



**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**  
A Mutual Company Incorporated in 1909  
Madison, WI

**GROUP VISION CARE INSURANCE CERTIFICATE**

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

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

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

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

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

**Kimberly A. Shaul, Secretary**

**Joseph Celentano, President**

**NON-PARTICIPATING**

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

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT  
A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD  
CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A  
SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

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## PART I. DEFINITIONS

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

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

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

**Co-Pay** – An Insured's share of the costs that are incurred by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.

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

**Contact Lenses, Non-Elective or Visually Necessary** – Non-Elective or Visually Necessary 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. Keratoconus.
2. Aphakia (after cataract surgery);
3. When best visual acuity with eyeglasses:
  - a. is between 20/50 and 20/80 and can be corrected to 20/40 or better with contact lenses.
  - b. is worse than 20/80 and can be improved in at least one eye by double the visual acuity with contact lenses. (e.g. 20/100 to 20/50, 20/200 to 20/100, 20/400 to 20/200); or .
  - c. if the patient has vision in both eyes, and the reduced Best corrected visual acuity is in just one eye, and there is an expectation of improved binocularity with contact lenses.
4. Anisometropia of 3.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
5. Any structural, neurologic or refractive ocular issues interfering with the normal development of visual acuity and/or binocular function in a child that cannot be met with eyeglasses only. Any structural deformity, scar, post-operative irregularity or distortion of the cornea or iris that prevents the attainment of optimal visual acuity with eyeglasses only, that can be improved significantly with contact lenses.
6. Any chronic pain, discomfort or photophobia due to chronic, persistent corneal, iris or lacrimal system inflammatory disease, injury, surgery or deformity that prevents the attainment of optimal visual acuity with spectacle correction that can be improved significantly with contacts
7. Refractive error equal to or greater than 12.00 diopters spherical equivalent in either eye.

Prior authorization is required.

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

**Covered Vision Exams and Materials** – Means the Vision Exams and Materials that qualify for benefits under the Group Policy. Covered Vision Exams and 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 They complete the required Waiting Period, if any.

**Eligible Dependent** - Means a person listed below:

1. Your Spouse;
2. Your unmarried dependent child under age 26, who is Your natural or adopted child, Your Spouse's child, a foster child, or a child for whom You are a legal guardian or required by a medical support order to provide vision insurance coverage, or a child during the pendency of adoption and who is primarily dependent on You for support and maintenance.
3. Your unmarried child who has reached age 26 and who is:

- a. primarily dependent upon You for support and maintenance; and
  - b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.  
Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.
4. Your unmarried grandchild under the age of 25, who is a dependent of You for federal income tax purposes at the time of application for coverage of the grandchild is made.

**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.

**Their, Them, and They** – Refers to the male or female gender.

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

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

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

**Insured**– Means a person for whom insurance under the Policy has become effective, as a Member or Eligible Dependent.

**Late Entrant** - Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the section titled "Limitations."

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

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

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

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

**Plano Lens** - A lens that has no refractive power.

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

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

following the initial effective date.

**Re-enrollee** - Any Insured who terminated Their coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

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

**Spouse** – Your legally recognized spouse or Domestic Partner:

1. By a union between two adults having the effect of marriage that is recognized by law in the state where You reside; or
2. By a mutual agreement, recognized by the Policyholder, between two consenting adults who:
  - a. are not married or legally separated;
  - b. occupy the same residence; and
  - c. share household expenses.

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

**You or Your** – The Member.

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

## **PART II. 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.

This Policy also provides coverage for the Member's Eligible Dependents.

**Dual Eligibility Status:** If both a Member and Their Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the Spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other Spouse's coverage.

### **B. ENROLLMENT**

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Member has enrolled for coverage, and paid the required premium, if any.

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

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

**Late Entrants:** Members who do not enroll within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a Change in Family Status, as described below.

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

1. Marriage or domestic partnership;
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 III. 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, domestic partnership, birth or adoption, coverage is effective on the date specified by the Policyholder. This is subject to Our receipt of the required Enrollment and payment of the premium, if any.

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

Adopted Children: A child adopted by You is covered from the date of You have filed a petition seeking adoption of such child. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of the petition seeking adoption, together with any additional premium, must be submitted to Us within 31 days of the petition in order to continue the coverage beyond the initial 31-day period.

