YOUR GROUP INSURANCE PLAN BENEFITS

OUACHITA PARISH POLICE JURY
CLASS 0001
VISION

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

B907.0004

CERTIFICATE OF COVERAGE

Guardian
7 Hanover Square
New York, New York 10004

We, Guardian, certify that the *employee* named below is entitled to the insurance benefits provided by *Guardian* described in this certificate, provided the eligibility and effective date requirements of the *plan* are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above *plan* or under any other *plan* providing similar or identical benefits issued to the *Planholder* by *Guardian.*

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

B905.0003

CGP-LA-03

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The forms listed below are attached to and made part of this certificate. The listed forms describe the coverages which the *Planholder* has elected.

All terms in italics are defined terms with special meanings. Definitions are shown in the Glossary or are defined where they are used.

Vision Care Expense Insurance

GENERAL PROVISIONS

As used in this certificate:

"Accident and health" means any accidental death and dismemberment, dental, long term disability, short term disability or vision insurance provided by this *plan.*

"Covered person" means *you* or any of *your* dependents insured by this *plan,* except in the "Repayment" section where "covered person" has a special meaning. See that section for details.

"Employee" means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

"Employer" and "Planholder" mean the employer who purchased this *plan.*

"Our," "Guardian," "us," and "*we"* mean The Guardian Life Insurance Company of America.

"Plan" means the *Guardian* group *plan* purchased by *your employer,* except in the "Coordination of Benefits" section where "plan" has a special meaning. See that section for details.

"You," "your," and "certificateholder" mean an *employee* covered by this *plan.*

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Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of *Guardian,* has the authority to act for *us* to: (a) determine whether any contract, *plan* or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or *plan,* or any requirements of *Guardian;* (c) bind *us* by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* will be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his or her lifetime.

If this *plan* replaces a *plan your employer* had with another insurer, *we* may rescind the *employer's plan* based on misrepresentations made by the *employer* or an *employee* in a signed application for up to two years from the effective date of this *plan.*

Conformity with State Statute

The group *plan* is governed by the laws of the state of Louisiana. However, with respect to this certificate, any terms which are in conflict with any insurance statute or regulation of the jurisdiction where the *certificateholder* resides and which are applied regardless of where the policy is issued, are hereby amended to conform to the minimum requirements of such statute or regulation.

This provision will apply only to those *certificateholders* who are residents of that other jurisdiction and who are insured by the group *plan* on the date the claim for benefits is made.

B908.0037

Vision Claims Provisions

Your right to make a claim for any vision benefits provided by this *plan,* is governed as follows:

Notice Written notice of an injury or sickness for which a claim is being made must be given to *us* within 20 days of the date the injury occurs or the sickness starts. This notice should include *your* name and *plan* number. If the claim is being made for one of *your* covered dependents, the dependent's name should also be noted.

We will not void or reduce a claim if notice is not given within the required time. But, notice must be given to *us* as soon as reasonably possible.

Claim Forms *We* will provide forms for filing proof of loss within 15 days of receipt of notice. But if *we* do not provide the forms on time, *we* will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The nature and extent of the loss for which the claim is being made must be detailed.

Uniform Claim Forms All claim forms will be processed to conform with uniform claim form regulations issued by the Louisiana Department of Insurance.

Proof of Loss Written proof of loss must be furnished to *us* at *our* designated office.

This proof must be furnished within 90 days of the loss.

We will not void or reduce a claim if proof is not given within the required time. But, proof must be given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Payment of Benefits *We* will pay vision benefits as soon as *we* receive written proof of loss.

Unless otherwise required by law or regulation, *we* pay all vision benefits to *you* if *you* are living. If *you* or any other payee is not living, *we* have the right to pay all vision benefits, to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; (e) *your* brothers and sisters; or (f) any unpaid provider of health care services.

When proof of loss is filed, *you* or any other payee may direct *us,* in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. *We* may honor such direction at *our* option. But, *we* can not require that a particular provider provide such care. And, *you* or any other payee may not assign *your* right to take legal action under this *plan* to such provider.

