



# 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, Suite 150  
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.

**Mathew Dew, Secretary**

**Mark Solverud, President**

**COVERAGE SUBJECT TO PREMIUM RATE CHANGE  
NON-PARTICIPATING**

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

## IMPORTANT NOTICE

### IMPORTANT NOTICE

You may call National Guardian Life Insurance Company's toll-free telephone number for information or to make a complaint at:

**1-800-923-6766**

You may also write to National Guardian Life Insurance Company at:

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

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: 512-475-1771

Web: <http://www.tdi.state.tx.us>

E-Mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact your agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become part or condition of the attached document.

### AVISO IMPORTANTE

Usted puede llamar al número de teléfono gratis de National Guardian Life Insurance Company para información o para someter una queja al:

**1-800-923-6766**

Usted también puede escribir a la oficina National Guardian Life Insurance Company:

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

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: 512-475-1771

Web: <http://www.tdi.state.tx.us>

E-Mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con su agente o la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

### UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

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## **PART I. CERTIFICATE SCHEDULE**

**Policyholder:** West Texas Public Schools EBC

**Group Policy Number:** 28790

**Effective Date:** September 1, 2012

**Initial Term:** 24 Months

**Eligible Classes:** All Employees working at least 20 hours per week

**Waiting Period:** 1<sup>st</sup> of the month following or coincident with date 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 12 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                  | \$0                      |
| <b>Eyeglass Lenses/Frames:</b> | \$25                  | \$0                      |
| <b>Contact Lens Fit:</b>       | \$0                   | 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                                 | \$42 Allowance                             |
| Optometrist (O.D.)                              | Covered in Full                                 | \$37 Allowance                             |
| <b>Materials- Eyeglass Lenses: <sup>3</sup></b> |   |  |
| Single Vision                                   | Covered in Full                                 | \$32 Allowance                             |
| Progressive                                     | Covered up to the providers price for trifocals | Covered up to the same amount as trifocals |
| Bifocals  | Covered in Full                                 | \$46 Allowance                             |
| Trifocals                                       | Covered in Full                                 | \$61 Allowance                             |
| Lenticular                                      | Covered in Full                                 | \$84 Allowance                             |
| Scratch Coating                                 | Covered in Full                                 | Not Covered                                |
| <b>Materials – Frames: <sup>3</sup></b>         | \$125 Allowance                                 | \$68 Allowance                             |
| <b>Materials – Contact Lenses:</b>              |   |  |
| Non-Elective                                    | Covered in Full                                 | \$210 Allowance                            |
| Elective  | \$120 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.

### 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. 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 (1) 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 or Your spouse’s unmarried: (a) natural child; (b) stepchild; (c) foster child; (d) adopted child or child during the pendency of adoption; (e) a child for whom You are required by a court order, administrative order or a medical support order to provide health insurance coverage; or (f) grandchild who is dependent on you for federal income tax purposes. Such child(ren) must:
  - (1) be less than 25 years old; or
  - (2) have become incapable of self-support because of mental retardation or physical handicap while insured under this Certificate and prior to reaching age 25. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within thirty-one (31) days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 25.

**Eyeglass Lenses** – A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eyeglass 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.

**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, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one (1) parent.

### **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.

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. 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 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 or is covered from the moment of birth to thirty-one (31) days. A notice of birth, together with any additional premium, must be submitted to Us within thirty-one (31) days of the birth in order to continue the coverage beyond the initial thirty-one (31) day period.

Adopted Children: A child adopted by You is covered from the date that You become a party to a suit in which You seek to adopt the child. Coverage will continue unless the child's adoption is disrupted prior to legal adoption. A notice of your becoming a party to the adoption of a child, together with any additional premium, must be submitted to Us within thirty-one (31) days of the date of Your notice in order to continue the coverage beyond the initial thirty-one (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 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 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 sixty (60) 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**

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 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 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 (2) pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (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 VI.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 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 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 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.