



GUARDIANSM

**YOUR GROUP INSURANCE
PLAN BENEFITS**

CYPRESS-FAIRBANKS I.S.D.

CLASS 0001

VISION

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

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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



Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023

TABLE OF CONTENTS

IMPORTANT NOTICE	1
AVISO IMPORTANTE	1
IMPORTANT NOTICE	3
GENERAL PROVISIONS	
Limitation of Authority	5
Incontestability	5
Accident and Health Claims Provisions	6
Coordination Between Continuation Sections	7
An Important Notice About Continuation Rights	8
YOUR CONTINUATION RIGHTS	
Federal Continuation Rights	9
Uniformed Services Continuation Rights	13
ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE	
Employee Vision Care Expense Coverage	14
Your Right To Continue Group Coverage During A Family Leave Of Absence	15
Dependent Vision Care Expense Coverage	16
VISION CARE HIGHLIGHTS	20
VISION CARE EXPENSE INSURANCE	
Vision Service Plan - This Plan's Vision Care Preferred Provider Organization	21
How This Plan Works	23
Services or Supplies from a Preferred Provider	23
Services or Supplies From a Non-Preferred Provider	25
Covered Charges	25
Covered Services and Supplies	25
Special Limitations	27
Exclusions	28
GLOSSARY	30
STATEMENT OF ERISA RIGHTS	
The Guardian's Responsibilities	35
Group Health Benefits Claims Procedure	36
Termination of This Group Plan	40

IMPORTANT NOTICE

- 1) To obtain information or make a complaint:
- 2) You may call The Guardian's toll-free telephone number for information or to make a complaint at:

1-800-459-9401

- 3) You may also write to The Guardian at:

The Guardian Life Insurance
Company of America
East 777 Magnesium Road
Spokane, Washington 99208-5884

- 4) You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

- 5) 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
- 6) **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact The Guardian Life Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.
- 7) **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

CGP-3-R-DISC-TX-92

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-800-459-9401

Usted tambien puede escribir a The Guardian:

The Guardian Life Insurance
Company of America
East 777 Magnesium Road
Spokane, Washington 99208-5884

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: <http://www.tdi.state.tx.us>
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el The Guardian Life Insurance Company primero. Si no se resuelve la disputa, puedo entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

B120.0068

IMPORTANT NOTICE

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.

CGP-3-R-COMP-TX-92

B120.0015

GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan*.

"Covered person" means an *employee* or a dependent insured by this *plan*.

"Employer" means the *employer* who purchased this *plan*.

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

"Plan" means the Guardian *plan* of group insurance purchased by your *employer*.

"You" and "your" mean an *employee* insured by this *plan*.

CGP-3-R-GENPRO-90

B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-90

B160.0003

Accident and Health Claims Provisions

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

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents*, his or her name should also be noted.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled within 60 days after we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

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

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

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

CGP-3-R-AHC-90-TX

B160.0033

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87

B240.0044

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

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

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

Conversion Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

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

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

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

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

Federal Continuation Rights (Cont.)

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

CGP-3-R-COBRA-96-1

B235.0164

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

CGP-3-R-COBRA-96-2

B235.0075

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

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

Concurrent Continuations If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

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

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

The Qualified Continuee's Responsibilities A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Federal Continuation Rights (Cont.)

Notice of an event that would qualify a person for continuation under this section must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date on which an event that would qualify a person for continuation under this section occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice.

Notice of a disability determination must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

CGP-3-R-COBRA-96-3

B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Federal Continuation Rights (Cont.)

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

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

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

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;

Federal Continuation Rights (Cont.)

- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

B235.0198

Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this *plan* as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this *plan* would otherwise end because you enter into active military service, this *plan* will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this *plan*.

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.

CGP-3-R-COBRA-96-4

B235.0195

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Care Expense Coverage

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

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

This *plan's* vision open enrollment period occurs from May 2nd to June 10th of each year.

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

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

CGP-3-EC-90-1.0

B505.0060-R

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

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

CGP-3-EC-90-2.0

B505.0075

When Your Coverage Ends Your coverage under this *plan* ends on the last day of the month in which your active *full-time* service ends for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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

Employee Vision Care Expense Coverage (Cont.)

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

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

CGP-3-EC-90-3.0

B505.0083

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

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

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

When Continuation Ends Coverage may continue until the earliest of the following:

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B449.0727

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 25; and (c) your unmarried dependent children from age 25 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan*. You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary*.

CGP-3-DEP-90-2.0

B505.0792

Dependent Vision Care Expense Coverage (Cont.)

