



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**MCCOY CORPORATION  
CLASS 0001  
VISION**

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

### **Have a complaint or need help?**

If You have a problem with a claim or Your premium, call Your insurance company first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company. If You don't, You may lose Your right to appeal.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

To get information or to file a complaint with your insurance company or HMO:

Call: (toll-free) 1-888-GUARDIAN (1-888-482-7342)

Online: [www.guardiananytime.com/contact-us](http://www.guardiananytime.com/contact-us)

Email: [corporate\\_inquiries@glic.com](mailto:corporate_inquiries@glic.com)

Mail: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: [www.tdi.texas.gov](http://www.tdi.texas.gov)

E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

### **Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tambien debe presentar una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame: (telefono gratuito) 1-888-GUARDIAN (1-888-482-7342)

En linea: [www.guardiananytime.com/contact-us](http://www.guardiananytime.com/contact-us)

Correo electronico: [corporate\\_inquiries@glic.com](mailto:corporate_inquiries@glic.com)

Direccion postal: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En linea: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electronico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714



**The Guardian Life Insurance Company of America**

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000  
[www.GuardianAnytime.com](http://www.GuardianAnytime.com)

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

**New Mexico Residents**  
**Consumer Complaint Notice**

**If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:**

**<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>**

CCN-2019-NM

B999.0042



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**CERTIFICATE OF COVERAGE**

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**The Guardian Life Insurance Company of America**

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000

The Group Vision Insurance Coverage described in this Certificate is attached to the group Policy effective January 1, 2013. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Employer by Guardian.

**GROUP VISION INSURANCE COVERAGE**

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Certificate's eligibility and Effective Date requirements; (b) be listed in Our and/or the Employer's records as a validly covered Employee under the Policy; and (c) all required premium payments must have been made by or on behalf of the Employee subject to the Policy's grace period.

The Employee is not covered by any part of the Certificate for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Employer's records.

**Employer:** MCCOY CORPORATION

**Group Policy Number:** 00481700

**Effective Date:** January 1, 2013

**The Guardian** Life Insurance Company of America



Harris Oliner, Senior Vice President,  
Corporate Secretary



Michael Prestileo,  
Senior Vice President

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

B436.0044





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## **GENERAL PROVISIONS**

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### **Applicable Benefits**

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This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

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### **Limitation of Authority**

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Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to any contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

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### **Incontestability**

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

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after his or her insurance has been in force for two years during his or her lifetime. In the absence of fraud, a statement may not be used to contest the validity of his or her insurance or to deny a claim for a loss incurred unless the statement is contained in a written instrument signed by the Covered Person.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

## **Grace Period**

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A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Employees is not paid before the end of the grace period, the Policy and this Certificate ends with respect to all Employees at the end of the grace period. If the Policyholder gives Us advance written notice of an earlier termination date during the grace period, the Policy and this Certificate will end as of such earlier date.

If the Policy and this Certificate ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time this Policy and this Certificate was in force during the grace period.

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## CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

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### Employee Eligibility

You are eligible for vision coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for vision coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Certificate.

**Enrollment:** If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from November 1st to December 31st of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's employment.
- Loss of eligibility under Your Spouse's vision plan.

- Divorce.
- Death of Your Spouse.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

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## **Dependent Eligibility**

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child from the moment of birth, natural child, an adopted child or any child to whom You or Your Spouse are a party to a suit to adopt the child, stepchild, a natural or adopted child of Your Spouse, a grandchild who is dependent on You for federal income tax purposes, a child for whom You are required by court to provide vision support or a child placed with You for foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mental incapacity. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:
    - The condition started before he or she reached the age limit; and
    - The child remained continuously covered until he or she reached the age limit; and
    - You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under the Policy as the Employee.

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## **Eligibility Waiting Period**

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

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## When Coverage Starts

Your Employer will inform You of Your Effective Date under the Group Vision Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Group Vision Policy as stated in the Conditions Of Eligibility for Group Vision Insurance section; and
- You and Your eligible dependents have enrolled in the Group Vision Policy; and
- Required premiums have been paid.

**Newborn Children:** Your newborn child is covered automatically from the moment of birth until the child is 31 days old. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of such birth and pay any required premium to have coverage continue beyond the 31 day period.