Time of Payment of Claims All claims will be paid within 30 days of receipt of written proof of loss in the forms required by the terms of the policy, unless just an reasonable grounds such as would put a reasonable and prudent businessperson on his or her guard, exist.

Legal Actions No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after one year from the date written proof of loss is required to be given.

Workers' Compensation The vision benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

B908.0022

All Options

Repayment

We will not pay any benefits under this *plan,* to or on behalf of a *covered person,* who has received payment in whole from a *third party,* or its insurer for past or future vision charges, resulting from the negligence, intentional act, or no-fault tort liability of a *third party.*

If a *covered person* or his or her beneficiary makes a claim to *us* for vision charges, under this *plan* prior to receiving payment from a *third party* or its insurer, the *covered person* or his or her beneficiary must agree, in writing, to repay *us* from any amount of money they receive from the *third party,* or its insurer. But, this will only apply if the amount of money received fully compensates him or her for all damages he or she suffered. If the *covered person* or his or her beneficiary claims that the *covered person* was not fully compensated, he or she may be required to provide proof that the amount received did not equal full compensation.

The repayment will be equal to the amount of benefits paid by *us.* However, the *covered person* or his or her beneficiary may deduct the *reasonable pro-rata expenses incurred* in effecting the *third party* payment from the repayment to *us.*

The repayment agreement will be binding upon the *covered person* or his or her beneficiary whether: (a) the payment received from the *third party,* or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the *third party,* or its insurer, has admitted liability for the payment; or (c) the vision charges, are itemized in the *third party* payment.

As used in this provision:

"Covered person" means *you* or your dependent, including the legal representative of a minor or incompetent, insured by this *plan.*

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"Reasonable pro-rata expenses" are those costs, such as lawyers fees and court costs, *incurred* to effect a third party payment, expressed as a percentage of such payment.

"Third party" means anyone other than *Guardian,* the *employer* or the *covered person.*

B908.0035

All Options

YOUR CONTINUATION RIGHTS

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to *your employer's* plan. *You* must contact *your employer* to find out if: (a) *your employer* is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to *you.*

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All Options

Federal Continuation Rights

Important Notice

This provision applies only to any dental or vision coverages which are part of this *plan.* In this provision, these coverages are referred to as "group health benefits."

This provision does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this provision.

Under this provision, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this provision, is covered for group health benefits under this *plan* as: (a) an active, covered *employee;* (b) the spouse of an active covered *employee;* or (c) the dependent child of an active, covered *employee.* A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this *plan* during a continuation provided by this provision is not a qualified continuee.

If Your Group Health Benefits End

If *your* group health benefits end due to *your* termination of employment or reduction of work hours, *you* may elect to continue such benefits for up to 18 months, if *you* were not terminated due to gross misconduct.

The continuation: (a) may cover *you* or any other qualified continuee; and (b) is subject to the the "When Continuation Ends" section section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to *your* termination of employment or reduction of work hours, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

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To elect the extra 11 months of continuation, a qualified continuee must give *your employer* written proof of Social Security's determination of the disabled qualified continuee's disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify *your employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to the "When Continuation Ends" section.

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by *your employer* during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

Special Continuance for Retired Employees and their Dependents

If *your* group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the *employer, you* may elect to continue such benefits, provided that:

(a) *you* are or become a retired employee on or before the date group health benefits end; and

(b) *you* and *your* dependents were covered for group health benefits under this *plan* on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for *your* lifetime. After *your* death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for *you* and *your* dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If *you* die before the bankruptcy proceeding under Title 11 of the United States Code, *your* surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for *your* surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

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All Options

If You Die While Insured

If *you* die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the "When Continuation Ends" section.

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All Options

If Your Marriage Ends

If *your* marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the "When Continuation Ends" section.

If a Dependent Child Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this *plan,* other than *your* coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to the "When Continuation Ends" section.

