NATIONAL GUARDIAN LIFE INSURANCE COMPANY
A Mutual Company Incorporated in 1909
Madison, WI

GROUP VISION CARE INSURANCE CERTIFICATE

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

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

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

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while an Insured is covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Kimberly A. Shaul, Secretary **Knut A. Olson, President**

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

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PART I. DEFINITIONS

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

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

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

Co-Pay – An Insured's share of the costs that are incurred by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.

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

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

1. Keratoconus.
2. Aphakia (after cataract surgery); A pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective or Visually Necessary Contact Lenses for this condition.
3. When best visual acuity with eyeglasses:
   a. is between 20/50 and 20/80 and can be corrected to 20/40 or better with contact lenses.
   b. is worse than 20/80 and can be improved in at least one eye by double the visual acuity with contact lenses. (e.g. 20/100 to 20/50, 20/200 to 20/100, 20/400 to 20/200); or .
   c. if the patient has vision in both eyes, and the reduced Best corrected visual acuity is in just one eye, and there is an expectation of improved binocularity with contact lenses.
4. Anisometropia of 3.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
5. Any structural, neurologic or refractive ocular issues interfering with the normal development of visual acuity and/or binocular function in a child that cannot be met with eyeglasses only. Any structural deformity, scar, post-operative irregularity or distortion of the cornea or iris that prevents the attainment of optimal visual acuity with eyeglasses only, that can be improved significantly with contact lenses.
6. Any chronic pain, discomfort or photophobia due to chronic, persistent corneal, iris or lacrimal system inflammatory disease, injury, surgery or deformity that prevents the attainment of optimal visual acuity with spectacle correction that can be improved significantly with contacts.
7. Refractive error equal to or greater than 12.00 diopters spherical equivalent in either eye.

Prior authorization is required.

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

Covered Vision Exams and Materials – Means the Vision Exams and Materials that qualify for benefits under the Group Policy. Covered Vision Exams and Materials are shown in the Schedule of Benefits.

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

Eligible Dependent - Means a person listed below:

1. Your Spouse;
2. Your unmarried dependent child under age 27, who is Your natural or adopted child, Your Spouse's child, a foster child, or a child for whom You are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.
   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

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

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

Initial Term - The period following the group's initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period, subject to the Premium Adjustments provision.

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

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

Insured– Means a person for whom insurance under the Policy has become effective, as a Member or Eligible Dependent.

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

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

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

Ophthalmologist- A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optician – A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Out-of-Network Provider – An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges. They are not listed in the In-Network Provider Directory.

Plano Lens - A lens that has no refractive power.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder's effective date and renew 12 OR 24 months following the initial effective date.

Re-enrollee - Any Insured who terminated Their coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

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

Spouse – Your legally recognized spouse.

Their, Them, and They – Refers to the male or female gender.

Vision Exam – An examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

You or Your – The Member.

Waiting Period - The period of time a Member must wait before any Insured is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

This Policy also provides coverage for the Member's Eligible Dependents.

Dual Eligibility Status: If both a Member and Their Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the Spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other Spouse's coverage.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Member has enrolled for coverage, and paid the required premium, if any.

Initial Enrollment: Members should enroll for coverage within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

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

Late Entrants: Members who do not enroll within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a Change in Family Status, as described below.

Change in Family Status: Members may enroll or change Their coverage if a Change in Family Status occurs, provided written application to enroll is made within 31 days of the event. A Change in Family Status means any of the following events:

1. Marriage or domestic partnership;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a Spouse or child;
5. Other changes as permitted by the Policyholder.

PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, domestic partnership, birth or adoption, coverage is effective the date specified by the Policyholder. This is subject to Our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent Spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

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

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for all Insureds stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any Premium Due Date, if full payment for Your insurance is not made within 31 days following the Premium Due Date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date They are no longer an Eligible Dependent;
2. the date We receive Your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of Their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

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

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

RIGHT TO CHANGE PREMIUM RATES: We have the right to change the premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any twelve (12) month period. We will notify the Policyholder in writing at least forty-five (45) days before any increase in premium rates. This is subject to the Premium Adjustments provision, as stated below.