**Adopted Children:** Your adopted child is covered automatically for the first 31 days from the date that You or Your Spouse become a party to a suit in which You or Your Spouse seek to adopt the child. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the adoption and pay any required premium to have coverage continue beyond the 31 day period.

**Children who are the Subjects of a Medical Support Order:** A child who is the subject of a medical support order to provide vision coverage is covered automatically for the first 31 days from the date of such an order. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the court or administrative order and pay any required premium to have coverage continue beyond the 31 day period.

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## Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

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## **Family Status Change**

You may request the addition of Vision Insurance Coverage if You have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

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## **When Your Coverage Ends**

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.

- The last day of the period for which required payments are made for or by You, subject to the Policy's grace period.
- The date You die.

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### **When Your Dependent Coverage Ends**

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent, subject to the Policy's grace period.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

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## **CONTINUATION OF COVERAGE**

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You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with Your Employer or administrator.

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### **Continuation Rights**

You may be eligible to continue Your group vision coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group vision coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

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### **Uniformed Services Continuation Rights**

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group vision coverage under the Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

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### **COBRA Continuation Rights**

If vision insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit Our website at [www.GuardianAnytime.com](http://www.GuardianAnytime.com).

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### **Family Medical Leave Of Absence (FMLA)**

There are certain leaves of absence that may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

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## **Dependent Survivorship Benefit**

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If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's vision coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

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## VISION CLAIM PROVISIONS

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You may visit any provider. After VSP pays its portion of the covered charges, You are responsible for the rest. This includes any Deductible, Copayment, and amounts above any coverage maximum, as well as, any remaining charges up to the provider's total charge for services received.

Your reimbursement will be based on VSP's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

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## Filing A Claim

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If You have services performed by a Preferred Provider, Your claim will be submitted for You and the payment will be sent directly to Your Preferred Provider.

If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

**Administration:** We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate. We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

**Notice:** You must send Us written notice for which a claim is being made within 20 days of the service. We will not void or reduce Your claim if You cannot send Us notice of claim within the required time. In that case, You must send Us notice of claim as soon as reasonably possible. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

**Claim Forms:** We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, You will be considered to have complied with the requirements of the Certificate as to proof of loss and We will accept a written description and adequate proof of the service that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

**Proof Of Loss:** You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year from the date that proof of loss is otherwise required, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

**Time Of Payment Of Benefits:** We will pay Vision benefits no later than 60 days from the date We receive written proof of loss, subject to all the terms and conditions of this Policy.

**Payment Of Benefits:** Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living or to Your assignee. If You are not living, We have the right to pay all Vision benefits to one of the following:

Your

- Estate;
- Spouse;
- Parents;
- Children; or
- Brothers and sisters.

Upon written notice received by Us, benefits payable on behalf of a covered dependent child will be paid to the Texas Department of Human Services if:

- a Covered Person enrolled for dependent coverage is required to pay child support by a court order or court approved agreement; and
  - is a possessory conservator of the child under a court order issued in Texas; or
  - is not entitled to possession or access to the child;
- the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
- We are notified through an attachment to the claim for benefits at the time the claim is first submitted to Us that the benefits must be paid directly to the Texas Department of Human Services.

Benefits payable on behalf of a covered dependent child will be paid to a person who is not covered under this plan if, at the time the claim is first submitted to Us, such person provides:

- Written notice that he or she is a possessory conservator of the child on whose behalf a claim is made; and
- A certified copy of a court order designating the person as possessory or managing conservator of the child.

All claims must be sent to VSP within one year of the date services are completed or supplies are received. To obtain a claim form visit Our website at [www.GuardianAnytime.com](http://www.GuardianAnytime.com).

Proof of Loss and other claim data should be submitted to:

**The Guardian Life Insurance Company of America**

Vision Service Plan  
P.O. Box 385018  
Birmingham, AL 35238-5018

**Legal Actions:** No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after 3 years from the date in which written proof of loss is required under the Policy to be filed.

**Workers' Compensation:** The Vision benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

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## **VISION EXPENSE BENEFITS**

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This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

This Certificate includes the Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

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### **Vision Service Plan (VSP) - This Plan's Vision Care Preferred Provider Organization**

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The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to VSP, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of VSP Preferred Providers in his or her area.