Adopted Children, Step-Children and Grandchildren An *employee's* "unmarried dependent children" include: (a) his or her legally adopted children; (b) his or her grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren are made; and (c) if they depend on him or her for most of their support and maintenance, his or her step-children.

We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible We exclude any dependent who is insured by this *plan* as an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

B505.0222

Handicapped Children You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself. Subject to all of the terms of this section and the *plan*, such a child may stay eligible for dependent vision care benefits past this *plan's* age limit.

The child will stay eligible as long as he stays unmarried and unable to support himself, if: (a) his conditions started before he reached this *plan's* age limit; (b) he became insured by this *plan* before he reached the age limit, and stayed continuously insured until he reached such limit; and (c) he depends on you for most of his support and maintenance.

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B505.0119

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

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

If you do this within 31 days of your *eligibility date*, date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.

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

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

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

CGP-3-DEP-90-6.0

B505.0714

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

CGP-3-DEP-90-7.0

B505.0132

Newborn Children We cover your newborn child from the moment of birth if you're already insured for dependent vision coverage, and you notify us within 31 days of the child's birth. If you fail to notify us on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is your first *eligible dependent*, we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child's birth. If you fail to enroll on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is not your first *eligible dependent*, but you did not previously enroll your other *eligible dependents* for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other *eligible dependents* at this time.

CGP-3-DEP-90-8.0

B505.0153

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

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

Dependent Vision Care Expense Coverage (Cont.)

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

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

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the *employee* for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B505.0746

VISION CARE HIGHLIGHTS

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

PPO Copayments	Examinations	\$20.00
	Standard Frames and/or Standard Lenses	\$20.00
	Necessary Contact Lenses	\$20.00

Non-PPO Cash Deductibles	Examinations	\$20.00
	Standard Frames and/or Standard Lenses	\$20.00
	Necessary Contact Lenses	\$20.00

Payment Rates	For Covered Charges	100%
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CGP-3-VSN-96-BEN3

B505.0004

VISION CARE EXPENSE INSURANCE

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

CGP-3-VSN-96-VIS

B505.0007

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

Vision Service Plan This *Plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *Covered Person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care Preferred Provider Organization (PPO).

This vision care PPO is made up of *Preferred Providers* in a *Covered Person's* geographic area. A vision care *Preferred Provider* is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP and (b) has a participatory agreement in force with VSP.

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

When an *employee* and his or her dependents enroll in this *Plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *Preferred Providers*.

What we pay is based on all the terms of this *Plan*. The *Covered Person* should read this material with care and have it available when seeking vision care. Read this *Plan* carefully for specific benefit levels, *Copayments*, *Deductibles*, payment rates and payment limits.

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

Choice of Preferred Providers When a person becomes enrolled in this *Plan*, and annually thereafter, he or she will receive a list of VSP *Preferred Providers* in his or her area. A *Covered Person* may receive vision services from any VSP *Preferred Provider*.

Replacement of Preferred Provider If a *Preferred Provider* terminates his or her relationship with VSP for any reason, VSP shall be responsible for furnishing vision services to *Covered Persons* either through that provider or through another VSP *Preferred Provider*.

Vision Service Plan

This Plan's Vision Care Preferred Provider Organization (Cont.)

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

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

CGP-3-VSN-96-PPOATX

B505.0393

Pre-Treatment Review for Necessary Contact Lenses Subject to prior approval by VSP consultants, we will pay benefits for Necessary Contact Lenses provided to a *Covered Person*. A *Covered Person's* doctor will request approval for Necessary Contact Lenses from VSP.

If Contact Lenses are not found to be medically necessary, and a *Covered Person* receives Contact Lenses under this Policy, they will be treated as Elective Contact Lenses and the provisions of the Elective Contact Lenses section of this Policy will not apply.

What we pay for Necessary Contact Lenses is subject to all of the terms of this *Plan*.

CGP-3-VSN-96-PTR2TX

B505.0395

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

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

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

Vision Service Plan

This Plan's Vision Care Preferred Provider Organization (Cont.)

The procedure for arbitration shall be conducted pursuant to the rules of the American Arbitration Association.

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

- (1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.
- (2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
- (3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person*. Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.
- (4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.
- (5) All complaints will be retained in the Professional Relations Department.

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

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(877) 814-8970 or (800) 877-7195

CGP-3-VSN-96-APP

B505.0015

How This Plan Works

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

Services or Supplies from a Preferred Provider

If a *Covered Person* uses the services of a *Preferred Provider*, the *Preferred Provider* will receive approval from VSP prior to providing the *Covered Person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *Plan* for specific requirements.

Copayments The *Covered Person* must pay a *Copayment* when he or she receives services from a *Preferred Provider*. We pay benefits for the covered charges a *Covered Person* incurs in excess of the *Copayment*. This *Plan's* *Copayments* are as follows:

Services or Supplies From a Preferred Provider (Cont.)