PREMIUM ADJUSTMENTS: The Company may adjust the premium rate on the Policy Anniversary Date, including during any applicable premium rate guarantee period, if any one of the following occurs:

1. The terms of this Policy change;
2. The number of Insureds increase or decrease by more than 10% since the later of the Policy Effective Date and the date of the last renewal of the Policy;
3. Coverage is reinstated following failure to pay premium during the Grace Period;
4. An acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets that affects, increases or decreases by 10% or more the number of Insureds.
5. Any federal, state, or other law or regulation is enacted, adopted, amended, or requiring implementation that affects: (a) Our benefit obligations under this Policy; or (b) any monetary assessments, or changes in those assessments, We are required to pay.

PART VI. DESCRIPTION OF COVERAGE

A. COVERED VISION EXAMS AND MATERIALS

Covered Vision Exams and Materials are shown in the Schedule of Benefits. In order to be a Covered Vision Exams and Materials, it must be furnished to an Insured:

1. To check or improve Their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Vision Exams and Materials; or
2. the limits of coverage shown in the Schedule of Benefits.

We pay a benefit if an Insured receives Covered Vision Exams and Materials at the allowable Frequency while Their coverage under this Certificate is in force. An Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

IN-NETWORK BENEFITS

When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A provider's status may occasionally change. We recommend that You call the Administrator to verify the provider's participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Vision Exams and Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The

Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Note Exception: If You use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that You pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Schedule Of Benefits.

Both the Co-Pay and the Frequency for Covered Vision Exams and Materials are shown in the Schedule of Benefits.

OUT-OF-NETWORK BENEFITS

If an Insured chooses to use an Out-of-Network Provider, You pay the provider in full. When benefits are payable, We will reimburse You up to the amount of Out-of-Network benefits shown in the Schedule of Benefits. It is Your responsibility to send Us a Claim by submitting the itemized invoice or receipt to Us (See the "Notice of Claim" provision.).

PART VII. LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Corrective Eyeglass Lenses, Frames, Contact Lenses, and related materials; and services for the fitting thereof;
2. Replacement frames and/or lenses, (Including Low Vision Devices) except at normal intervals when covered services are otherwise available;
3. Plano or non-prescription lenses or sunglasses;
4. Orthoptics, vision training and any associated supplemental testing;
5. Frame cases;
6. Low (subnormal) vision aids or aniseikonic lenses;
7. Medical and surgical treatment of the eyes;
8. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
9. Experimental or non-conventional treatment or device;
10. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
11. Services and materials provided by another vision plan;
12. Services for which benefits are paid by Worker's Compensation;
13. Benefits provided under the Insured's medical insurance;
14. Blended bifocal lenses;
15. Groove, Drill or Notch, and Roll and Polish;
16. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
17. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
18. Cosmetic items;
19. Faceted lenses;
20. High-Index Lenses;
21. Laminated Lenses;
22. Oversize Lenses – any lens with an eye size of 61mm or greater;
23. Photochromic (Transition) lenses;
24. Polarized lenses;
25. Polished bevel lenses;
26. Polycarbonate lenses;
27. Prism lenses;

28. Slab-off lenses;
29. Tints (except Pink tint #1 and #2);
30. Ultra-violet tint or coating;
31. Additional cost for contact lenses over the allowance;
32. Additional cost for a frame over the allowance;
33. Progressive Lenses*

*Progressive Lens. If this type of lens is not a covered benefit under Your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

PART VIII. CLAIM PROVISIONS

A. IN-NETWORK CLAIMS
When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator. (Note the exception under Part VI, "In-Network Benefits.)

B. OUT-OF-NETWORK CLAIMS
In order to pay benefits for covered services provided by an Out-of-Network Provider, You must furnish written Proof of Loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

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

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

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

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

F. PAYMENT OF CLAIMS
Benefits will be paid within 30 days after Our Administrator receives written Proof of Loss. Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

G. TIME OF PAYMENT OF CLAIMS
Benefits payable under this Policy will be paid immediately upon Our receipt of written Proof of Loss.

H. OVERPAYMENTS
If We pay a benefit and it is later shown that a lesser amount should have been paid, We will be entitled to a refund of the excess. This applies to payments made to You, to a Covered Dependent, or to the provider of the Covered Vision Exams and Materials.

PART IX. GRIEVANCE AND APPEALS PROCEDURE

We have a formal grievance and appeals process through Our Administrator. This process allows You to dispute issues that you could not solve using Our Administrator's Customer Service.

