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: National Vision Administrators, L. L. C.
1200 Rt 46 West, 2nd Floor, Clifton, NJ 07013

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

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

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while 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.

Mathew J. Dew, Secretary  
Mark Solverud, President

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY
PART I. CERTIFICATE SCHEDULE

Policyholder: Southern State Community College

Group Policy Number: NVAI8437

Effective Date: July 1, 2013

Initial Term: 48 Months

Eligible Classes: All Full Time Employees Working At Least 40 Hours Per Week After Completing the Required Length Of Service

Waiting Period: First of the Month Following First Day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month
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**PART IV. DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

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

**Eligible Dependent** - Means a person listed below:
1. Your spouse;
2. Your unmarried dependent child under age 22, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child age 22 or older but less than age 26 who is:
   a. Not regularly employed on a full-time basis;
b. Primarily dependent upon You for support and maintenance; and

c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.

4. Your unmarried child who has reached age 22 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

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

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

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

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

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

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

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

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

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

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

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

**Ophthalmologist** - A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured; 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 12 or 24 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.

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

**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 V. 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 parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other spouse’s coverage.
B. ENROLLMENT

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

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

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

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 31 days of the event. A change in family status means any of the following events:
1. Marriage or Domestic Partnership;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART VI. 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 Domestic Partner is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

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

PART VII. INDIVIDUAL TERMINATION DATES

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

In addition, coverage for each Covered Dependent stops on the earliest of:
1. the date He is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART VIII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:
1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

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

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

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 6 month period. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART IX. 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.)

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.

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 X. LIMITATIONS AND EXCLUSIONS

No benefits are payable for 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;
11. Services for which benefits are paid by Worker’s Compensation;
12. Benefits provided under the employee’s medical insurance;
13. Blended bifocal lenses;
14. Groove, Drill or Notch, and Roll and Polish;
15. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
17. Cosmetic items;
18. Faceted lenses;
19. High-Index Lenses;
20. Laminated Lenses;
21. Oversize Lenses — any lens with an eye size of 61 mm or greater;
22. Photochromic (Transition) lenses;
23. Polarized lenses;
24. Polished bevel lenses;
25. Polycarbonate lenses;
26. Prism lenses;
27. Slab-off lenses;
28. Tints (except Pink tint #1 and #2);
29. Ultra-violet tint or coating;
30. Additional cost for contact lenses over the allowance;
31. Additional cost for a frame over the allowance;
32. Progressive Power Lenses*
*Progressive Power Lens Benefit. If this type of lens is not a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens you have selected. You pay the Provider the difference, if any, between the two.

PART XI. 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 IX.A, “In-Network Benefits.”)

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

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

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

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

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

F. Payment Of Claims
Benefits will be paid within 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 National Vision Administrators, L. L. C.
1200 Rt 46 West, 2nd Floor, Clifton, NJ 07013

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

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

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

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

PART XIII. GENERAL PROVISIONS

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

**Legal Actions:** No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.
Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association

1840 Mackenzie Drive

Columbus, OH 43220

Ohio Department of Insurance

50 West Town Street

Third Floor – Suite 300
The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.
COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policy holder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS OF AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a
maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

*Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act:* For unallocated annuities that fund governmental retirement plans under §§ 401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

*For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at: olhiga.org.*
ENDORSEMENT

The Policy and Certificate to which this endorsement is attached are amended as follows:

Notice: if you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefits section, and compare them with the rules of any other plan that covers you or your family.

In the Certificate, Part IX Coordination of Benefits (COB) is hereby deleted and following Part is added:

PART IX. COORDINATION OF BENEFITS (COB)

"Coordination of Benefits" is the procedure used to pay vision care expenses when a person is covered by more than one plan. The Policy follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than Your actual bills.

When You or Your Covered Dependents are covered by another group plan in addition to this one, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if You had no other coverage. If the primary plan denies the claim or does not pay the full bill, You may then submit the balance to the secondary plan.

The Policy pays for vision care only when you follow Our rules and procedures. If Our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and You will be forced to choose which plan to use.

PLANS THAT DO NOT COORDINATE

The Policy will pay benefits without regard to benefits paid by the following kinds of coverage.
—Medicaid
—Group hospital indemnity plans which pay less than $100 per day
—School accident coverage
—Some supplemental sickness and accident policies

HOW THE POLICY PAYS AS PRIMARY PLAN

—When We are primary, We will pay the full benefit allowed by your contract as if you had no other coverage.

HOW THE POLICY PAYS AS SECONDARY PLAN

—When We are secondary, Our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will We pay more than We would have paid had we been primary.
—We will pay only for vision care expenses that are covered by the Schedule of Benefits.
—We will pay only if you have followed all of our procedural requirements, including care obtained from a participating or non-participating provider.
—We will pay no more than the allowable expense for the vision care involved. If our allowable expense is lower than the primary plan’s, we will use the primary plan’s allowable expense. That may be less than the actual bill.
WHICH PLAN IS PRIMARY?

To decide which plan is primary, We have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

1. Non-coordinating Plan: If You have another group plan which does not coordinate benefits, it will always be primary.
2. Employee: The plan which covers You as an employee (neither laid off nor retired) is always primary.
3. Children (Parents Divorced or Separated): If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, We follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
4. Children & the Birthday Rule: When Your children's vision care expenses are involved, We follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If Your birthday is in January and Your spouse's birthday is in March, Your plan will be primary for all of Your children. However, if Your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
5. Other Situations: For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. (See the Certificate provisions entitled Grievance Procedure.) If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-886-1526.

This Endorsement is effective on the later of the policy effective date or the certificate effective date to which it is attached.

There are no other changes to the policy or certificate.

In witness whereof We have caused this Endorsement to be signed by Our President and Secretary.

Mathew J. Dew
Mathew J. Dew, Secretary

Mark Solfed
Mark Solverud, President
NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

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

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

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

Types of Information we 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 (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:
Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:
- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

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

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

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

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

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

How We Protect Your Information:
NGL has developed strong security measures to guard the Information of our customers.

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

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

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