



**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**

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

2 East Gilman Street Madison, Wisconsin 53701

**GROUP VISION INSURANCE  
MASTER POLICY**

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

Administrator: National Vision Administrators, L. L. C.  
1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013

In return for the application, which is attached, and payment of premium as it becomes due, National Guardian Life Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown on the Policy Schedule.

This Policy may be continued in force by payment of premium at the rates We establish until the insurance ends as provided.

**The following are made part of this Policy: the provisions of the attached Certificates; all riders; all endorsements; and all amendments issued on and after the Effective Date.**

This Policy is governed by the laws of the jurisdiction shown below.

<b>POLICYHOLDER:</b>	<b>Milwaukee Public Schools</b>
<b>GROUP POLICY NUMBER:</b>	<b>NVAI00148</b>
<b>POLICY EFFECTIVE DATE:</b>	<b>July 1, 2014</b>
<b>ANNIVERSARY DATE:</b>	<b>July 1, 2015</b>
<b>JURISDICTION:</b>	<b>Wisconsin</b>
<b>PREMIUM DUE DATE:</b>	<b>1<sup>st</sup> of every Month</b>
<b>COVERAGE PROVIDED:</b>	<b>See Incorporated Certificate's Schedule of Benefits</b>
<b>INITIAL TERM:</b>	<b>48 Months</b>

Kimberly Shaul, Secretary

Mark L. Solverud, President

**NON-PARTICIPATING**

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## PART I: PREMIUMS

### A. PREMIUM SCHEDULE

Refer to the attached Group Application for premium rate information.

**B. PAYMENT OF PREMIUMS:** The premiums due under this Policy are payable in advance directly to Us at the Administrator's Office. The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the GRACE PERIOD provision.

**C. RIGHT TO CHANGE PREMIUM RATES:** We have the right to change the premium rates on any premium due date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any six (6)-month period. We will notify the Policyholder in writing at least forty-five (45) days before any increase in premium rates. This is subject to the Premium Adjustments provision, as stated below.

**D. PREMIUM ADJUSTMENTS:** The Company may adjust the premium rate on the Policy Anniversary Date, including during any applicable premium rate guarantee period, if any one of the following occurs:

1. The terms of this Policy change;
2. The number of Insureds increase or decrease by more than 10% since the later of the Policy Effective Date and the date of the last renewal of the Policy;
3. Coverage is reinstated following failure to pay premium during the Grace Period;
4. An acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of Insureds.
5. Any federal, state, or other law or regulation is enacted, adopted, amended, or requiring implementation that affects: (a) Our benefit obligations under this Policy; or (b) any monetary assessments, or changes in those assessments, We are required to pay.

**E. PREMIUM CALCULATION:** The total premium for insurance coverage under this Policy is the sum of the premiums for each Insured.

**F. GRACE PERIOD:** A Grace Period of 31 days (without interest charge) is granted for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the premium is not paid by the end of the Grace Period, all insurance under this Policy will end on the last day of the Grace Period. The Policyholder will owe Us all premiums then due and unpaid including the premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later.

The Policyholder will owe Us the pro-rata premium for the time the insurance was in effect during the Grace Period.

## PART II: WHEN INSURANCE UNDER THIS POLICY ENDS

By giving the Policyholder written notice at least 60 days in advance, We have the right to end coverage at the end of the Initial Term or on any Premium Due Date.

All insurance or any part may be ended on any date by mutual agreement between the Policyholder and Us.

After the Initial Term, the Policy shall continue on a month-to-month basis. It will automatically renew on the first day of each renewal period unless either We or the Policyholder has given to the other at least 60 days advance written notice of cancellation.

Insurance will end as provided above without the consent of, or notice to, any Insured or Beneficiary.

### **PART III: GENERAL PROVISIONS**

**A. ENTIRE CONTRACT:** The entire contract consists of:

1. this Policy;
2. the application of the Policyholder;
3. the provisions shown in the Certificate;
4. the Member 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 this 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 this 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, if any.

**B. INCONTESTABILITY:** This Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

**C. CHANGES IN POLICY:** The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our President or Our Secretary. Any changes will be made without the consent of, or notice to, any Insured or Beneficiary, if any. No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

**D. CONFORMITY WITH LAW:** If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

**E. POLICY NON-PARTICIPATING:** This Policy is not entitled to share in the surplus earnings of Our company.

**F. INFORMATION TO BE FURNISHED BY POLICYHOLDER:** The Policyholder will furnish Us with all information which pertains to this Policy. Failure to furnish Us with such information without good and sufficient cause will permit Us to terminate this Policy. We may inspect at all reasonable times (while this Policy is in effect and thereafter until all rights and payments have been made) any records of the Policyholder which have a bearing on the insurance or premiums.

**G. CLERICAL ERROR:** Clerical error (whether by the Policyholder or Us) in keeping records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

**H. POLICYHOLDER NOT AGENT:** The Policyholder will in no event be considered Our agent for any purpose under this Policy.

