



NATIONAL GUARDIAN LIFE INSURANCE COMPANY

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

2 East Gilman Street Madison, Wisconsin 53701

GROUP VISION CARE INSURANCE CERTIFICATE

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

Administrator: Block Vision, Inc.
6737 W. Washington Street, Suite 2202
Milwaukee, WI 53214

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

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

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

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

Sherri Kliczak, Secretary

Mark Solverud, President

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

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

IMPORTANT NOTICE

IMPORTANT NOTICE

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

1-866-265-0517

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

National Guardian Life Insurance Company
c/o Block Vision, Inc.
6737 W. Washington Street, Suite 2202
Milwaukee, WI 53214

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

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

E-Mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

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

1-866-265-0517

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

National Guardian Life Insurance Company
c/o Block Vision, Inc.
6737 W. Washington Street, Suite 2202
Milwaukee, WI 53214

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

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

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

E-Mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU POLIZA:

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

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PART I. CERTIFICATE SCHEDULE

Policyholder: Harris County and Harris County Flood Control District and any other political subdivisions or agencies authorized by Harris County to participate

Policyholder's Address: 1310 Prairie, Suite 400, Houston, TX 77002

Group Policy Number: 308670

Effective Date: March 1, 2011

Initial Term: 12 months with six (6) one-year renewal options

Eligible Classes: Elected officials, appointed officials, employees working at least thirty two (32) hours per week, or a benefit eligible retiree

Waiting Period: Eligibility begins on the first day of the calendar month after completing three (3) months of continuous employment

Mode of Premium Payment: Monthly

PART II. SCHEDULE OF BENEFITS

FREQUENCY	Rolling Benefit Plan (date-of-service to date-of-service)	Once every 12 months Once every 12 months Once every 12 months Once every 12 months	Once every 12 months Once every 12 months Once every 12 months Once every 12 months
CO-PAY AMOUNT		\$10/Exam \$25/Eyewear	\$10/Exam \$25/Eyewear
Benefits	Provided / Not Covered	Participating Provider – In- Network	Non Participating Provider – Out-Of- Network*
Vision Exam	Provided	Covered in Full	\$35
MATERIALS			
<i>Standard Lenses</i>			
Single Vision	Provided	Covered in Full	\$25
Bifocals	Provided	Covered in Full	\$40
Trifocals	Provided	Covered in Full	\$45
Lenticular	Provided	Covered in Full	\$80
Frames	Provided	\$130 retail	\$70
Contact Lenses**			
Standard Optical	Provided	\$130 Retail	\$80
Medical Necessity	Provided	Covered in Full	\$150

* All Out-of-Network benefits are subject to Co-Pay amount listed above.

** In lieu of Eyeglass lenses and Frames. Allowances include the contact lens fitting fee.

PART III. DEFINITIONS

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

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

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

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

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

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

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

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of an In-Network Provider.

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

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

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

Eligible Dependent - Means a person listed below:

1. Your spouse.
2. Your or Your spouse's unmarried: (a) natural child; (b) stepchild; (c) foster child; (d) adopted child or child during the pendency of adoption; (e) a child for whom You are required by a court order, administrative order or a medical support order to provide health insurance coverage; or (f) grandchild who is dependent on you for federal income tax purposes. Such child(ren) must:
 - (1) be less than 25 years old; or
 - (2) have become incapable of self-support because of mental retardation or physical handicap while insured under this Certificate and prior to reaching age 25. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated.

Additional proof may be required from time to time but not more often than once a year after the child attains age 25.

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

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

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

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

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

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

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

Insured Member– Means a person:

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

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

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

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

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

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

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

Plano Lens - A lens that has no refractive power.

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

Rolling Benefit Plan – Benefits begin anew as detailed in the “Frequency” section of Part II. Schedule of Benefits.

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

You or Your – The Insured Member.

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

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

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

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

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

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

B. ENROLLMENT

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

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period.

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

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

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

5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

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

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

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

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

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

PART VI. INDIVIDUAL TERMINATION DATES

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

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

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

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

PART VII. INDIVIDUAL PREMIUMS

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

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

The Certificate Schedule shows the method of premium payment.

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

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

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 60 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

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

A. IN-NETWORK BENEFITS

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

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

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

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

B. OUT-OF-NETWORK BENEFITS

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

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

C. COVERED SERVICES OR MATERIALS

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

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

In no event will coverage exceed the lesser of:

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

PART IX. LIMITATIONS AND EXCLUSIONS

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

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

Exclusions

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

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

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

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

PART X. CLAIM PROVISIONS

A. IN-NETWORK CLAIMS

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

B. OUT-OF-NETWORK CLAIMS

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

C. NOTICE OF CLAIM

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

National Guardian Life Insurance Company
c/o Block Vision, Inc.
P.O. Box 14035
Milwaukee, WI 53214

D. CLAIM FORMS

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

E. PROOF OF LOSS

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

F. PAYMENT OF CLAIMS

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

G. TIME OF PAYMENT OF CLAIMS

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

H. OVERPAYMENTS

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

PART XI. COORDINATION OF BENEFITS (COB)

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

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or services for vision services on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