If You file a grievance or appeal, You may authorize another person, including Your provider, to act on Your behalf at any stage in the standard review process. Your authorization must be in writing. Although we have thirty-five (35) days to give You Our final determination, You have the right to allow Us additional time if You wish.

The grievance and appeals process begins with an internal review by Our Administrator. Once you have exhausted your internal options, You have the right to a review by the Michigan Department of Insurance and Financial Services.

A. STANDARD INTERNAL REVIEW PROCEDURES:

1. You or Your authorized representative sends Our Administrator a written statement explaining why You disagree with Our decision. Mail Your written grievance to:

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

2. Our Administrator will contact You to schedule a conference once they receive Your grievance. During Your conference, You can provide Our Administrator with any other information You want them to consider in reviewing Your grievance. You can choose to have the conference in person or over the telephone. The written decision Our Administrator gives You after the conference is the final decision.

3. If You disagree with the final decision, or You do not receive the decision within thirty-five (35) days after Our Administrator received Your original grievance, You may request an external review. See below for how to request a standard external review.

B. STANDARD EXTERNAL REVIEW PROCEDURES: Once you have gone through the standard internal review process, You or Your authorized representative may request an external review:

1. Within 127 days of the date You receive or should have received Our final decision, send a written request for an external review to the Department listed below.

2. Send Your request and the required forms that We give You to:

   Department of Insurance and Financial Services
   Office of General Counsel
   Health Care Appeals Section
   PO Box 30220
   Lansing, MI 48909-7720

   Phone: 877-999-6442
   Online Portal: https://difs.state.mi.us/Complaints/ExternalReview.aspx
   Email: DIFS-HealthAppeal@michigan.gov
   Fax: 517-284-8848

When You file a request for an external review, You will have to authorize the release of medical records that may be required to reach a decision during the external review.

If You ask for an external review about a medical issue and the issue is found to be appropriate for external review, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers.

Upon completion of a preliminary review, the Department shall immediately provide a written notice to You and, if applicable, Your authorized representative as to whether the request is complete and whether it has been accepted for external review.

If a request is not accepted:

If a request is not accepted for external review because the request is not complete, the Department will inform You and if applicable, Your authorized representative what information or materials are needed to make the request complete. Your or, if applicable, Your authorized representative will provide the information or materials identified by the Department within 30 days after receiving the notification. If a request is not accepted for external review, the Department will provide written notice to You or if applicable, Your authorized representative, and Us of the reasons for its nonacceptance.

If a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria, the director shall assign an independent review organization at the time the request is accepted for external review.

1. **Reviews of Medical Issues**
    a. The Department will assign an independent review group to review Your request if it concerns a medical issue that is appropriate for external review.

        i. You will have the chance to provide additional information to the Department within seven (7) days of sending Your request for an external review.

        ii. We must give the independent review group all of the information We considered when We made a final decision, within seven (7) days of getting notice of Your request from the Department.

        iii. Immediately notify the health carrier in writing of the acceptance of the request for external review.
    b. The review group will recommend within fourteen (14) days whether the Department should uphold or reverse Our decision. The Department must decide within seven (7) business days whether to accept the recommendation and then notify You of its decision. The decision is Your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

    The director shall provide written notice to the covered person, if applicable the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or the final adverse determination within 7 business days after the date of receipt of the selected independent review organization's recommendation. If the director has kept a request for review, the director shall provide written notice to the covered person, if applicable the covered person's authorized representative, and the health carrier of his or her decision within 14 days after the decision to keep the request.

    Upon receipt of the assigned independent review organization's recommendation the director immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

2. **Reviews of Nonmedical Issues**
    If a request is accepted for external review, does not appear to involve issues of medical necessity or clinical review criteria, and appears to only involve purely contractual provisions of a health benefit plan, such as covered benefits or accuracy of coding, the director may keep the request and conduct his or her own external review or may assign an independent review organization as provided in subsection (7) at the time the request is accepted for external review. Except as otherwise provided in subsection (18), if the director keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during

the director's review of a request it is determined that a request does appear to involve issues of medical necessity or clinical review criteria, the director shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

a. The Departments staff will review Your request if it involves nonmedical issues and is appropriate for external review.

b. They will recommend if the Department should uphold or reverse Our decision. The Department will notify You of the decision. This is Your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Failure to provide documents and information:
Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within 7 business days, the director may terminate the external review and make a decision to reverse the adverse determination or final adverse determination and shall immediately notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier of his or her decision.

