



National Guardian Life Insurance Company

Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191
(called We, Our and Us)

**Group Vision Care
Certificate of Coverage**

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

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

This certificate explains the plan of insurance underwritten by National Guardian Life Insurance Company, and accompanies the Identification Card that is needed to use benefits. The Insured's are entitled to the vision care services described in the group Policy. This certificate is provided as a summary of the group Policy to explain the Insured's vision care benefits and describe the procedure for using these benefits. However, the group Policy alone is the contract of insurance and determines the coverage and benefits. **Please read this certificate carefully to become familiar with its coverage.**

Important Notice

Benefits are payable only for expenses incurred while an Insured's coverage is in force. No agent has the right to change the Policy or to waive any part of it.

The Policy, under which this Certificate is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the policy.

The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Signed for by National Guardian Life Insurance Company:

Sherri Kliczak, Secretary

John Larson, President

Table of Contents

DEFINITIONS	3
BENEFITS SUMMARY	5
COVERED SERVICES AND MATERIALS	6
PROCEDURE FOR USING BENEFITS	7
ELIGIBILITY DETERMINATION	7
RENEWAL PROVISIONS	7
BASIS FOR TERMINATION	7
CANCELLATION	7
TERMINATION OF POLICY – SERVICES BEING RENDERED	7
WITHDRAWAL FROM ELECTIVE PLANS	8
INDIVIDUAL CONTINUATION OF COVERAGE	8
LIMITATIONS AND EXCLUSIONS	8
PREMIUMS	9
CLAIMS & GENERAL PROVISIONS	9
GRIEVANCE PROCEDURE	10

DEFINITIONS

Calendar Year Plan - means benefits begin anew on January 1 of each Calendar Year. For persons enrolled other than on January 1, of a given Calendar Year, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Calendar Year with full twelve (12) month benefits becoming effective January 1 of the next Calendar Year.

Claim Form - A form provided by Us for the purpose of determining eligibility and claim payment.

Copay Amount - An Insured's share of costs, paid to the Contracting Provider at the time the services are rendered. Copay Amounts that apply to the various vision benefits are listed in the Certificate of Coverage Benefits Summary.

Elective Plan - A plan in which individual Employees may elect whether they choose to participate.

Employee - The individual employed by the Policyholder.

Employer - The entity for whose Employees or Members vision care benefits are being provided.

Group - The aggregate of Employees which is eligible to be the recipient of benefits under the Policy.

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

Initial Term - The twenty-four (24) month period following the group's initial effective date. Rates are guaranteed not to change during this period.

Insured - The Member and Insured Dependents if dependent coverage is provided by the Employer participating in the program.

Late Entrant - Is any active eligible employee or eligible dependent enrolling more than thirty-one (31) days after first becoming eligible for coverage. Benefits are limited for Late Entrants under Limitations.

Materials - Eyeglass lenses, frames, contact lenses.

Member - An Employee who became insured under the policy.

Network or Contracting Provider - An Ophthalmologist, Optician or Optometrist who has elected to enter into a contract with the Vision Benefit Manager and who is listed in the Provider Directory.

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, who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optical Necessity - Situation when a prescription or a change of prescription is required to correct visual function.

Optician - A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an Optometrist or an Ophthalmologist, who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optometrist - A person licensed to practice optometry as defined by the laws of the state in which his or her services are rendered, who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Orthoptics - The teaching and training process for the improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

Out-of-Network Provider - An Ophthalmologist, Optician or Optometrist who has elected not to enter into a contract with the Vision Manager and who is not listed in the Provider Directory.

Plan - The coverage and benefits provided by the Policy to the Insured.

Policyholder - The entity that contracts with Us on behalf of its Members.

Policy Year Plan - means benefits begin immediately on the Policyholder's effective date and renew twelve (12) months following the initial effective date. For persons enrolled on other than the Policyholder's initial effective date or a subsequent Plan anniversary, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Plan Year with full twelve (12) month benefits becoming effective on the next Plan anniversary of the next Calendar Year.

Professional Service - Examination, material selection, fitting of glasses, related adjustments, etc.