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to *your* termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, either: (a) the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above; or (b) *you* become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule

If *you* become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after *your* later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from *your* termination of employment or reduction of work hours; or (b) 36 months from the date of *your* earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify *your employer,* in writing, of: (a) *your* legal divorce or legal separation from *your* spouse; or (b) the loss of dependent eligibility, as defined in this *plan,* of an insured dependent child.

Such notice must be given to *your employer* within 60 days of either of these events.

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Your Employer's Responsibilities

A qualified continuee must be notified, in writing, of: (a) his or her right to continue this *plan's* group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) *your* death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if *you* are a retired *employee,* a bankruptcy proceeding under Title 11 of the United States Code with respect to the *employer.* Upon receipt of notice of a qualifying event from *your employer* or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this *plan's* group health benefits no later than 14 days after receipt of notice.

If *your employer* is also the plan administrator, in the case of a qualifying event for which an *employer* must give notice to a plan administrator, *your employer* must provide notice to a qualified continuee of the right to continue this *plan's* group health benefits within 44 days of the qualifying event.

If *your employer* determines that an individual is not eligible for continued group health benefits under this *plan,* they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this *plan* are cancelled prior to the maximum continuation period, *your employer* must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Employer's Liability

Your employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, *us,* if: (a) he or she fails to remit a qualified continuee's timely premium payment to *us* on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give *your employer* written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from *your employer* as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to *your employer,* by the qualified continuee, in advance, at the times and in the manner specified by *your employer.* No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group *plan* on a regular basis. It includes any amount that would have been paid by *your employer.* Except as explained in the " Extra Continuation for Disabled Qualified Continuees" section, an additional charge of two percent of the total premium charge may also be required by *your employer.*

If the qualified continuee fails to give *your employer* notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the *plan* in an amount that is not significantly less than the amount the *plan* requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless *your employer* notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to *your employer.*

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon *your* termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon *your* death, *your* legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) with respect to a dependent whose continuation is extended due to *your* entitlement to Medicare while the dependent is on continuation, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(5) the date the *employer* ceases to provide any group health *plan* to any *employee;*

(6) the end of the period for which the last premium payment is made;

(7) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(8) the date, after the date of election, he or she becomes entitled to Medicare.

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All Options

GLOSSARY

This Glossary defines the italicized terms appearing in *your* certificate.

General Definitions

Active Work, Actively-At-Work Or Actively Working means *you* are able to perform and are performing all the regular duties of *your* work for *your employer* and working *your* regular number of hours at: (a) one of *your employer's* usual places of business; (b) some place where *your employer's* business requires *you* to travel; or (c) any other place *you* and *your employer* have agreed on for *your* work

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All Options

Eligibility Date for dependent coverage is the earliest date on which *you:* (a) have dependents; and (b) are eligible for dependent coverage.

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All Options

Enrollment Period for dependent coverage is the 31 day period which starts on the date that *you* first become eligible for dependent coverage.

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All Options

Full-time means *you* regularly work at least the number of hours in the normal work week set by *your employer* (but not less than 30 hours per week), at *your employer's* place of business.

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All Options

Initial Dependents means those eligible dependents *you* have at the time *you* first become eligible for employee coverage. If at this time *you* do not have any eligible dependents, but *you* later acquire them, the first eligible dependents *you* acquire are *your initial dependents.*

B941.0007

All Options

Newly Acquired Dependent means an eligible dependent *you* acquire after *you* already have coverage in force for *initial dependents.*

B941.0008

All Options

Qualified Retirees are covered as outlined in your company's benefit provisions. Please see Your Plan Administrator for details.

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All Options

Definitions Applicable to Vision Care Expense Coverage

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All Options

Anisometropia means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

B941.0036

All Options

Benefit Period means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan,* the covered service is again available to a *covered person.*

B941.0037

All Options

Blended Lenses mean bifocals which do not have a visible dividing line.

B941.0038

All Options

Coated Lenses mean finished lenses that have a substance added on one or both surfaces.

B941.0039

All Options

Copayment means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

B941.0040

All Options

Customary means, when referring to a covered charge, that the charge for the covered vision condition is not more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.