A Covered Person may receive vision services from any VSP Preferred Provider. If a Preferred Provider ends his or her relationship with VSP for any reason, VSP will be responsible for furnishing vision services to Covered Persons either through that provider or another VSP Preferred Provider.

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

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call VSP should he or she have any questions about the vision coverage.

VSP Customer Care

877-814-8970

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## Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact VSP to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

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## How This Plan Works

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

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from VSP. See Obtaining Services from a Preferred Provider. If authorization is not received, benefits will be paid as if services and supplies were received from a Non-Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. Please refer to Vision Claim Provisions in this Certificate.

If a Covered Person requires Emergency Care, as defined below, the Covered Person's Payment Rate will be the same for those emergency services provided by a Preferred Provider as those provided by a Non-Preferred Provider. What We pay is based on all of the other terms of this Certificate.

Emergency Care means services or supplies that are provided by a provider that are needed immediately because of an injury or sudden illness and the time required to reach a Preferred Provider can reasonably be expected to result in serious deterioration of, or risk of permanent damage to, the Covered Person's health. These services are considered to be Emergency Care as long as transfer of the Covered Person to a Preferred Provider is precluded because of risk to the Covered Person's health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the vision condition.

**Copayments:** A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule Of Benefits.

**Cash Deductibles:** There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered Person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

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

**Payment Rates:** Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule Of Benefits. What We pay is subject to all of the terms of this Certificate.

**Discounts:** If a Covered Person receives a vision examination and lenses or frames from a Preferred Provider, he or she will receive a discount on the cost to purchase an unlimited number of prescription glasses from the same Preferred Provider. He or she may also receive a discount on the costs to evaluate and fit contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination from the same Preferred Provider. Discounts may not be available at all locations, check with Your Preferred Provider.

The discounts are:

- For prescription glasses . . . . . 20% off of the Preferred Provider's Usual and Customary fee
- For non-prescription sunglasses . . . . 20% off of the Preferred Provider's Usual and Customary fee
- For contact lens exam (evaluation and fitting) . . . . . 15% off of the Preferred Provider's Usual and Customary fee

**Discounts:** If a Covered person receives a vision examination and lenses or frames from a Preferred Provider, he or she will receive a discount on the cost to purchase an unlimited number of additional prescription glasses and non-prescription sunglasses from the same Preferred Provider on the same day. Discounts may not be available at all locations, check with Your Preferred Provider.

The discount is:



For prescription glasses . . . . . 30% off of the Preferred Provider's Usual and Customary fee

For non-prescription sunglasses . . . . 30% off of the Preferred Provider's Usual and Customary fee

B436.0063

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## Covered Services And Supplies

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

B435.0048

**Vision Examinations:** We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to \$50.00.

B435.0049

**Vision Materials** We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lens benefit.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.0060

**Standard Lenses:** We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, Polycarbonate Lenses.

B435.0578

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0583

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) \$48.00 for each pair of single vision lenses; (2) \$67.00 for each pair of bifocal lenses; (3) \$86.00 for each pair of trifocal lenses; and (4) \$126.00 for each pair of Lenticular Lenses.

B435.0590

## Covered Services And Supplies (Cont.)

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If the Covered Person chooses elective contact lenses, We do not cover Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

B435.0597

**Standard Frames:** We cover charges for Standard Frames.

If a Covered Person uses a Preferred Provider, We cover charges up to a retail frame allowance of \$130.00. Most Preferred Providers discount any amount over the allowance by 20%. Discounts may not be available at all locations, check with Your Preferred Provider.

If a Covered Person uses a Non-Preferred Provider, We limit what we pay for each set of Standard Frames to \$48.00.

We only cover charges for one set of Standard Frames in any two calendar year Benefit Period.

If the Covered Person chooses elective contact lenses, We do not cover Standard Frames for one calendar year from the date the elective contact lenses are purchased.

B435.1060

**Necessary Contact Lenses:** We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia or Keratoconus.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to \$210.00 in any one calendar year Benefit Period.

B435.0616

**Elective Contact Lenses:** We cover charges for elective contact lenses, but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

## Covered Services And Supplies (Cont.)

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If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year and Standard Frames for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for elective contact lenses to \$130.00

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to \$120.00.