### **PART IV. INDIVIDUAL TERMINATION DATES**

Coverage for all Insureds stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the date that 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 They are 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 V. INDIVIDUAL PREMIUMS**

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

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

The Certificate Schedule shows the method of premium payment.

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

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

**RIGHT TO CHANGE PREMIUM RATES:** We have the right to change the premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any twelve (12) month period. We will notify the Policyholder in writing at least sixty (60) days before any increase in premium rates. This is subject to the Premium Adjustments provision, as stated below.

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

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

## **PART VI. DESCRIPTION OF COVERAGE**

### **A. COVERED VISION EXAMS AND MATERIALS**

Covered Vision Exams and Materials are shown in the Schedule of Benefits. In order to be a Covered Vision Exam and Material, it must be furnished to an Insured:

1. To check or improve Their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician.

In no event will coverage exceed the lesser of:

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

We pay a benefit if an Insured receives Covered Vision Exams and Materials at the allowable Frequency while Their 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.

### **IN-NETWORK BENEFITS**

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

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

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

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Schedule Of Benefits.

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

## **OUT-OF-NETWORK BENEFITS**

If an Insured chooses to use an Out-of-Network Provider, You pay the provider in full. When benefits are payable, We will reimburse You up to the amount of Out-of-Network benefits shown in the Schedule of Benefits. It is Your responsibility to send Us a Claim by submitting the itemized invoice or receipt to Us (See the "Notice of Claim" provision.). 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.

## **PART VII. LIMITATIONS AND EXCLUSIONS**

### **LIMITATIONS:**

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 and 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 and the Eyeglass Frame benefit only after the Eyeglass Lenses benefit Frequency has ended.

Dilation is covered in full under the Vision Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

### **EXCLUSIONS**

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

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

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

\*Progressive Lens. 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 VIII. CLAIM PROVISIONS**

### **A. IN-NETWORK CLAIMS**

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

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

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

### **C. NOTICE OF CLAIM**

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

National Guardian Life Insurance Company  
 c/o National Vision Administrators, L. L. C.  
 1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013

### **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 60 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.

If any Insured is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such Insured's court appointed guardian.

#### **G. TIME OF PAYMENT OF CLAIMS**

Benefits payable under this Policy will be paid immediately upon Our receipt of written Proof of Loss.

#### **H. REIMBURSEMENT TO THE TEXAS DEPARTMENT OF HUMAN SERVICES**

In the event that the cost of an Insured's care and/or services for which benefits are payable under the Policy is paid through a medical assistance program of the Texas Department of Human Services, such benefits will be paid to the said Department. Such payment will be made up to the actual amount of such Department's coverage, but not to exceed the amount of benefits due under the Policy.

#### **I. OVERPAYMENTS**

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

### **PART IX. GRIEVANCE PROCEDURE**

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

**National Guardian Life Insurance Company  
c/o National Vision Administrators, L. L. C.  
1200 Rt 46 West, 2<sup>nd</sup> Floor, Clifton, NJ 07013**

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

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

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

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

### **PART X. 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.

**Physical Examinations and Autopsy:** We reserve the right and opportunity, at Our own expense, to examine the Insured when and as often as it may reasonably require for a pending claim and to make an autopsy in case of death where it is not forbidden by law.

**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.

## PART XI. CERTIFICATE SCHEDULE

**Policyholder:** Harris County Hospital District dba Harris Health - Buy-Up Plan

**Group Policy Number:** NVAI3461

**Policy/Certificate Effective Date:** October 1, 2025

**Initial Term:** 48 Months

**Eligible Classes:** Employees Working 30 Hours Per Week Are Eligible for Coverage

**Waiting Period:** None

**Mode of Premium Payment:** Monthly

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

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

## PART XII. SCHEDULE OF BENEFITS

Your Certificate is on a Policy Year Plan Basis.