**I. ASSIGNMENT:** No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us at Our Home Office.

**J. INDIVIDUAL CERTIFICATES:** We will issue to the Policyholder, to make available to each Member under this Policy, a Certificate of insurance that describes the essential features of this Policy. The Certificate may be made available electronically. The word Certificate includes Certificate riders and Certificate supplements, if any.

**K. ADDITIONAL INSUREDS:** The following will be added to the group originally insured:

1. All new persons becoming eligible to and applying for insurance in such group or class, including new members of a family; and
2. Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

**L. 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.

**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**

**GROUP VISION APPLICATION**

National Vision Administrators, L. L. C.  
1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013

Group No. NVAI00148 SIC No. \_\_\_\_\_

**Legal Name of Group** Milwaukee Public Schools Phone (414) 475-8136

Physical Address P.O. Box 2181 5225 West Vliet Fax ( )

City\State\Zip Milwaukee, Wi 53208 **EMAIL ADDRESS** \_\_\_\_\_

**Billing Address (If different)** \_\_\_\_\_ Phone ( )

City\State\Zip \_\_\_\_\_ Fax ( )

**Contact for Administration & Eligibility** Stephanie Brandt **Contact for Billing** Stephanie Brandt

# Employees: 8341 # Eligible \_\_\_\_\_ # of Employees with Dependents \_\_\_\_\_ Group Effective Date: 7 / 1 / 2014

Initial Premium Rate:

Single (Employee only):	\$4.44
Employee & Spouse:	\$10.77
Employee & Child:	\$10.77
Employee & Children:	\$10.77
Family:	\$10.77

and are guaranteed for the period July 1, 2014 to June 30, 2018. Premiums are not guaranteed beyond that date.

**Eligibility:**

Permanent employees are eligible for coverage.  
An eligible employee must be actively at work in order to be eligible for coverage.  
An eligible dependent is covered to age 26, as of end of month following birthdate.

**Participation:** Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.

I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of full-time employees of this group. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

Monthly Administration Fee: N/A

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

- Group Attn: \_\_\_\_\_ Phone: ( )
- Broker or Agent

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY (IN TEXAS AND KANSAS MAY BE GUILTY) OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name Title Date

National Guardian Representative \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date



# NATIONAL GUARDIAN LIFE INSURANCE COMPANY

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

2 East Gilman Street Madison, Wisconsin 53701

## GROUP VISION CARE INSURANCE CERTIFICATE

Administrator: National Vision Administrators, L. L. C.  
1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013

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 an Insured is covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a 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 Shaul, Secretary**

**Mark L. Solverud, President**

**NON-PARTICIPATING**

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



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## PART I. CERTIFICATE SCHEDULE

**Policyholder:** Milwaukee Public Schools

**Group Policy Number:** NVAI00148

**Effective Date:** 7/1/2014

**Initial Term:** 48 Months

**Eligible Classes:** Permanent Employees

**Waiting Period:** Permanent Employees Actively at Work

**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>	<b>Once every 12 Months</b>
<b>Eyeglass Lenses:</b>	<b>Once every 12 Months</b>
<b>Frames:</b>	<b>Once every 12 Months</b>
<b>Contact Lenses:</b>	<b>Once every 12 Months</b>
<b>Lens Add-ons:</b>	<b>Once every 12 Months</b>

<b>CO-PAY (PER INSURED)</b>		
	In-Network Providers:	Out-of-Network Provider:
Vision Exam:	\$0.00	N/A
Eyeglass Lenses:	\$0.00	N/A
Frames:	\$0.00	N/A
Contact Lenses:	\$0.00	N/A
Lens Add-ons:	\$0.00	\$0.00

<b>BENEFITS AND ALLOWANCES <sup>1</sup></b>		
	Other In-Network Providers:	Out-of-Network Provider:
Vision Exam:		
By Ophthalmologist	Covered in Full	N/A
By Optometrist	Covered in Full	N/A
Materials- Eyeglass Lenses <sup>3</sup> :		
Single Vision	Covered in Full	N/A
Bifocals	Covered in Full	N/A
Trifocals	Covered in Full	N/A
Lenticular	Covered in Full	N/A
Materials – Frames <sup>3</sup> :	\$82 Allowance	N/A
Materials – Contact Lenses <sup>2</sup> :		
Non-Elective <sup>4</sup>	\$100 Allowance	N/A
Elective	\$100 Allowance	N/A
Lens Add-Ons <sup>5</sup> :		

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

<sup>2</sup> The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. Contact Lenses consist of (3) components: materials, exams and fittings. Coverage is for materials and the exam, up to the Contact Lenses allowance. Fittings may be covered but only up to the amount of any unused Contact Lenses allowance – after Materials.

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

<sup>4</sup> Prior Authorization required

<sup>5</sup> See Supplement to Schedule of Benefits

You may choose to use the insured benefit or take advantage of a sale or coupon, but not both.

