



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

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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 dental service or supply. We will determine the customary charge from within the range of charges made for such dental 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: Great Bend USD #428

Group Policy Number: 28517 Policy Effective Date: October 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	\$34
O.D.	Provided	Covered in Full	\$26
CONTACT LENS FITTING			
Standard Fit	Provided	Covered in Full	Not Covered
Specialty Fit	Provided	Covered Up to \$50	Not Covered
MATERIALS			
Standard Lenses			
Single Vision	Provided	Covered in Full	\$29
Progressive	Provided	Covered to the providers price for standard trifocals	Covered up to the same amount as trifocals
Bifocals	Provided	Covered in Full	\$43
Trifocals	Provided	Covered in Full	\$53
Lenticular	Provided	Covered in Full	\$84
Frames	Provided	\$100 Allowance	\$47
Contact Lenses*			
Standard Optical	Provided	\$120 Allowance	\$100
Medical Necessity	Provided	Covered in Full	\$210
* In lieu of Eyeglass lenses and Frames.			
CO-PAY AMOUNT			
Vision Exam	Provided	\$10	\$10 Copay will be deducted from out-of-network allowance.
Contact Lens Fitting	Provided	\$25	Not Covered
Materials	Provided	\$10 Applies to lenses and/or frame, not contact lenses	\$10 Copay will be deducted from out-of-network allowance.
FREQUENCY	Rolling Benefit		
Vision Exam		Once every 12 months	Once every 12 months
Contact Lens Fitting		Once every 12 months	Not Covered
Lenses		Once every 12 months	Once every 12 months
Frames		Once every 24 months	Once every 24 months
Contact Lenses		Once every 12 months	Once every 12 months

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 fit 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

Eligible Employees are defined as all full-time Employees of the Employer who work thirty (30) or more hours per week at the Employer's normal place of business and who have completed nine (9) months of service with Employer.

Dependents: If dependent coverage is provided under the Policy, dependents eligible shall be the covered Employee's spouse and the Employee's or spouse's unmarried dependent children, adopted (or in the process thereof) children when placed in the Employee's home, and children for which the Employee or spouse are required to provide medical support by a valid order issued pursuant to state or federal law who have not attained their 19th birthday, or to their 25th birthday if attending an accredited college, university or at a vocational, technical, vocational-technical or trade school or institute or secondary school full-time. A child born to or adopted at birth by the Insured while this Policy is in force will be covered at birth to thirty-one (31) days and is subject to written notice and payment of the applicable premium, which must be received by us within thirty-one (31) days after such child's birth.

An unmarried child age 19 or over may continue to be eligible as a dependent if the child is:

1. Incapable of self-sustaining employment by reason of mental or physical handicap, and
2. Chiefly dependent upon the covered Employee for support and maintenance (as defined by I.R.S. Regulations).

PROVIDED, HOWEVER, proof of such incapacity and dependency is furnished to the Company by the Covered Person within thirty-one (31) days of the request for such information by the Company, and subsequently as may be required by the Company but not more frequently than annually.

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 under section entitled Basis For Termination of Policy.

INDIVIDUAL CONTINUATION OF COVERAGE

The Group Vision Care Policy is available to groups of a minimum of ten (10) Employees for employer-funded groups, or two hundred and fifty (250) Employees for groups where premiums are funded by Members 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 Member 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 Member and his or her dependents. If, and only to the extent, COBRA applies to the parties insured under this Policy, 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.

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 forty-five (45) 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 five (5) years after the time proofs of loss are required to be filed.

Entire Contract: The Policy, any endorsements and attached papers, all applications of the Covered Persons 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 Covered Persons 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.