For each vision examination from a *Preferred Provider* \$20.00

For each pair of *Standard Frames* and/or
Standard Lenses from a *Preferred Provider* \$20.00

For Necessary Contact Lenses from a *Preferred Provider* \$20.00

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

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

For Covered Charges 100%

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

The discounts are:

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

For Non-Prescription Sunglasses 20% off of the *preferred provider's*
usual and customary fee

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

If a covered person receives a vision examination, and lenses or frames from a *preferred provider*, he or she will receive a discount on the cost of purchasing an unlimited number of additional prescription glasses and non-prescription sunglasses from the same *preferred provider* on the same day.

The discounts are:

For Prescription Glasses 30% off of the *preferred provider's*
usual and customary fee

For Non-Prescription Sunglasses 30% off of the *preferred provider's*
usual and customary fee

Services or Supplies From a Non-Preferred Provider

If a *Covered Person* uses the services of a *Non-Preferred Provider*, the *Covered Person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received, or as soon as reasonably possible. The benefits we pay are subject to all of the terms of this *Plan*.

Cash Deductible for Services of a Non-Preferred Provider There are separate cash *Deductibles* for each covered service provided by a *Non-Preferred Provider*. These cash *Deductibles* are shown below. The *Covered Person* must have covered charges in excess of the cash *Deductible* before we pay him or her any benefits for the service or supply.

For each vision examination provided by a *Non-Preferred Provider* . . . \$20.00

For each pair of *Standard Frames* and/or
Standard Lenses from a *Non-Preferred Provider* \$20.00

For each pair of Necessary Contact Lenses from
a *Non-Preferred Provider* \$20.00

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

Payment Rates Once a *Covered Person* has met any applicable *Deductible*, we pay benefits for Covered Charges under this *Plan* as follows. What we pay is subject to all of the terms of this *Plan*.

For Covered Charges 100%

CGP-3-VSN-BEN2TX

B505.0401

Covered Charges

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

Covered Services and Supplies

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

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

Covered Services and Supplies (Cont.)

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

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

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

And if a *covered person* uses a *non-preferred provider*, we limit what we pay for each vision examination to \$50.00.

CGP-3-VSN-96-LIST1

B505.0935

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

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

- \$48.00 for each pair of single vision lenses
- \$67.00 for each pair of bifocal lenses
- \$86.00 for each pair of trifocal lenses and
- \$126.00 for each pair of *lenticular lenses*.

B505.0941

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

B505.0962

CGP-3-VSN-09-SL-TX

B505.1029

Standard Frames We cover charges for standard frames.

If a *covered person* uses a preferred provider, we cover charges up to a retail frame allowance of \$130.00, plus 20% of any amount over the allowance.

If a *covered person* uses a non-preferred provider, we limit what we pay for each set of standard frames to \$48.00.

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

Covered Services and Supplies (Cont.)

We cover charges for one set of standard frames in any period of 2 calendar years.

CGP-3-VSN-09-SF

B505.0988

Necessary Contact Lenses We cover charges for Necessary Contact Lenses upon prior approval by VSP. We cover charges, and charges for related professional services, only if the lenses are needed:

- (a) following cataract surgery;
- (b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- (c) for certain conditions of *anisometropia*; or
- (d) for *keratoconus*.

We don't cover charges for more than one pair of Necessary Contact Lenses in any calendar year period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider*, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider*, we limit what we pay to \$210.00 in any calendar year period.

CGP-3-VSN-96-LIST7

B505.0996

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

If we cover charges for elective contact lenses, we will not cover charges for standard lenses until the next calendar year and standard frames for a period of 2 calendar years.

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to \$130.00

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to \$120.00.

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

CGP-3-VSN-09-ECL

B505.1006

Special Limitations

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

CGP-3-VSN-96-SL1

B505.0031

Exclusions

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

CGP-3-VSN-96-EXC1

B505.0034

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

B505.0998

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

B505.1015

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

B505.1016

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

B505.1017

- We will not pay for blended lenses.

B505.1018

- We will not pay for high index lenses.

B505.1019

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

B505.1020

- We will not pay for oversized lenses.

B505.1021

Exclusions (Cont.)