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All Options

Deductible means any amount which a *covered person* must pay before he or she is reimbursed for covered services provided by a *non-preferred provider.*

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All Options

Incurred, Or Incurred Date means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

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All Options

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

B941.0044

All Options

Lenticular Lenses mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

B941.0045

All Options

Non-Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has not contracted with this *plan's* PPO to provide services and/or materials to a *covered person.*

B941.0047

All Options

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

B941.0048

All Options

Oversize Lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

B941.0049

All Options

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

B941.0050

All Options

Plan Benefits mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan.*

B941.0051

All Options

Plano Lenses mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

B941.0052

All Options

Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has contracted with the *plan's* PPO to provide services and/or materials to a *covered person.*

B941.0053

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers.*

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All Options

Standard Lenses mean regular glass or plastic lenses.

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All Options

Tinted Lenses mean lenses which have an additional substance added to produce constant tint.

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All Options

Usual means, when referring to a covered charge, that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

B941.0057

All Options

Visually Necessary And Appropriate means medically or visually necessary for the restoration or maintenance of a *covered person's* visual acuity and health and for which there is no less expensive professionally acceptable alternative.

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The Guardian Life Insurance Company of America

VISION CARE EXPENSE INSURANCE

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

All Options

Employee Coverage

Eligible Employees To be eligible for employee coverage, *you* must be an active *full-time employee* or a *qualified retiree.* And *you* must belong to a class of *employees* covered by this *plan.*

Other Conditions *You* must enroll and agree to make required payments within 31 days of *your eligibility date.* If *you* fail to do so, *you* can not enroll until this *plan's* next vision open enrollment period.

This *plan's* vision open enrollment period occurs from October 20th to December 31st of each year.

Once *you* enroll in this *plan, you* can not drop *your* vision coverage until this *plan's* next vision open enrollment period. And if *you* drop *your* vision coverage, *you* can not enroll again until the next vision open enrollment period.

If *you* initially waived vision coverage under this *plan* because *you* were covered for vision care benefits under another group plan, and *you* wish to enroll in this *plan* because *your* coverage under the other plan ends, *you* may do so without waiting until the next vision open enrollment period. However, *your* coverage under the other plan must have ended due to one of the following events: (a) termination of *your* spouse's employment; (b) loss of eligibility under *your* spouse's plan; (c) divorce; (d) death of *your* spouse; or (e) termination of the other plan. But *you* must enroll in the vision coverage under this *plan* within 30 days of the date that any of these events occur.

B938.0012

All Options

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But *you* must be *actively at work* on that date unless *you* are a *qualified retiree.* And *you* must have met all of the applicable conditions explained above, and any applicable waiting period. If *you* are an active *full-time* or *part-time employee* and are not *actively at work* on that date, *we* will postpone *your* coverage until the date *you* return to *active work.*

If you are a *qualified retiree, you* can not be confined To a hospital or other health care facility on the scheduled effective date of coverage. *We* will postpone *your* coverage until the day after *you* are discharged from such facility. And *you* must have also met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

Sometimes, the effective date shown on the sticker is not a regularly scheduled work day. But coverage will still start on that date if *you* were *actively at work* on *your* last regularly scheduled work day.

B938.0024

All Options

When Your Coverage Ends

If *you* are an active *employee your* coverage ends on the last day of the month in which *you* cease *active work* for any reason. Such reasons include disability, retirement (except for *qualified retirees),* layoff, leave of absence and the end of employment.

Your coverage ends on the date *you* die.

It also ends on the date *you* stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which *you* belong ends.

If *you* are required to pay all or part of the cost of this coverage and *you* fail to do so, *your* coverage ends. It ends on the last day of the period for which *you* made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if *your* coverage ends. *You* may have the right to continue vision care benefits for a limited time.

B938.0029

All Options

Your Right To Continue Group Coverage During A Family Leave Of Absence

Important Notice

This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

If Your Group Coverage Would End

Group coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other *employee;* or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.
- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

Definitions

As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

B938.0133

All Options

Dependent Coverage

All Options

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) *your* legal spouse; and (b) *your* dependent children or grandchildren who are under age 26.

