NATIONAL GUARDIAN LIFE INSURANCE COMPANY

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

2 East Gilman Street Madison, Wisconsin 53701

GROUP VISION CARE INSURANCE CERTIFICATE

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

Administrator: Superior Vision Services, Inc.
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

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

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

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

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

Sherri Kliczak, Secretary **John Larson, President**

COVERAGE SUBJECT TO PREMIUM RATE CHANGE
NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

IMPORTANT NOTICE

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

1-800-923-6766

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

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

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104

Austin, TX 78714-9104

Fax: 512-475-1771

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

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

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

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become part or condition of the attached document.

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

1-800-923-6766

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

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

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

1-800-252-3439

Puede escribir al Departmento 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 compania 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 proposito de información y no se convierte en parte o condición del documento adjunto.

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PART I. CERTIFICATE SCHEDULE

Policyholder:	The University of Texas System
Group Policy Number:	26856
Effective Date:	September 1, 2009
Initial Term:	36 Months
Eligible Classes:	All Employees regularly scheduled to work twenty (20) or more hours per week
Mode of Premium Payment:	MONTHLY
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Policy Year Plan Basis	
Vision Exam:	Once every Plan Year
Eyeglass Lenses:	Once every Plan Year
Frames:	Once every Plan Year
Contact Lenses:	Once every Plan Year
Contact Lens Fit:	Once every Plan Year

CO-PAY (PER INSURED)		
	In-Network Providers:	Out-of-Network Provider:
Vision Exam:	$35	None
Eyeglass Lenses/Frames:	None	None
Contact Lens Fit:	$35	Not Covered

BENEFITS AND ALLOWANCES [1]		
	In-Network Providers: [2]	Out-of-Network Provider:
Vision Exam:		
Ophthalmologist (M.D.)	Covered in Full	$42 Allowance
Optometrist (O.D.)	Covered in Full	$37 Allowance
Materials- Eyeglass Lenses: [3]		
Single Vision	Covered in Full	$32 Allowance
Progressive	Covered up to the providers price for trifocals	Covered up to the same amount as trifocals
Bifocals	Covered in Full	$46 Allowance
Trifocals	Covered in Full	$61 Allowance
Lenticular	Covered in Full	$84 Allowance
Materials – Frames: [3]	$140 Allowance	$53 Allowance
Materials – Contact Lenses:		
Non-Elective	Covered in Full	$210 Allowance
Elective	$125 Allowance	$100 Allowance
Contact Lens Fit:		
Standard[4]	Covered in Full	Not Covered
Specialty[4]	$50 Allowance	Not Covered

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

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

[3] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

[4] Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over $50.

PART III. DEFINITIONS

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

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

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

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

Contact Lenses, Non-Elective – Non-elective Contact Lenses refer to contact lenses that are prescribed solely for the purpose of correcting one (1) of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

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

Reimbursement of Non-Elective Contact Lenses will be considered as payment in full if utilizing the services of an In-Network Provider. This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

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

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

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

Eligible Dependent - Means a person listed below:

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

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

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

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

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

In-Network Provider - An Ophthalmologist, Optometrist or Optician who has entered into 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.

Policy Year Plan - Benefits begin immediately on the Policyholder's effective date and renew twelve (12) months following the initial effective date.

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

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

You or Your – The Insured Member.

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

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

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

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

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

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one (1) parent.

B. ENROLLMENT

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

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

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

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

1. Marriage ;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

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

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

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

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

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

PART VI. INDIVIDUAL TERMINATION DATES

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

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

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

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

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one (1) of two (2) ways:

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

The Certificate Schedule shows the method of premium payment.

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

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

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a six (6) month period. We will give the Policyholder written notice at least sixty (60) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

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

A. In-Network Benefits

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

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

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

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

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

B. Out-of-Network Benefits

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

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

C. Covered Services or Materials

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

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

In no event will coverage exceed the lesser of:

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

PART IX. LIMITATIONS AND EXCLUSIONS

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

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

Coverage for a Re-Enrollee is limited to the Vision Exam benefit during the first twenty-four (24) months after such person's effective date of coverage.

Exclusions

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

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;

9. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;
11. Services for which benefits are paid by Worker's Compensation;
12. Benefits provided under the employee's medical insurance except in the case of Coordination of Benefits;
13. Blended bifocal lenses
14. Groove, Drill or Notch, and Roll and Polish;
15. Two (2) pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (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 <u>not</u> a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two (2).

PART X. CLAIM PROVISIONS

A. In-Network Claims

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

B. Out-of-Network Claims

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

C. Notice of Claim

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

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

D. Claim Forms

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

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

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

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

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

PART XII. GRIEVANCE PROCEDURE

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

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

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

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

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

In situations requiring urgent care, grievances will be resolved within seventy-two (72) hours of receiving the grievance.

PART XIII. GENERAL PROVISIONS

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

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

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 could 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.

Superior Vision Services, 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
Superior Vision Services, Inc.
11101 White Rock Road, Ste 150
Rancho Cordova, CA 95670

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.

Important Information About Coverage Under the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Services Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitation, and conditions of the Association Law. (The law is found in the Texas Insurance Code, Article 21 .28-D.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for any one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

ADMINISTRATIVE BENEFIT / CONTRACT CLARIFICATION

This information, along with your Certificate of Coverage, constitutes the SUMMARY PLAN DESCRIPTION.