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

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1106

**Low Vision Benefits:** We pay benefits for the covered charges at the Payment Rates shown in the Schedule of Benefits provided to a Covered Person who has severe visual problems which cannot be corrected with Standard Lenses.

Low Vision services are Low Vision Supplementary Testing and Low Vision Supplemental Care.

If a Covered Person receives Low Vision Supplementary Testing, We pay benefits for the covered charges for the testing up to \$125.00 per test.

We cover no more than two Low Vision Supplementary Test(s) per Covered Person in any 24 month Benefit Period.

We limit what We pay for all covered Low Vision services, including any amount paid for Low Vision Supplementary Testing, to \$1,000.00 per Covered Person in any 24 month Benefit Period.

B435.1126

## Exclusions

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No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.
- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.

- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).
- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).
- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.

B435.1127

- Progressive Multi-Focal Lenses.

B435.0089

- Anti-Reflective Coating of the lens or lenses.

B435.0090

- Photochromic Lenses.

B435.0092

- Ultraviolet Coating of lenses.

B435.0093

- Scratch Resistant Coating.

B435.0095

- High Index Lenses.

B435.0096

- Polycarbonate Lenses for adults.

B435.0097

- Polarized/Laminated Lenses. B435.0098
- Oversize Lenses. B435.0636
- Mirror and Ski Coating. B435.0099
- Edge Treatment. B435.0100
- Tinted Lenses. B435.0637
- Blended Lenses. B435.0101

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.0147

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## DEFINITIONS

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This section defines certain terms appearing in Your Certificate.

B040.0004

**Active Work or Actively At Work or Actively Working:** These terms mean You are able to perform, and are performing all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B435.0102

**Anisometropia:** This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

**Anti-Reflective Coating:** This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

**Benefit Period:** This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

**Blended Lenses:** This term means bifocals which do not have a visible dividing line.

B040.0847

**Certificate:** This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B435.0108

**Copayment:** This term means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a Covered Person to a Preferred Provider at the time covered services are received.

B435.0109

**Corneal Disorders:** This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

**Covered Person:** This term means You, if You are covered by the Policy, and any of Your covered dependents.

B435.0185

**Deductible:** This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B435.0111

**Edge Treatment:** This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

**Effective Date:** The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B435.0113

**Eligibility Date:** This term means the earliest date You are eligible for coverage under this Certificate as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

B435.0114

**Employee:** This term means the member of the group determined to be eligible by the Employer.

B435.0115

**Employer:** This term means the entity that purchased the Policy.

B435.0116

**Enrollment Period:** This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B040.0856

**Fitting and Evaluation:** This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

**Full-time:** This term means:

You are not a Part-Time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employer in Your Eligible class (but not less than 37 hours per week), at:

- Your Employer's place of business;

- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B435.0146

**High Index Lenses:** This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

**High Myopia:** Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

**Incurred, or Incurred Date:** These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

**Irregular Astigmatism:** This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

**Keratoconus:** This term means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

**Lenticular Lenses:** This term means mean high-powered lenses with the desired prescription power found only in the central portion. The outer portion has a front surface with a changing radius of curvature.

B040.0862

**Low Vision:** This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

**Low Vision Supplemental Care:** This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047



<b>Low Vision Supplementary Testing:</b>	This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.	B435.1048
<b>Mirror and Ski Coating:</b>	This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.	B435.0125
<b>Non-Preferred Provider:</b>	This term means any optometrist, therapeutic optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract, directly or indirectly, with VSP as a Preferred Provider.	B436.0035
<b>Orthoptics:</b>	This term means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	B040.0865
<b>Oversize Lenses:</b>	This term means larger than a standard lens blank, to accommodate prescriptions.	B040.0866
<b>Payment Limit:</b>	This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.	B435.0128
<b>Payment Rate:</b>	This term means the percentage rate that this Certificate pays for covered services and supplies.	B435.0129
<b>Photochromic Lenses:</b>	This term means lenses which change color with the intensity of sunlight.	B040.0870
<b>Plano Lenses:</b>	This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).	B435.0130
<b>Polarized/Laminated Lenses:</b>	This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.	B435.0131
<b>Policy:</b>	This term means the group Vision Insurance Coverage described in the Policy and this Certificate.	B435.0132