B. BENEFIT COORDINATION

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

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
 - a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
 - b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.
 - c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
 - i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
 - ii. The Plan of the parent with custody of the child;
 - iii. The Plan of the spouse of the parent with custody; and
 - iv. The Plan of the parent without custody of the child.
 - d. **Dependent Child/Joint Custody:** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
 - e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
 - f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

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

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART XII. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

**National Guardian Life Insurance Company
c/o Block Vision, Inc.
P.O. Box 14035
Milwaukee, WI 53214**

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

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

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XIII. GENERAL PROVISIONS

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

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



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

LASER VISION SURGERY BENEFIT RIDER

This Rider amends the Policy/Certificate to which it is attached. The following benefit is added:

DEFINITIONS

Insured means a person who is insured under the Policy/Certificate to which this Rider is attached.

Laser Vision Correction Services means laser assisted surgery, performed by an Ophthalmologist, for refractive error.

Ophthalmologist means an oculist who specializes in diseases and refractive errors of the eye.

Benefit Frequency Period – the frequency for Lenses, Frames or Contact Lenses listed on the schedule of benefits.

BENEFIT

If an Insured has Laser Vision Correction Services, the Insured may elect to receive such services in lieu of prescription eyewear during a single Benefit Frequency Period. The Laser Vision Correction Services must have been determined by an Ophthalmologist to be clinically appropriate for improvement of the refractive error. We will pay a single allowance of: \$300 if received from a participating In-Network Provider; or \$300 if received from a non-participating Out-of Network provider. We pay the benefit allowance for Laser Vision Correction Services one time only during the lifetime of each Insured. When Laser Vision Correction Services are received from a participating In-Network Provider, the Insured is also entitled to receive provider discounts, if any.

NON-COVERED SERVICES/MATERIALS

We do not pay the benefit for:

1. Any laser vision correction procedure subsequent to the Laser Vision Correction Services.
2. Any services or procedures resulting from the Laser Vision Correction Services.
3. Any Laser Vision Correction Services performed by anyone other than an Ophthalmologist who is licensed in the United States of America.
4. Any Laser Vision Correction Services performed by a participating in-network provider or an out of network non-participating provider located outside of the United States of America.
5. Any Lenses, Frames or Contact Lenses received during the same Benefit Frequency Period as Laser Vision Correction Services.
6. Any laser vision correction procedure that is experimental, unproven or related to a research protocol.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

Signed for National Guardian Life Insurance Company, at its Home Office in Madison, Wisconsin.


Sherri Kliczak, Secretary


Mark Solverud, President

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
Two East Gilman Street, PO Box 1191, Madison, Wisconsin 53701

AMENDMENT
AGE LIMITS FOR COVERED DEPENDENT CHILDREN

Attached to Policy/Certificate No.: 308670

The Policy/ Certificate to which this Amendment is attached are amended as follows, unless already so stated:

Extension of Age Limit for Covered Dependent Children:

Coverage for any Covered Dependent child may be extended beyond any limiting age stated in the Policy/Certificate. This extension is available for any dependent child, regardless of student status. Such coverage may be extended until the last day of the month in which the child attains the age of 26.

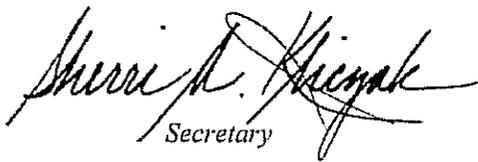
(The limiting age will not apply to a child who, at the time of the limiting age, is incapable of self-support by reason of mental retardation, mental illness or disorder or physical handicap, provided the incapacitated child is unmarried and dependent on an individual insured under the Policy/Certificate.)

To extend coverage for a Covered Dependent to age 26 You must send Us a written notice of Your request and pay any additional required premium. This must be done within 31 days after the dependent's limiting age stated in the policy/certificate to which this Amendment is attached.

This Endorsement takes effect on March 1, 2011, and expires on the same date as the policy/certificate to which it is attached.

There are no other changes to the policy/certificate.

In witness whereof, the Company has caused this Amendment to be signed by its President and Secretary.


Secretary


President



NGL Insurance Group Privacy Notice

National Guardian Life Insurance Company

Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or “NGL”) are committed to protecting the privacy of the personal information we receive (“Information”) about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is “your privacy is our priority.”

Why We Collect and How We Use Information:

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes

- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL’s website, www.nglic.com.

JOINT 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.

Block Vision, Inc. and National Guardian Life Insurance Company are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How We May Use or Disclose Your Health Information

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.
2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.
3. **Required by Law.** As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.
4. **Public Health.** As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.
5. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.
6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.
7. **Health and Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
8. **Government Functions.** We may disclose your health information for military, national security, prisoner and government benefits purposes.
9. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.
10. **Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.
2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.
4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.
5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.
6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.
7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.
2. Provide you with a notice of our legal duties and privacy practices with respect to your health information.
3. Abide by the terms of this Notice.
4. Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. Revised Notices will be distributed to you by mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Block Vision, Inc.
6737 W. Washington Street, Suite 2202
Milwaukee, WI 53214

You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: April 14, 2003.