GENERAL INFORMATION

Plan Name: The University of Texas System

Name and Address of Policyholder:
The University of Texas System
702 Colorado Street, Suite 2100
Austin, TX 78701-3043

Plan Sponsor's IRS Employer Identification Number:

Group Number: 26856

Plan Type: Group Vision Insurance

Type of Plan Administration:
Group Insurance Policy underwritten by:
National Guardian Life Insurance Company
2 East Gilman Street, Madison, WI 53701

Name, Address and Telephone Number of Plan Administrator:
Office of Employee Benefits
The University of Texas System
Austin, TX 78701-3043
(512) 499-4616

Premium Payments: Employees contribute to the cost.

Plan Year: September 1 through August 31

Agent for Legal Process: Plan Administrator.

Trustee: None

Collective Bargaining or Multiple Employer Agreements under which Plan is established: None

Eligibility Requirements: See Eligibility Determination section in the Insurance Certificate.

Description of Benefits: Your insurance Certificate describes the benefits provided by your Certificate, including the Covered Services and Materials, Premiums, Co-payments; Limitations and Exclusions, Claims Procedures, and any basis for termination of the plan.

Qualified Medical Child Support Orders ("QMSCO"): As a plan participant you can obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations, from your Plan Administrator.

RIGHTS TO CONTINUATION OF INSURANCE COVERAGE UNDER COBRA

If you or your Eligible Dependents lose vision coverage under the Master Group Policy as a result of a Qualifying Event, you may be entitled to extend coverage for a period of time under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, Domestic Partners and Eligible Dependents of Domestic Partners do not qualify for COBRA coverage.

You may elect to continue vision coverage under the Master Group Policy. Contact Your Human Resources or Employee Benefits office for more information.

Qualifying Events

COBRA continuation coverage may be elected if coverage under the Superior Vision Plan ends due to one or more of the following "Qualifying Events":

- Your employment ends (except for termination due to gross misconduct or fraud).
- Your work hours are reduced.
- You become entitled to Medicare benefits.
- Your death.
- Divorce or legal separation.
- Loss of dependent eligibility.
- If You are a covered retiree, filing by the Policyholder for bankruptcy under Title XI of the United States Code.

Continuation Period

Coverage may be continued under COBRA for up to the maximum period of time specified below. The length of time depends on the Qualifying Event(s) and circumstances.

18-Month Continuation Period. If You lose coverage due to termination of Your employment for any reason (other than gross misconduct), or due to reduced work hours, You may continue coverage for Yourself and Your Eligible Dependents for up to eighteen (18) months following the termination or work reduction date.

29-Month Continuation Period. If the Social Security Administration (SSA) determines that You are disabled at any time during the first sixty (60) days of continued coverage, and the Qualifying Event for continued coverage was termination of employment or a reduction in work hours, You may extend COBRA coverage by an additional eleven (11) months, for a total of twenty-nine (29) months of coverage subject to the certain conditions.

- You must notify the Policyholder's plan administrator of the disability within sixty (60) days of the SSA determination and before the end of the original eighteen (18) month COBRA continuation period; and
- You must agree to pay any increase in the required payment necessary to continue the coverage for the additional eleven (11) months.
- If You have any non-disabled Covered Dependents entitled to COBRA, they are also entitled to extend COBRA coverage by an additional eleven (11) months of coverage.

36-Month Continuation Period. Coverage may be continued for up to thirty-six (36) months from the date coverage would have stopped due to a Qualified Event other than described above.

If a second Qualifying Event occurs within the original eighteen (18) month continuation period, coverage may be continued for a total of thirty-six (36) months from the date of the first Qualifying Event. Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Notification Requirements

You must notify Your Human Resources or Employee Benefits office in writing within sixty (60) days when either of the following Qualifying Events occur:

- Divorce or legal separation
- A child loses eligibility as a dependent.

Your Human Resources or Employee Benefits office will send You the appropriate forms within fourteen (14) days after receiving Your notice.

Election Period

You have at least sixty (60) days to elect to continue coverage under COBRA. The election period ends on the later of:

- Sixty (60) days after the date coverage would have stopped due to a Qualifying Event; or
- Sixty (60) days after the date You receive notice of COBRA continuation rights.

Unless otherwise specified, You or Your spouse's election to continue coverage will be considered an election on behalf of all other Covered Dependents who would also lose coverage because of the same Qualifying Event.

Required Payment

You must pay for COBRA continuation coverage. Contact your Human Resources or Employee Benefits office for the total cost.

You have forty-five (45) days from the date of election to make the first required payment for COBRA continuation coverage. The first required payment will include any required payment for coverage that was continued from the time of loss of group coverage but prior to the date of election.

Continued Coverage Ends

Continuation of coverage under COBRA will end for You or Your Eligible Dependents on the earliest of the following dates:

1. The date Your maximum COBRA period ends.
2. The date You fail to make the required payment for continued coverage within the thirty (30) day grace period**.**
3. The date You become covered under any other group health plan that provides routine vision benefits.
4. For a spouse or dependent who was entitled to Medicare prior to a Qualifying Event due to termination of employment or reduction of work hours, eighteen (18) months after the Qualifying Event, or if later, thirty-six (36) months from the date you become entitled to Medicare.
5. The date the Master Group Policy terminates.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is a federal law which gives Insured employees certain rights to continuation of coverage under the Master Group Policy during a military leave, and to certain reinstatement rights upon return from a military leave. You may have additional protections under state laws. Under USERRA, employers must continue coverage for Covered Employees and their Covered Dependents during a military leave.

FMLA - Family and Medical Leave Act of 1993

Certain employers are subject to the FMLA. If you have a leave from active work certified by your employer, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage and any dependents coverage you have under the Group Policy will remain in force so long as you continue to meet the requirements as set forth in the FMLA.

Contact Your Human Resources or Employee Benefits office for more information about the information contained in this Administrative Benefit / Contract Clarification Sheet.