- Polycarbonate Lenses:** This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.  
B435.0133
- Preferred Provider:** This term means an optometrist, therapeutic optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract, directly, or indirectly with VSP to provide vision care services and or Vision Materials to Covered Persons.  
B436.0033
- Progressive Multi-Focal Lenses:** This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.  
B435.0135
- Scratch Resistant Coating:** This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.  
B435.0136
- Spouse:** This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.  
B435.0137
- Standard Frames:** This term means frames valued up to the limit published by VSP which is given to Preferred Providers.  
B435.0639
- Standard Lenses:** This term means regular glass or plastic lenses.  
B435.0139
- Tinted Lenses:** This term means lenses which have an additional substance added to produce constant tint.  
B040.0878
- Ultraviolet Coating (UV):** This term means a coating that blocks ultraviolet rays.  
B435.0141
- Usual And Customary:** This term means that the charge for the covered vision condition: (1) is the provider's standard charge for the service furnished; and (2) is not more than the usual charge made by most other providers with similar training and experience in the same geographic area. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.  
B040.0879

**Vision Materials:** This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

**We, Us, Our and Guardian:** These terms mean The Guardian Life Insurance Company of America.

B435.0143

**You, Your or Your:** These terms mean the covered Employee.

B435.0144

## VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date; or 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B435.1131

**Initial Election** You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B435.0151

**Group Enrollment Period** A group enrollment period is held each year from November 1st to December 31st. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

**PPO Copayments**

Examinations . . . . .		\$10.00
Standard Frames and/or Standard Lenses . . . . .		\$10.00
Necessary Contact Lenses . . . . .		\$10.00
Low Vision Examinations and Services . . . . .		None
Low Vision Materials . . . . .		None

**Non-PPO Cash Deductibles**

Examinations . . . . .		\$10.00
Standard Frames and/or Standard Lenses . . . . .		\$10.00
Necessary Contact Lenses . . . . .		\$10.00
Low Vision Examinations and Services . . . . .		None
Low Vision Materials . . . . .		None

**Payment Rates**

For Covered Charges . . . . .		100%
For Low Vision Supplementary Testing furnished by a Preferred Provider . . . . .		100%
For Low Vision Supplementary Testing furnished by a Non-Preferred Provider . . . . .		100%
For Low Vision Supplementary Care furnished by a Preferred Provider . . . . .		75%
For Low Vision Supplementary Care furnished by a Non-Preferred Provider . . . . .		75%

B435.1134

**Changes in Coverage Amounts** If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective until the date You return to Active Work on a Full-Time basis.

**Changes In Insurance Classification** If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change.

B435.1139

## CERTIFICATE RIDER

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

### Services and Supplies Received from Participating Retail Chain Providers

Vision care services and supplies that are covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider may also be covered by the Certificate when such services and supplies are received from a Participating Retail Chain Provider, subject to the limitations and exclusions below.

If services and supplies are received from a Participating Retail Chain Provider, We pay benefits for covered charges, after the Copayment, as shown below:

SERVICES AND SUPPLIES	PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB	OTHER PARTICIPATING RETAIL CHAIN PROVIDERS
<b>Eye Exam</b> - one in any one calendar year Benefit Period.	Covered In Full.	Covered In Full.
<b>Standard Lenses</b> - one pair in any one calendar year Benefit Period.		
● Single Vision	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Bifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Trifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Lenticular	Not Available.	Covered In Full. (Not all lens types may be available at all locations.)
<b>Lens Options</b> - once in any one calendar year Benefit Period.	Covered In Full. (Not all lens options may be available at all locations.)	Covered In Full. (Not all lens options may be available at all locations.)

B435.1387

B435.0668

## SERVICES AND SUPPLIES

**Standard Frames** - one set in any 2 calendar year Benefit Period.

**Elective Contact Lenses** - one pair in any one calendar year Benefit Period.

- Contact Lens (Materials Only)

## PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB

Covered In Full up to \$70.00. No discount available on charges in excess of the benefit amount.

Covered In Full up to \$130.00.

## OTHER PARTICIPATING RETAIL CHAIN PROVIDERS

Covered In Full up to \$130.00.

B435.1388

Covered In Full up to \$130.00.