Re-enrollee - Any active Member or dependent who was covered under the policy, terminated his coverage, and then subsequently re-enrolled for coverage at a later date.

Standard Lenses - Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top thirty-five (35) for plastic bifocal and lenticular lenses, glass trifocals through flat top twenty-eight (28) plastic trifocals through flat top thirty-five (35).

Sub-Normal Optical Correction - means vision is not correctable to better than twenty/seventy (20/70) in the better eye by the use of conventional lenses.

The Administrator - The entity which will provide complete claims service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Usual, Customary and Reasonable - means the lesser of: (a) the reasonable charges the provider charges for a vision service or supply; or (b) the customary charge for the vision service or supply. We will determine the customary charge from within the range of charges made for such vision service or supply by other providers of similar training and experience in that general geographic area.

Vision Benefit Manager - The entity which will provide a network of Network Providers and claims payment services as agreed to in a contract with The Administrator.

Vision Examination - An examination of principal vision functions. A Vision Examination 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 will be consistent with the community standards, rules and regulations of the jurisdiction in which the Contracting Provider practice is located.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

CERTIFICATE DECLARATIONS

Employer/Policyholder: The University of Texas System

Group Policy Number: 26856 Policy Effective Date: September 1, 2007

Policy Month: The period of time which begins on the 1st day of each calendar month and ends on the day just before that date of the next month. The first Policy Month begins on the Effective Date; the last Policy Month ends on the day the Policy ends.

FILING FORMAT

Plan selected: _____ Standard Enhanced _____ Plus _____ Other

BENEFITS SUMMARY

Benefits	Provided / Not Provided	Providers	
		In-Network	Out-of-Network
VISION EXAM			
M.D.	Provided	Covered in Full	\$42
O.D.	Provided	Covered in Full	\$37
MATERIALS			
Standard Lenses			
Single Vision	Provided	Covered in Full	\$32
Progressive	Provided	Covered to the providers price for standard trifocals	Covered up to the same amount as trifocals
Bifocals	Provided	Covered in Full	\$46
Trifocals	Provided	Covered in Full	\$61
Lenticular	Provided	Covered in Full	\$84
Frames	Provided	\$140 Allowance	\$53
Contact Lenses*			
Standard Optical	Provided	\$125 Allowance	\$100
Medical Necessity	Provided	Covered in Full	\$210
* In lieu of Eyeglass lenses and Frames. Allowances include the contact lens fitting fee.			
CO-PAY AMOUNT			
Vision Exam	Provided	\$35	\$0
Materials	Provided	\$0	\$0
FREQUENCY	Plan Year Benefit		
Vision Exam		Once every plan year	Once every plan year
Lenses		Once every plan year	Once every plan year
Frames		Once every plan year	Once every plan year
Contact Lenses		Once every plan year	Once every plan year

Note: The Copay Amount for Materials is a Copay for frames & lenses. Insureds who elect contact lenses are responsible for any separate contact lens professional fitting fee not paid by the contact lens allowance above. The Certificate Declarations for an Employee's Eligible Class, together with the Group Insurance Certificate and Certificate Riders (if any), forms that Member's Certificate of Insurance while insured under the Policy and replaces any previous Certificates of Insurance issued under the Policy to that Member. Any insurance set out in the Certificate Declaration applies to the Employee only if the Employee enrolls for, and becomes and remains insured for, such insurance in accord with the terms and conditions of the Policy.

Coordination of Benefits: (a) Insureds insured under both another plan and this plan: We consider ourselves primary in all circumstances. (b) Insureds insured under two (2) group policies with Us: Primary coverage is under the plan in which the Insured Person is the Member. In case the Insured is a dependent child who is not insured as an Employee, primary coverage is under father's plan.

COVERED SERVICES AND MATERIALS

The amount of Vision Benefits payable hereunder and the manner of payment is determined by whether the Insured utilizes the services of a Network Provider or an Out-of-Network Provider.

The Insured will receive an identification card or cards for use while covered under this Certificate. The Policyholder shall submit to the Administrator on a monthly basis, a list of all Insureds. When the Insured incurs the services of a Network Provider, such Insured may be required to present the program on the identification card to the Network Provider. The Network Provider will submit the information on the identification card electronically and may: (1) verify eligibility; and (2) notify the Insured of any out-of-pocket expenses.

