact Lenses:</b>	Once every 12 Months
<b>Contact Lens Fit:</b>	Once every 12 Months

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

<b>BENEFITS AND ALLOWANCES <sup>1</sup></b>		
	In-Network Providers: <sup>2</sup>	Out-of-Network Provider:
<b>Vision Exam:</b>		
Ophthalmologist (M.D.)	Covered in Full	\$44 Allowance
Optometrist (O.D.)	Covered in Full	\$39 Allowance
<b>Materials- Eyeglass Lenses: <sup>3</sup></b>		
Single Vision	Covered in Full	\$34 Allowance
Progressive	Covered up to the providers retail trifocal amount	\$64 Allowance
Bifocals	Covered in Full	\$48 Allowance
Trifocals	Covered in Full	\$64 Allowance
Lenticular	Covered in Full	\$88 Allowance
<b>Materials – Frames: <sup>3</sup></b>	\$150 Allowance	\$77 Allowance
<b>Materials – Contact Lenses: <sup>4</sup></b>		
Non-Elective	Covered in Full	\$210 Allowance
Elective	\$150 Allowance	\$100 Allowance
<b>Contact Lens Fit:</b>		
Standard	Covered in Full	Not Covered
Specialty	\$50 Allowance	Not Covered

<sup>1</sup> Where an “Allowance” is shown, You are responsible for paying any charges in excess of the Allowance.

<sup>2</sup> 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.

<sup>3</sup> Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

<sup>4</sup> 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 twenty/seventy (20/70) in the better eye except through the use of Contact Lenses (must be twenty/sixty (20/60) or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to twenty/sixty (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, children of adopting parents pending finalization of adoption procedures, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance or children for whom coverage has been court ordered.
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
  - c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.
4. Your unmarried child who has reached age 19 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. We may require proof again from time to time but not more often than once a year after the child reaches the age limit.

**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 thirty-five (35) for plastic bifocal and lenticular lenses, through flat top twenty-eight (28) for glass trifocals, and through flat top thirty-five (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 an 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 sections 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) or twenty-four (24) 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 but 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 Child Coverage: A child of the Insured born while the policy is in force is covered from the moment of birth until the 31st day of age. If premium is required for coverage of a child, such premium, along with a notice of birth, must be submitted to us within thirty-one (31) days of the birth in order to continue coverage beyond the initial thirty-one (31) day period. If premium is not required, we should be notified of the child's birth to facilitate the administration of the child's coverage.

Adopted and Foster Children Coverage: A minor child who comes under the charge, care, and control of the Covered Person while the policy is in force is covered from the moment such child is placed in the Covered Person's home. The coverage of such child will be the same as provided for other members of the Covered Person's family. Coverage shall begin at the moment of birth for an adopted child if the petition for adoption, application for coverage and payment of premium occurs within thirty-one (31) days after the child's birth. If premium is required for coverage of a child, the Covered Person must pay the required premium within thirty-one (31) days after placement of the child in the Covered Person's home. If no additional premium is required, we should be notified of

the birth or placement in order to facilitate the administration of the child's coverage. Coverage for such minor child will continue until such child is removed from the Covered Person's home.

## **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 thirty-one (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.

## **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 (1) of two (2) 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 thirty-one (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 twelve (12) month Term. After the Initial twelve (12) month Term, We will not increase the premium rates more than once in a twelve (12) month period. Any subsequent revisions will be based upon twelve (12) months of experience. 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.

### **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**

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.

### **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 or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation ACT only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or under an order of the North Carolina Industrial Commission approving settlement agreement under the North Carolina Workers' Compensation Act;
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 (2).

## **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 twenty (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 one hundred eighty (180) 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 Claims**

Benefits will be paid within thirty (30) days after our Administrator receives written proof of loss. Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

### **G. Time of Payment of Claims**

Benefits payable under this Policy will be paid immediately upon Our receipt of written proof of loss.

### **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.

## **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:** Means a Non-Elective item of expense for health care, when the item is covered at least in part by one or more Plans covering the Insured for whom claim is made.

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

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Is any of these which provides benefits or services for, or because of, medical or vision care or treatment:
  - a) 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.
  - b) 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.)
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 will be equal to 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.

## **PART XII. GRIEVANCE PROCEDURE**

If a claim for benefits is wholly or partially denied, the Insured 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 an Insured may file a grievance and make a written request for review to:

National Guardian Life Insurance Company  
c/o Superior Vision Services, Inc.  
P.O. 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 Insured 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 Insured 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 an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

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

### **PART XIII. GENERAL PROVISIONS**

**Cancellation:** We may cancel the Policy at any time by providing at least sixty (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.