For a grandchild to be an eligible dependent, *you* must have legal custody of the grandchild and the grandchild must live with *you.*

If a child or grandchild is an *eligible dependent* of more than one *employee* under this plan, the child may be insured for vision care benefits by only one *employee* at a time.

B938.0206

All Options

Adopted Children and Step-Children

Your "dependent children" include: (a) *your* legally adopted children and (b) *your* step-children. *We* treat a child as legally adopted from the time the child is placed in *your* home for the purpose of adoption or voluntary surrender. *We* treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And *we* exclude any dependent who is on active duty in any armed force.

B938.0207

All Options

Handicapped Children

You may have a child with a mental or physical handicap, or developmental disability, who can not support himself or herself. Subject to all of the terms of this coverage and the *plan,* such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she is unable to support himself or herself, if: (a) his or her condition started before he or she reached this coverage's age limit; (b) he or she became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on *you* for most of his or her support and maintenance. With respect to a grandchild, the grandchild must also remain in *your* custody and reside with *you* in order to stay eligible.

But, for the child to stay eligible, *you* must send *us* written proof that the child is handicapped and depends on *you* for most of his or her support and maintenance. *You* have 31 days from the date the child reaches the age limit to do this. *We* can ask for periodic proof that the child's condition continues. But, after two years, *we* can not ask for this proof more than once a year.

The child's coverage ends when *yours* does.

B938.0208

All Options

When Dependent Coverage Starts

In order for *your* dependent coverage to begin, *you* must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan,* the date *your* dependent coverage starts depends on when *you* elect to enroll all of *your initial dependents* and agree to make any required payments.

If *you* do this on or before *your eligibility date, your* dependent coverage is scheduled to start on the later of the date *you* sign the enrollment form and the date *you* become insured for employee coverage.

If *you* do this during the enrollment period *, your* dependent coverage is scheduled to start on the date *you* become insured for employee coverage.

If *you* do this after the *enrollment period* ends, *you* can not enroll *your initial dependents* until the next vision open enrollment period.

Once *you* have coverage for *your initial dependents, you* must notify *us* when *you* acquire any new dependents, and agree to make any additional payments required for the coverage. If *you* do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent becomes eligible. If *you* fail to notify *us* on time, *you* can not enroll the *newly acquired dependent* until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can not be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can not be enrolled again until the next vision open enrollment period.

B938.0132

All Options

Exception If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is unable to carry out the normal activities of someone of like age and sex on the date his or her dependent benefits would otherwise start, *we* will postpone the effective date of such benefits until the day after his or her discharge from such facility; or until he or she resumes the normal activities of someone of like age and sex.

B938.0041

All Options

Newborn Children *We* cover *your* newborn child from the moment of birth if (a) *you* are already insured for dependent vision coverage when the child is born, and (b) you enroll the child and agree to make the required payments within 31 days of the child's birth. If *you* fail to do this, once the child is enrolled, the child will be covered as of the date *you* sign the enrollment form.

We also cover *your* newborn grandchild for dependent benefits from the moment of birth, if the child is in *your* legal custody and residing with *you.*

B938.0042

All Options

When Dependent Coverage Ends Dependent coverage ends for all of *your* dependents when *your* coverage ends. But if *you* die while insured, *we* will automatically continue dependent benefits for those of *your* dependents who are insured when *you* died. *We* will do this for six months at no cost, provided: (a) the group *plan* remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of *your* dependents when *you* stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If *you* are required to pay part of the cost of dependent coverage, and *you* fail to do so, *your* dependent coverage ends. It ends on the last day of the period for which *you* made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child, step-child or grandchild at 12:01 a.m. on the date the child attains this coverage's age limit or for a handicapped child who has reached the age limit, when he or she is no longer dependent on the *employee* for support and maintenance. A grandchild's coverage also ends when he or she is no longer in the custody of or residing with the employee. And a spouse's coverage ends when a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

B938.0209

VISION CARE HIGHLIGHTS

This page provides a quick guide to some of the Vision Care Expense Insurance plan features which people most often want to know about. But it's not a complete description of *your* Vision Care Expense Insurance plan. Read the following pages carefully for a complete explanation of what *we* pay, limit and exclude.