If the Insured incurs the services of an Out-of Network Provider, such Insured will be required to pay the full cost of such services at the time of the purchase.

Vision Examination Benefit. If an Insured incurs expenses for a Vision Examination, We will pay such expenses up to the applicable Vision Examination Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Vision Examination Benefit Frequency shown in the Benefits Summary.

Standard Lenses Benefit. If an Insured incurs expenses for Standard Lenses, We will pay such expenses up to the Standard Lenses Maximum Benefit shown in the Benefits Summary subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Standard Lenses Benefit Frequency shown in the Benefits Summary.

Eyeglass Frame Benefit. If an Insured incurs expenses for eyeglass frames, We will pay such expenses up to the applicable Eyeglass Frame Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Eyeglass Frame Benefit Frequency shown in the Benefits Summary.

Contact Lenses Benefit. If an Insured incurs expenses for contact lenses, We will pay such expenses up to the applicable Contact Lenses Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary; and 3) the Contact Lenses are due to an optical necessity.

In addition to the above, benefits will not be payable for expenses incurred for Sub Normal Optical Correction, unless: 1) the Network or Out-of-Network Provider of such services, makes a request, in writing, to the Vision Benefit Manager that a special contact lens or lenses is necessary to achieve the best possible correction for the Insured; and 2) the Vision Benefit Manager, upon review of such request, approves the request. Benefits will be payable at the Contact Lenses Benefit Frequency and amount shown in the Benefits Summary.

PROCEDURE FOR USING BENEFITS

1. The Insured's Identification Card should be readily available when scheduling and visiting a Network Provider. For information on Network Providers, the Insured can call the toll-free number listed on the Identification Card.
2. The Insured should present their Identification Card at the time services and materials are received from a Network Provider. The Copay Amount and any other charges that are not covered must be paid at the time of service. No paperwork is required.
3. If an Insured is using an Out-of-Network Provider, they do not receive Network Pricing. Full payment must be provided to the Out-of-Network provider at the time of service and the original invoice, including an itemized statement of charges and prescription(s), should be submitted to:

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Time of Payment of Claim: Upon receipt of an itemized invoice, prescription and a photocopy of the membership card, claims will be paid immediately.

ELIGIBILITY DETERMINATION

Child (or Children) means a Member's unmarried natural child, stepchild, adopted child (including a child for which the insured is a party in a suit in which the adoption of the child by the insured is sought), and a grandchild under age 25 (all children must be eligible dependents for federal income tax purposes at the time of application). It also means a child for whom the insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

RENEWAL PROVISIONS

After the Initial Term of the Policy, the Policy shall continue on a "month-to-month" basis automatically renewing the first day of each month unless proper notice has been given in accordance with the termination conditions.

When the Company initiates a premium increase, the date said premium increase is to take effect shall become the Policy anniversary date.

BASIS FOR TERMINATION OF POLICY

1. Failure of the Policyholder to make payment to Us as outlined under the "Premiums" section of the Policy, or
2. The Policyholder falls below minimum size requirement. However, in the event the Policyholder falls below the minimum size, the Group may continue receiving benefits under this Certificate by making premium payment to the Company at the minimum Group size.

Terminating Members are dropped as reported by their Employer with thirty (30) days notice to Us.

CANCELLATION

In the event of cancellation of the Policy by Us or the Policyholder, We shall within thirty (30) days return to Policyholder the pro rata portion of the money paid to Us which corresponds to any unexpired period for which payment has been received, if any, less any amounts due to Us.

TERMINATION OF POLICY - SERVICES BEING RENDERED

If service for an Insured hereunder is being rendered as of the termination date of the Policy, coverage shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

WITHDRAWAL FROM ELECTIVE PLANS

Once an Employee and/or dependent elects to participate in the Plan, they must remain in the Plan for at least twenty-four (24) months or the remainder of the Policy term (including renewals) if shorter, unless the Policy is canceled in accordance with the cancellation conditions shown on page seven of the Policy.