- We will not pay for laminating of the lens or lenses. B505.1022
 - We will not pay for edge treatment. B505.1023
 - We will not pay for progressive lenses. B505.1024
 - We will not pay for progressive multifocal lenses. B505.1025
 - We will not pay for the anti-reflective coating of the lens or lenses. B505.1026
 - We will not pay for polycarbonate lenses. B505.1027
- CGP-3-VSN-09-EXC B505.1027
- Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments or deductibles*, if any.
- CGP-3-VSN-96-EXC17 B505.0037

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Anisometropia	means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.	
	CGP-3-VSN-96-DEF1	B750.0457
Benefit Period	with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this <i>plan</i> , the covered service is again available to a <i>covered person</i> .	
	CGP-3-VSN-96-DEF3	B750.0458
Blended Lenses	mean bifocals which do not have a visible dividing line.	
	CGP-3-VSN-96-DEF3	B750.0459
Coated Lenses	means substance added to a finished lens on one or both surfaces.	
	CGP-3-VSN-96-DEF3	B750.0460
Copayment	with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a <i>covered person</i> to a <i>preferred provider</i> at the time covered vision services are received.	
	CGP-3-VSN-96-DEF3	B750.0461
Covered Person	with respect to Vision Care Insurance, means an <i>employee</i> or eligible dependent who meets this <i>plan's</i> eligibility criteria and who is covered under this <i>plan</i> .	
	CGP-3-VSN-96-DEF3	B750.0462
Customary	with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the <i>usual</i> charge made by most other doctors with similar training and experience in the same geographic area.	
	CGP-3-VSN-96-DEF3	B750.0484
Deductible	with respect to Vision Care Insurance, means any amount which a <i>covered person</i> must pay before he or she is reimbursed for covered services provided by a <i>non-preferred provider</i> .	
	CGP-3-VSN-96-DEF3	B750.0483
Eligibility Date	for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.	
	CGP-3-GLOSS-90	B900.0003
Eligible Dependent	is defined in the provision entitled "Dependent Coverage."	
	CGP-3-GLOSS-90	B750.0015

Glossary (Cont.)

Employee	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	CGP-3-GLOSS-90	B750.0006
Employer	means CYPRESS-FAIRBANKS I.S.D. .	CGP-3-GLOSS-90	B900.0051
Enrollment Period	with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.	CGP-3-GLOSS-90	B900.0004
Full-time	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 15 hours per week), at his <i>employer's</i> place of business.	CGP-3-GLOSS.1	B750.0230
Incurred, Or Incurred Date	with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.	CGP-3-VSN-96-DEF3	B750.0466
Initial Dependents	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0006
Keratoconus	means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.	CGP-3-VSN-96-DEF11	B750.0467
Lenticular Lenses	mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.	CGP-3-VSN-96-DEF11	B750.0485
Newly Acquired Dependent	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0008
Non-Preferred Provider	with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the <i>plan</i> to provide vision care services and/or vision care materials to <i>covered persons</i> of the <i>plan</i> .	CGP-3-VSN-96-DEF14	B750.0487
Orthoptics	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	CGP-3-VSN-96-DEF16	B750.0472

Glossary (Cont.)

Oversize lenses	mean larger than a <i>standard lens</i> blank, to accommodate prescriptions.	
	CGP-3-VSN-96-DEF17	B750.0489
Photochromic Lenses	mean lenses which change color with the intensity of sunlight.	
	CGP-3-VSN-96-DEF17	B750.0490
Plan	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.	
	CGP-3-GLOSS-90	B900.0039
Plan Benefits	with respect to Vision Care Insurance, mean the vision care services and vision care materials which a <i>covered person</i> is entitled to receive by virtue of coverage under this <i>plan</i> .	
	CGP-3-VSN-96-DEF17	B750.0492
Plano Lenses	mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	
	CGP-3-VSN-96-DEF17	B750.0491
Preferred Provider	with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the <i>plan</i> to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	
	CGP-3-VSN-96-DEF14	B750.0488
Standard Frames	mean frames valued up to the limit published by VSP which is given to <i>preferred providers</i> .	
	CGP-3-VSN-96-DEF17	B750.0478
Standard Lenses	mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.	
	CGP-3-VSN-96-DEF17	B750.0479
Tinted Lenses	mean lenses which have an additional substance added to produce constant tint.	
	CGP-3-VSN-96-DEF17	B750.0480
Usual	means, when referring to a covered charge, that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.	
	CGP-3-VSN-96-DEF17	B750.0481
Visually Necessary Or Appropriate	means medically or visually necessary to for the restoration or maintenance of a <i>covered person's</i> visual acuity and health and for which there is no less expensive professionally acceptable alternative.	
	CGP-3-VSN-96-DEF17	B750.0482

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

The Guardian's Responsibilities

B800.0048

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

B800.0055

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

B800.0049

Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and

Group Health Benefits Claims Procedure (Cont.)

- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0076

Termination of This Group Plan

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

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

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

B800.0086

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com



GUARDIANSM

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