PPO Copayments	Examinations	$10.00
	Standard Frames and/or *Standard Lenses*	$25.00
	Necessary Contact Lenses	$25.00
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or *Standard Lenses*	$25.00
	Necessary Contact Lenses	$25.00
Payment Rates	For Covered Services and Supplies	100%

B938.0050

VISION CARE BENEFITS

This insurance will pay many of *your* and *your* covered dependent's vision care expenses. What *we* pay and the terms for payment are explained below.

B938.0054

All Options

Vision Service Plan
This Plan's Vision Care Preferred Provider Organization

Vision Service Plan

This *plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

This vision care PPO is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP; and (b) has a participatory agreement in force with VSP.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from any vision care provider. And, he or she is free to change providers at any time. But, this *plan* usually pays more in benefits for covered services furnished by a vision care *preferred provider.* Conversely, it usually pays less for covered services not furnished by a vision care *preferred provider.*

When an *you* and *your* dependents enroll in this *plan,* they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers.*

What *we* pay is based on all the terms of this *plan.* The *covered person* should read this material with care, and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, *copayments, deductibles,* payment rates and payment limits.

The *covered person* can call VSP if he or she has any questions after reading this material.

Choice of Preferred Providers

When a person becomes enrolled in this *plan,* he or she will receive a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider.*

Replacement of Preferred Provider

If a *preferred provider* terminates his or her relationship with VSP for any reason, VSP will be responsible for furnishing vision services to *covered persons* either through that provider or through another VSP *preferred provider.*

Pre-Authorization of Preferred Provider Services

When a *covered person* desires to receive treatment from a *preferred provider,* the *covered person* must contact the *preferred provider* BEFORE receiving treatment. The *preferred provider* will contact VSP to verify the *covered person's* eligibility and VSP will notify the *preferred provider* of the 60 day time period during which the *covered person* may schedule an appointment. If the *covered person* cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the *covered person* must contact the *preferred provider* again to receive authorization.

What *we* pay is subject to all the terms of this *plan.*

B938.0056

All Options

Pre-Treatment Review for Necessary Contact Lenses

Subject to prior approval by VSP consultants, *we* will pay benefits for necessary contact lenses provided to a *covered person.* A *covered person's* doctor must request approval for necessary contact lenses from VSP.

No benefits will be paid for necessary contact lenses if prior approval is not received from VSP.

What *we* pay for necessary contact lenses is subject to all of the terms of this *plan.*

B938.0059

All Options

Claim Appeals and Arbitration of Disputes

If, under the provisions of this *plan,* a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to VSP within 60 days following the denial of benefits. The request should contain sufficient information to identify the *covered person* whose benefits were denied. This includes the name of the *covered person,* the *employee's* social security number and the *employee's* date of birth. The *covered person* may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. VSP will review the claim and give the *covered person* the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of VSP, including specific reasons for the decision, will be provided and communicated to the *covered person* in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation. If any issue cannot be resolved in this fashion, it may be submitted to arbitration, if both parties agree.

Preferred Provider Grievance Procedures

Grievances are handled by VSP's Professional Relations Vice President for action. The grievance process is designed to address *covered persons'* concerns quickly and satisfactorily. The following grievance procedures have been established:

(1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.

(2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.

(3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person.* Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.

(4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.

(5) All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(800) 622-7444

B938.0060

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How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. The services and supplies covered under this *plan* are explained in the "Covered Services and Supplies" section of this *plan.* What we pay is subject to all of the terms of this *plan.* Read the entire *plan* to find out what we limit or exclude.