INDIVIDUAL CONTINUATION OF COVERAGE

The Group Vision Care Policy is available to voluntary groups of a minimum of two hundred and fifty (250) Employees and employer-funded groups of ten (10) and is, therefore, not available on an individual basis. When a Policyholder terminates coverage, individual coverage is not available for Members who may desire to retain same.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that under certain circumstances health plan benefits available to an eligible participant and his or her dependents be made available for purchase by said persons upon the termination of employment of said participant, or the termination of the relationship between said participant and his or her dependents. If, and only to the extent, COBRA applies to the parties covered under this Certificate, the Company shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

LIMITATIONS AND EXCLUSIONS

The Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and Eyeglass Frame Benefit. An Insured shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

The Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit is payable in lieu of the Contact Lenses Benefit. An Insured shall be eligible to receive benefits under the Contact Lenses Benefit only after the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit Frequency has ended.

In no event will coverage exceed the lesser of:

1. the actual cost of insured Services or Materials; or
2. the limits of coverage shown in the Certificate of Coverage Benefits Summary.

Materials paid for under the Policy that are lost or broken will only be replaced at normal intervals when other Services are available.

Vision – Late Entry Benefit: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first twenty-four (24) months after the Late Entrant's or Re-Enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents if enrolled.

We will not cover:

1. Professional Services and/or Materials in connection with:
 - a) blended bifocals, no line, or progressive addition lenses.
 - b) compensated or special multi-focal lenses.
 - c) plain (non-prescription) lenses.
 - d) anti-reflective, scratch, UV400, or any coating or lamination applied to lenses.
 - e) Subnormal Visual Aids.
 - f) tints other than solid.
 - g) Orthoptics, vision training and developmental vision procedures.
 - h) polycarbonate lenses.
2. Medical or surgical treatment of the eyes.
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses. Although no-line bifocals and blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
6. Sub-normal vision aids.
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a) the Member resides in the U.S. or Canada; and

- b) the charges are incurred while on a business or pleasure trip.
8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials.
9. Experimental or non-conventional treatment or device.
10. Safety eyewear.
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary.
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
13. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within thirty-one (31) days from the date of such order.
15. Services rendered or Materials ordered before the date coverage began under this Certificate.
16. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Benefits Summary.

PREMIUMS

Premium Payments: Premiums will be payable by the Policyholder to Us for the coverage provided under the Policy. Premium payments are due on the first day of each consecutive calendar month.

Grace Period: If the Policyholder has not given written notice to Us that the coverage under the Policy is to be terminated at least sixty (60) days prior to the premium due date, a grace period of thirty-one (31) days will be allowed for any premium due after the first premium. If the Policyholder fails to pay such premium prior to the end of the grace period all coverage will lapse as of the first of the month for which the premium is in default. The policyholder will be liable to Us for payment of the pro-rata premium for the time the policy was in force during such grace period.

Change in Premiums: We have the right to change the premium rates after the Initial Term shown on the face page of the Policy, and not more than once in any six (6) month period following the Initial Term. We will notify the Policyholder in writing at least thirty (30) days before any increase in policy rates.

Misstatement of Age: If the age of any Insured has been misstated and the amount of insurance would be affected by such misstated age, the amount of insurance will be adjusted to the amount to which the Insured would have been entitled at his correct age and the premiums will be based on the adjusted amount.

CLAIMS AND GENERAL PROVISIONS

Notice of Claim: Written notice of claim must be given to Us within twenty (20) days of the date such loss begins. Notice must be given to Us with enough information to identify the Insured. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to file notice within such time. However, the notice must be given as soon as reasonably possible.

Claim Forms: We will provide claim forms upon request of Insured or when We receive notice of claim We will also give claim forms. If the forms are not given within fifteen (15) days, the Insured can submit written proof covering the occurrence, character and extent of loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us not later than ninety (90) days after the date of such loss. Failure to give such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible, but in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the date of time such proof is otherwise required.

Physical Exam: We, at Our own expense, will have the right and opportunity to examine the person whose loss is the basis of claim under the Policy when and so often as may be reasonably required while the claim is pending.