<b>BENEFITS AND ALLOWANCES <sup>1</sup></b>		
	<b>In-Network:</b>	<b>Out-of-Network:</b>
<b>Comprehensive Eye Exam</b>		
<b>By Ophthalmologist</b> <b>By Optometrist</b>  <b>Benefit Frequency:</b> Once every 12 Months	Co-Pay: \$10 Co-Pay: \$10	Allowance: up to \$40 Allowance: up to \$40
<b>Contact Lenses Evaluation, Fitting and Follow-Up Care:</b>		
Standard Daily Wear Standard Extended Wear Specialty Wear  <b>Benefit Frequency:</b> Once every 12 Months	Co-Pay: \$20 Co-Pay: \$30 Co-Pay: \$50	Allowance: up to \$20 Allowance: up to \$30 Allowance: up to \$50
<b>Vision Materials</b>		
<b>Eyeglass Frames</b>		
<b>Benefit Frequency:</b> Once every 12 Months	Allowance: up to \$130	Allowance: up to \$45
<b>Eyeglass Lenses – per pair</b>		
<b>Benefit Frequency:</b> Once every 12 Months	Co-Pay: \$20	Co-Pay: None
<b>Single Vision</b>	Covered in Full	Allowance: up to \$40
<b>Bifocal</b>	Covered in Full	Allowance: up to \$60
<b>Trifocal</b>	Covered in Full	Allowance: up to \$80
<b>Lenticular</b>	Covered in Full	Allowance: up to \$80

<b>Lens Options – per pair Add-On Items</b>		
<b>Benefit Frequency:</b> Once every 12 Months		
<b>Polycarbonate Lenses</b> Single Vision Multifocal  Age 18 and Under	Covered in Full Covered in Full	Allowance: up to \$25 Allowance: up to \$30
<b>Scratch Resistant Coating</b>	Covered in Full	Allowance: up to \$10
<b>Tint Solid</b> Single Vision Multifocal	Covered in Full Covered in Full	Allowance: up to \$10 Allowance: up to \$10
<b>Tint Gradient</b> Single Vision Multifocal	Covered in Full Covered in Full	Allowance: up to \$12 Allowance: up to \$12
<b>Progressive Lenses</b> Tier 1 Tier 2	Covered in Full Covered in Full	Allowance: up to \$50 Allowance: up to \$80
<b>Anti-Reflective Coating</b> Tier 1	Covered in Full	Allowance: up to \$40
<b>Ultraviolet (UV) Coating</b>	Covered in Full	Allowance: up to \$12

<b>Contact Lenses <sup>2</sup></b>		
<b>Benefit Frequency:</b> Once every 12 Months		
<b>Elective</b>	Allowance: up to \$105	Allowance: up to \$105
<b>Non-Elective/Visually-Necessary Contact Lenses <sup>2,3</sup></b>	Covered in Full	Allowance: up to \$210

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

<sup>2</sup> Contact Lenses are payable in lieu of Eyeglass Lenses or Frames.

<sup>3</sup>Prior Authorization Required



# NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909  
2 East Gilman Street Madison, Wisconsin 53703

## LOW VISION BENEFIT RIDER LIMITED BENEFITS – PLEASE READ CAREFULLY

Attached to and made part of the Policyholder’s Group Vision Policy and each Certificate of Insurance issued under such policy. It is hereby agreed that the policy and certificate is amended by adding the benefits provisions as defined below:

**RIDER EFFECTIVE DATE:** This Rider is effective on the effective date of the Group Vision Policy.

### BENEFIT DESCRIPTION

This Rider provides a benefit if an Insured is diagnosed with Low Vision. The benefit payable for Low Vision Testing and Low Vision Aids is shown in the Rider Schedule of Benefits. The benefit is subject to the frequency and benefit limitations as outlined in this Rider.

### RIDER SCHEDULE OF BENEFITS

<u>SERVICE OR MATERIAL</u>	<u>IN-NETWORK PROVIDER BENEFIT</u>	<u>OUT-OF-NETWORK PROVIDER BENEFIT</u>	<u>FREQUENCY</u>
Low Vision Testing	Covered in Full	Up to \$125	Once every 2 years
Low Vision Aids	75% of amount up to \$1000.00*	75% of amount up to \$1000.00*	Once every 2 years

**\*Maximum benefit for all Low Vision Testing and Aids is \$1000.00 every two Calendar Years.**

**Low Vision benefits secured from Non-Network Providers (if covered) are subject to the same time and Copayment provisions described above for In-Network Providers. The Insured should pay the Non-Network Provider’s full fee at the time of service.**

### DEFINITIONS

**Low Vision** means acuity or visual field loss that cannot be corrected with regular Eyeglass Lenses.

**Low Vision Testing** means the evaluation, diagnosis and prescription of Low Vision Aids by an Optometrist or Ophthalmologist who specializes in Low Vision rehabilitation. Low Vision Testing does not include orthoptics or vision training.