## PART III. SUPPLEMENT TO SCHEDULE OF BENEFITS

(In-Network Benefits Only)

The Add-On items listed below as a Covered Service or Material are paid for in addition to or in lieu of the allowance for Standard Lenses, as indicated. Add-Ons and upgrades that are not a Covered Service or Material, or that exceed the stated allowance, are Your responsibility to pay to the Provider.

SV Gradient Tint	\$4.00
BI Gradient Tint	\$6.00
TRI Gradient Tint	\$6.00
Solid Tint	Covered in Full
Prisms	Covered in Full

#### **PART IV. 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.

**Calendar Year Plan** - Benefits begin anew on January 1 of each Calendar Year.

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

**Co-Pay** – An Insured’s share of the costs that are incurred 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 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.

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

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

the Supplement to 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 child under age 26, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian .

**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, subject to the Premium Adjustments provision.

**In-Network Provider** - An Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide the Covered Vision Exam 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 a person 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.

**Policy Year Plan** - Benefits begin immediately on the Policyholder's effective date and renew 12 or 24 months following the initial effective date.

**Rolling Benefit Plan** – Benefits begin anew 12 or 24 months from the date of service.

**Spouse** – Your legally recognized spouse in the state where You reside.

**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 Member.

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

## **PART V. 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 parent. If the Spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other Spouse's coverage.

### **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 Member has enrolled for coverage, and paid the required premium, if any.

Initial Enrollment: Members should enroll for coverage within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll 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 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 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 VI. 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 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 VII. INDIVIDUAL TERMINATION DATES**

Coverage for all Insureds 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.

## **PART VIII. 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 PREMIUM RATES:** We have the right to change the premium rates on any premium due date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any twelve (12) month period. We will notify the Policyholder in writing at least forty-five (45) days before any increase in premium rates. This is subject to the Premium Adjustments provision, as stated below.

**PREMIUM ADJUSTMENTS:** The Company may adjust the premium rate on the Policy Anniversary Date, including during any applicable premium rate guarantee period, if any one of the following occurs:

1. The terms of this Policy change;
2. The number of Insureds increase or decrease by more than 10% since the later of the Policy Effective Date and the date of the last renewal of the Policy;
3. Coverage is reinstated following failure to pay premium during the Grace Period;
4. An acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of Insureds.
5. Any federal, state, or other law or regulation is enacted, adopted, amended, or requiring implementation that affects: (a) Our benefit obligations under this Policy; or (b) any monetary assessments, or changes in those assessments, We are required to pay.

## **PART IX. DESCRIPTION OF COVERAGE**

We pay a benefit if an Insured receives Covered Vision Exam 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 Vision Exam 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 Vision Exam 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 pay the provider in full. When benefits are payable, We will reimburse You up to the amount of Out-of-Network benefits shown in the Schedule of Benefits. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us (See the "Notice of Claim" provision.).

## **C. COVERED VISION EXAM OR MATERIALS**

Covered Vision Exam or Materials are shown in the Schedule of Benefits. In order to be a Covered Vision Exam or Materials, the Vision Exam 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.

In no event will coverage exceed the lesser of:

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

## **PART X. LIMITATIONS AND EXCLUSIONS**

### **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. Corrective Eyeglass Lenses, Frames, Contact Lenses, and related materials; and services for the fitting thereof;
2. Replacement frames and/or lenses, (Including Low Vision Devices) except at normal intervals when covered services are otherwise available;
3. Plano or non-prescription lenses or sunglasses;
4. Orthoptics, vision training and any associated supplemental testing;
5. Frame cases;

6. Low (subnormal) vision aids or aniseikonic lenses;
7. Medical and surgical treatment of the eyes;
8. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
9. Experimental or non-conventional treatment or device;
10. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
11. Services and materials provided by another vision plan;
12. Services for which benefits are paid by Worker's Compensation;
13. Benefits provided under the employee's medical insurance;
14. Blended bifocal lenses;
15. Groove, Drill or Notch, and Roll and Polish;
16. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
17. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
18. Cosmetic items;
19. Faceted lenses;
20. High-Index Lenses;
21. Laminated Lenses;
22. Oversize Lenses – any lens with an eye size of 61mm or greater;
23. Photochromic (Transition) lenses;
24. Polaroid lenses;
25. Polished bevel lenses;
26. Polycarbonate lenses;
27. Prism lenses;
28. Slab-off lenses;
29. Tints (except Pink tint #1 and #2;
30. Ultra-violet tint or coating;
31. Additional cost for contact lenses over the allowance;
32. Additional cost for a frame over the allowance;
33. 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 XI. 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 IX.A, "In-Network Benefits.")

### **B. OUT-OF-NETWORK CLAIMS**

In order to pay benefits for covered services 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

**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 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 Vision Exam or Materials.

**PART XIII. 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 National Vision Administrators, L. L. C.  
1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013**

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 four (4) business days of receiving the grievance.

#### **PART XIV. GENERAL PROVISIONS**

**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.