B435.0672

## LIMITATIONS

- Limitations and exclusions of benefits described in the Certificate for VSP Preferred Providers shall also apply to services and supplies received from Participating Retail Chain Provider Providers.
- If a service or supply is not covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by the Certificate when received from a Participating Retail Chain Provider.
- Services and supplies received from a Participating Retail Chain Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through a Participating Retail Chain Provider. Membership fees are not covered under the Certificate.

B435.1160

## EXCLUSIONS

- We do not cover charges for:
  - Medically Necessary Contact Lenses.
  - Safety Glasses.
  - Interim Benefits.
  - Primary Eye Care.
  - Diabetic Eye Care Plus Program.

B435.1161

## DEFINITIONS

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

**Participating Retail Chain Provider:** This term means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this rider. Not all Participating Retail Chain Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at

(877) 814-8970 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Certificate.

**Copayment:** This term means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or a Participating Retail Chain Provider at the time covered vision services or supplies are received.

This Rider is a part of the Certificate. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Certificate.

**The Guardian** Life Insurance Company of America

A handwritten signature in black ink, appearing to read "M Prestileo".

Michael Prestileo, Senior Vice President

B435.0691



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## CERTIFICATE AMENDATORY RIDER

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This Rider amends this Certificate by replacing the Grace Period In Payment Of Premiums Termination Of Group Certificate provision as shown below and is effective on its issue date.

### **Grace In Payment Of Premiums - Termination Of Certificate**

A grace period of 60, without interest charge, will be allowed for each premium payment except the first. If any premium is not paid before the end of the grace period, this Certificate ends at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, the Certificate will end as of such earlier date.

If the Certificate ends during or at the end of the grace period, You will still owe Us premium for all the time the Certificate was in force during the grace period.

The Certificate ends immediately on any date when an insurance coverage under the Certificate ends and, as a result, no benefits remain in effect under the Certificate.

This Rider is a part of the Certificate. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Certificate.

**The Guardian Life Insurance Company of America**



Michael Prestileo,  
Senior Vice President



Harris Oliner  
Senior Vice President and  
Corporate Secretary

B401.3521

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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**CERTIFICATE RIDER**

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This Rider amends this plan to provide additional services as described below.

**ADDITIONAL NON-INSURANCE SERVICES**

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered Persons will be provided the following service(s):

- Comprehensive Employee Assistance (EAP) Services - provides counseling services, legal and financial services, and training resources through telephonic assistance and referrals to local counselors. There is no additional charge above the premium to the covered person for these services.

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

**The Guardian** Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0137

**The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.**

## STATEMENT OF ERISA RIGHTS

### The Guardian Life Insurance Company of America

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000

Your group Vision benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

#### Receive Information about Your Plan and Benefits

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

#### Prudent Actions by Plan Fiduciaries

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

#### Enforcement of Your Rights

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

## Statement of Erisa Rights (Cont.)

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

### **Assistance with Questions**

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

### **Qualified Medical Child Support Order and Qualified Domestic Relations Order**

Federal law required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Vision Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

### **Vision Benefits Claims Procedure**

Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

## Statement of Erisa Rights (Cont.)

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Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B435.0152

**Definitions** "Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

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

Guardian will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

**Adverse Benefit Determination** If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the Adverse Benefit Determination;

- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

**Appeal of Adverse Benefit Determinations** If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a vision or medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify vision or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

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

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**SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE**

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You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

MCCOY CORPORATION Plan

- **Employer's Name:** (Plan Sponsor)

MCCOY CORPORATION

**Address:** 1350 IH 35 NORTH  
SAN MARCOS TX 78666

**Phone Number:** 512-395-6644

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**741542718

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

MCCOY CORPORATION

**Address:** 1350 IH 35 NORTH  
SAN MARCOS TX 78666

**Phone Number:** 512-395-6644

- **Agent for the Service of Legal Process:**

MCCOY CORPORATION

**Address:** 1350 IH 35 NORTH  
SAN MARCOS TX 78666

**Phone Number:** 512-395-6644

(Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.
- **Date of End of Record Year:** January 1st .
- **Sources of Contribution:**Contributions to the plan are provided by:
  - the Employer
  - the Employee
  - Both the Employer and the Employee (assuming there are situations where both contribute).
- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.
- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.
- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383





**The Guardian Life Insurance  
Company of America**  
10 Hudson Yards  
New York, New York 10001