**Low Vision Aids** means supplemental aids that are prescribed as a result of Low Vision Testing. Low Vision Aids include, but are not limited to, reading telescopes, closed circuit TV reading systems, magnifiers, and bioptic eyewear. Conventional glasses or contacts are not considered Low Vision Aids.

### EXCLUSIONS

We will not pay for:

1. Medical or surgical treatment of the eyes;
2. Replacement of any Low Vision Aid, except at the normal frequency when benefits are otherwise available;
3. Conventional glasses or contacts.

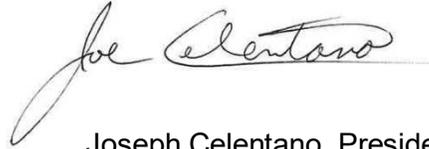
This rider takes effect on the date specified on Page 1 of the Rider. It terminates on the same date as the Policy/Certificate to which it is attached.

This rider is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of the Policy/Certificate.

Signed for National Guardian Life Insurance Company, at its Home Office, 2 East Gilman Street, Madison, WI 53703.



Kimberly A. Shaul, Secretary



Joseph Celentano, President

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts) **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

**For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:**

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, TX 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 149104  
Austin, TX 78714-9104  
1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### National Vision Administrators LLC

To get information or file a complaint with your insurance company or HMO:

**Call: Customer Service Manager at 800-672-7723**

**Toll-free: 800-672-7723**

Email: [NVA\\_CustomerService@e-nva.com](mailto:NVA_CustomerService@e-nva.com)

Mail: National Vision Administrators, LLC

Customer Services Department

1200 US Route 46 West, Clifton NJ 07013

### The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## ¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### National Vision Administrators LLC

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Gerente De Servicio al Cliente al 800-672-7723**

**Teléfono gratuito: 800-672-7723**

Correo electrónico: [NVA\\_CustomerService@e-nva.com](mailto:NVA_CustomerService@e-nva.com)

Dirección postal: National vision Administrators, LLC

Customer Service Department

1200 US Route 46 West, Clifton NJ 07013

### El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091



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

**AMENDMENT**  
**DEFINITION OF ELIGIBLE DEPENDENT**

The Policy and Certificate to which this Amendment is attached are amended as described below. Under Part I. Definitions, the definition of Eligible Dependent is deleted in its entirety and replaced with the following.

**Eligible Dependent** - Means a person listed below:

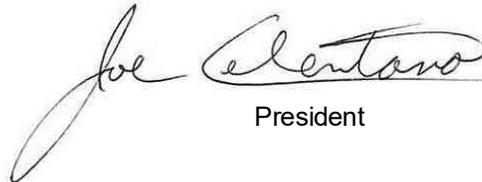
1. Your Spouse;
2. Your unmarried dependent child under age 26, who is Your natural or adopted child, Your Spouse's child, a foster child, or a child for whom You are a legal guardian or required by a medical support order to provide vision coverage, or a child during the pendency of adoption. Eligibility continues until the last day of the month in which Your child reaches that age.
3. Your unmarried child who has reached age 26 and who is:
  - a. primarily dependent upon You for support and maintenance; and
  - b. incapable of self-sustaining employment by reason of intellectual disability or physical disability.Proof of the child's incapacity or dependency must be furnished to Us within 31 days of the date that an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.
4. Your unmarried grandchild under the age of 25, who is Your dependent for federal income tax purposes at the time of application for coverage of the grandchild is made.

This Endorsement takes effect 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



# Privacy Notice

## 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 could collect include, but 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 (MIB, Inc.)
- 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.

**Massachusetts Policyholders:** You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

## 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](http://www.nglic.com).