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider,* the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider.* We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment.* This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* $10.00

For each pair of *standard frames* and/or *standard lenses* from a *preferred provider* $25.00

For Necessary Contact Lenses from a *preferred provider* $25.00

Payment Limits Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates Once a *covered person* has paid any applicable *copayment,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges 100%

Discounts If a *covered person* receives a vision examination, and lenses or frames from a *preferred provider,* he or she will receive a discount on the cost of purchasing an unlimited number of additional prescription glasses and non-prescription sunglasses from any *preferred provider.* The *covered person* may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

The discounts are:

For Prescription Glasses . . . . . 20% off of the *preferred provider's usual* and *customary* fee

For Non-Prescription Sunglasses	20% off of the *preferred provider's usual* and *customary* fee
For Contact Lens Evaluation and Fitting Costs	15% off of the *preferred provider's usual* and *customary* fee

B938.0220

All Options

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider,* the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits *we* pay are subject to all of the terms of this *plan.*

Cash Deductible for Services of a Non-Preferred Provider

There are separate cash *deductibles* for each covered service provided by a *non-preferred provider.* These cash *deductibles* are shown below. The *covered person* must have covered charges in excess of the cash *deductible* before *we* pay him or her any benefits for the service or supply.

For each vision examination provided by a *non-preferred provider* . . .	$10.00
For each pair of *standard frames* and/or *standard lenses* from a non-preferred provider	$25.00
For each pair of necessary contact lenses from a *non-preferred provider*	$25.00

Payment Limits

Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates

Once a *covered person* has met any applicable *deductible, we* pay benefits for covered charges under this *plan* as follows. What *we* pay is subject to all of the terms of this *plan.*

For covered services and supplies	100%

B938.0066

Covered Charges

Covered charges are the *usual* and *customary* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan.* Charges in excess of any payment limits shown in this *plan* are not covered charges.

Covered Services and Supplies

This section lists the types of charges we cover. But what we pay is subject to all of the terms of this *plan.* Read the entire *plan* to find out what we limit or exclude.

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider. The services or supplies must be the *usual* and *customary* treatment for a vision condition.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are *visually necessary and appropriate* for the proper visual health of a *covered person,* professional services covered by this *plan* include:

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

We don't cover more than one vision examination in any calendar year period.

And if a *covered person* uses a *non-preferred provider,* we limit what we pay for each vision examination to $39.00.

B938.0221

All Options

Standard Lenses

We cover charges for single vision, bifocal, trifocal or *lenticular lenses.* We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

If a *covered person* uses a *non-preferred provider,* we limit what we pay to

- $23.00 for each pair of single vision lenses

- $37.00 for each pair of bifocal lenses
- $49.00 for each pair of trifocal lenses and
- $64.00 for each pair of *lenticular lenses.*

B938.0277

All Options

We cover charges for one pair of *standard lenses* in any calendar year *benefit period.*

B938.0297

All Options

Standard Frames

We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $150.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $46.00.

If the covered person chooses elective contact lenses, we do not cover standard frames until the beginning of the calendar year following the date the elective contacts are purchased.

We cover charges for one set of standard frames in any calendar year period.

B938.0324

All Options

Necessary Contact Lenses

We cover charges for Necessary Contact Lenses upon prior approval by VSP. See "Pre-Treatment Review for Necessary Contact Lenses" for details. We cover charges, and charges for related professional services, only if the lenses are needed:

(a) following cataract surgery;

(b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

(c) for certain conditions of *anisometropia;* or

(d) for *keratoconus.*

We limit what *we* pay for necessary contact lenses to $210.00 in any calendar year period.

B938.0331

All Options

Elective Contact Lenses

We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses until the next calendar year and standard frames until the next calendar year.

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to $150.00

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to $100.00.

We cover charges for one set of elective contact lenses in any calendar year period.

B938.0343

All Options

Special Limitations

If this VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan,* a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan,* the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan. We* apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan.*

B938.0078

All Options

Exclusions

- *We* will not pay for *orthoptics* or vision training and any associated supplemental testing.
- *We* will not pay for medical or surgical treatment of the eyes.
- *We* will not pay for any eye examination or corrective eyewear required by an employer as a condition of employment.