Legal Proceedings: No action at law or in equity can be brought to recover on the Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time proofs of loss are required to be filed.

Entire Contract: The Policy, all applications of the Insured (if any) and the application of the Policyholder, a copy of which is attached hereto, make up the entire contract between the parties. All statements made by the Policyholder or by the Insureds are deemed representations and not warranties. No such statement will be used in any contest under the Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person or his beneficiary, if any.

Our Right to Contest: The validity of the Policy cannot be contested, except for non-payment of premiums, after it has been in force for two (2) years from its effective date. No statement, except for a fraudulent misstatement, made by any Insured relating to his insurability will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two (2) years during such Insured's lifetime nor unless it is contained in written instrument, signed by him, and a copy of such instrument is or has been furnished to him or his beneficiary.

GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Member 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 a Member may file a grievance and make a written request for review to:

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

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

The Member 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 Member 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 a Member regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Member.

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

NGL Insurance Group Privacy Notice

National Guardian Life Insurance Company
NGL American Life Insurance Company
Settlers Life Insurance Company

The NGL Insurance Group is 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 - National Guardian Life Insurance Company, NGL American Life Insurance Company, or Settlers Life Insurance Company (the “NGL Insurance Group” or “NGL”) 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, or to offer you other products or services that we provide.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process, such as name, address, age, social security number, name of beneficiary, other insurance coverage, and other Information relating to your health, finances, occupation, general reputation, avocations and other personal characteristics. We also collect Information about your transactions with us, our affiliates or others, such as the type of product you buy, your premium amount and your payment history. Additional Information is received from medical personnel, medical institutions, the Medical Information Bureau, other insurers, agents, employers, public records and consumer reporting agencies.

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law with our affiliates and with nonaffiliated third parties in order to evaluate, process and service your request for our products or services, to generally administer our business, to prevent fraud, for audit or research purposes, or to offer you products or services that may be of interest to you. Examples of nonaffiliated third parties with whom we may share your Information include:

- Regulatory authorities;
- Businesses that provide administrative, security, marketing or other services for us;
- Financial services companies with whom we have joint marketing agreements; and

- NGL’s independent agents;
- Reinsurance companies.

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, we require that they agree to our privacy standards.

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

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers. We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices. We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

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

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

How We May Use or Disclose Your Health Information

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

When We May Not Use or Disclose Your Health Information

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

Statement of Your Health Information Rights

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

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

Our Obligations Under This Notice

We are required by law to:

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

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

Complaints

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

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

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

Effective Date of This Notice: April 14, 2003.

ADMINISTRATIVE BENEFIT / CONTRACT CLARIFICATION

This information, along with your Certificate of Coverage, explains your coverage. Contact your Human Resources or Employee Benefits Office for more information.

GENERAL INFORMATION

Plan Name: The University of Texas System

Name and Address of Policyholder:

The University of Texas System
702 Colorado Street, Suite 2.100
Austin, TX 78701-3043

Plan Sponsor's IRS Employer Identification Number:

Group Number: 26856

Plan Type: Group Vision Insurance

Type of Plan Administration:

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

Name, Address and Telephone Number of Plan Administrator:

Office of Employee Benefits
The University of Texas System
702 Colorado Street, Suite 2.100
Austin, TX 78701-3043
(512) 499-4616

Premium Payments: Employees contribute to the cost.

Plan Year: September 1 to August 31

Agent for Legal Process: Plan Administrator.

Trustee: None

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

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

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

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

RIGHTS TO CONTINUATION OF INSURANCE COVERAGE UNDER COBRA

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

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

Qualifying Events

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

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

Continuation Period

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

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

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

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

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

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

Notification Requirements

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

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

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

Election Period

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

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

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

Required Payment

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

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

Continued Coverage Ends

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

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

USERRA

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

FMLA - Family and Medical Leave Act of 1993

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

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

IMPORTANT NOTICE

IMPORTANT NOTICE

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

1-800-923-6766

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

National Guardian Life Insurance Company
c/o Superior Vision Services
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX# 512-475-1771

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

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

1-800-923-6766

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

National Guardian Life Insurance Company
c/o Superior Vision Services
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX# 512-475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU POLIZA:

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