B938.0079

All Options

- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this *plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for expenses associated with securing materials such as lenses and frames.
- We will not pay for refitting of contact lenses after the initial 90 day fitting period.
- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.
- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

B938.0350

All Options

- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B938.0352

All Options

- We will not pay for UV (ultraviolet) protected lenses.

B938.0353

All Options

- We will not pay for the scratch resistant coating of the lens or lenses.

B938.0354

All Options

- We will not pay for blended lenses.

B938.0355

All Options

- We will not pay for high index lenses.

B938.0356

All Options

- We will not pay for the mirror/ski coating of the lens or lenses.

B938.0357

All Options

- We will not pay for oversized lenses.

B938.0358

All Options

- We will not pay for laminating of the lens or lenses.

B938.0359

All Options

- We will not pay for edge treatment.

B938.0360

All Options

- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.

B938.0361

All Options

- We will not pay for the anti-reflective coating of the lens or lenses.

B938.0362

All Options

- We will not pay for polycarbonate lenses.

B938.0363

All Options

Charges not covered due to this section are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles,* if any.

B938.0082

SAMPLE BENEFIT CALCULATOR

We pay benefits for covered charges shown in the Covered Services and Supplies section of this *plan. We* only pay for covered charges incurred by a *covered person* while he or she is insured. Charges in excess of any payment limits shown in the *plan* are not covered charges.

A *covered person* may receive covered services or supplies from a VSP *preferred provider.* He or she may also receive covered services from any other vision care provider. But, this *plan* usually pays more in benefits for covered services furnished by a *preferred provider.* The example below shows how benefits may differ.

The benefits shown below are for illustration only. Read this plan carefully to determine actual covered services, copayments, deductibles, payment rates or payment levels.

Example of In and Out-of-Network Benefits
For Split Copayment, Full-Service Plan

Preferred Provider - Split Copayment Plan

Cost of Exam:	Paid by VSP
Copayment Applied to Exam:	**$10.00**
Cost of Standard Lenses:	Paid by VSP
Cost of Standard Frames:	Paid by VSP
Copayment Applied to Lenses:	**$20.00**
Copayment Applied to Frames:	**$20.00**
Insured's Total Costs:	**$50.00**

Non-Preferred Provider - Split Copayment Plan

Cost of Exam:	$65.00
Deductible Applied to Exam:	**$10.00**
Remainder:	$55.00
Exam Allowance:	$35.00
Insured Pays Additional:	**$20.00**

Cost of Lenses:	$55.00
Deductible Applied to Lenses:	**$20.00**
Remainder:	$35.00
Lens Allowance:	$25.00
Insured Pays Additional:	**$10.00**
Cost of Frames:	$80.00
Deductible Applied to Frames:	**$20.00**
Remainder:	$60.00

Frame Allowance:	$35.00
Insured Pays Additional:	**$25.00**
Insured's Total Costs:	**$105.00**

B938.0085

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CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Vision Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-LA B938.0204

STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

All Options

The Guardian's Responsibilities

CGP-3 B800.0048

All Options

The vision care expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

CGP-3 B800.0055

All Options

The Guardian is located at 7 Hanover Square, New York, New York 10004.

CGP-3 B800.0049

Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA").

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

Urgent Care Claims. Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

Pre-Service Claims. Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

Post-Service Claims. Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

CGP-3 B800.0086

All Options

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information(PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian(using the information supplied below), or on our Web site at: www.GuardianLife.com/PrivacyPolicy

What is Protected Health Information (PHI):

PHI is individually identifiable information(including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage(including medical, dental, vision and LTC coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

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All Options

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. A breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national

security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.

- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0047

All Options

Your Rights with Regard to Your Protected Health Information (PHI): Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation,(ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of the disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list(e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply(except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0048

All Options

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it(ii) if we do not maintain the PHI at issue(iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457

B998.0049

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

GUARDIAN℠

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004-2616

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