The assigned independent review organization shall provide its recommendation to the director within 14 days after the assignment by the director of the request for an external review.

C. EXPEDITED INTERNAL GRIEVANCE REVIEW PROCEDURES:

This process is used when Your provider shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize Your life or health or Your ability to regain maximum function. You may request an expedited internal review if You believe We wrongly denied, terminated, cancelled, or reduced Your coverage for a service before You receive it or We failed to respond in a timely manner to a request for benefits or payment.

1. Call (800) 672-7723 to ask for an expedited review. Your provider should also call this number to confirm that You qualify for an expedited review.

2. We must give You our decision within seventy-two (72) hours of getting both Your grievance and the provider's substantiation.

3. If You do not agree with Our decision, You may, within ten (10) days of receiving it, request an expedited external review.

D. EXPEDITED EXTERNAL REVIEW PROCEDURES:

You may request an expedited external review if You believe that We wrongly denied, terminated, cancelled, or reduced Your coverage for a service before You receive it or We failed to respond in a timely manner to a request for benefits or payment.

1. A request for external review form will be sent to You or Your representative with Our final determination.

2. Complete this form and send it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Phone: 877-999-6442

Online Portal: https://difs.state.mi.us/Complaints/ExternalReview.aspx
Email: DIFS-HealthAppeal@michigan.gov
Fax: 517-284-8848

When You file a request for an external review, You will have to authorize the release of medical records that may be required to reach a decision during the external review.

3. The Department will decide if Your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within thirty-six (36) hours if the Department should uphold or reverse Our decision.

4. The Department must decide whether to accept the recommendation within twenty-four (24) hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

PART X. GENERAL PROVISIONS

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

Change of Beneficiary: You have the right to change Your beneficiary. The consent of the beneficiary is not required to make such change.

Physical Examinations and Autopsy: We reserve the right and opportunity, at Our own expense, to examine the Insured when and as often as it may reasonably require for a pending claim and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written Proof of Loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

PART XI. CERTIFICATE SCHEDULE

Policyholder:	MARTIN TRANSPORTATION SYSTEMS, INC.
Group Policy Number:	NVAI3134
Original Policy/Certificate Effective Date:	January 1, 2020
Revised Policy/Certificate Effective Date:	January 1, 2021
Initial Term:	48 Months
Eligible Classes:	Permanent Employees are Eligible for Coverage
Waiting Period:	1st of the Month Following 60 Days of Active Work
Mode of Premium Payment:	Monthly
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART XII. SCHEDULE OF BENEFITS

Your Certificate is on a Calendar Year Plan Basis.

BENEFITS AND ALLOWANCES [1]			
	In-Network		**Out-of-Network:**
	Walmart	**Other In-Network**	
Comprehensive Eye Exam			
By Ophthalmologist **By Optometrist** **Benefit Frequency:** Once every 12 Months	Covered in Full Covered in Full	Covered in Full Covered in Full	Allowance: up to $50 Allowance: up to $50
Contact Lenses Evaluation, Fitting and Follow-Up Care:			
Standard Daily Wear Standard Extended Wear Specialty Wear **Benefit Frequency:** Once every 12 Months	Co-Pay: $20 Co-Pay: $30 Co-Pay: $50	Co-Pay: $20 Co-Pay: $30 Co-Pay: $50	Allowance: up to $20 Allowance: up to $30 Allowance: up to $50
Vision Materials			
Eyeglass Frames			
Benefit Frequency: Once every 24 Months	Allowance: up to $52	Allowance: up to $130	Allowance: up to $75
Eyeglass Lenses – per pair			
Benefit Frequency: Once every 12 Months			
Single Vision	Covered in Full	Covered in Full	Allowance: up to $50
Bifocal	Covered in Full	Covered in Full	Allowance: up to $75
Trifocal	Covered in Full	Covered in Full	Allowance: up to $100
Lenticular	Covered in Full	Covered in Full	Allowance: up to $150

Lens Options – per pair Add-On Items			
Benefit Frequency: Once every 12 Months			
Tint **Solid** Single Vision Multifocal	 Covered in Full Covered in Full	 Covered in Full Covered in Full	 Not Covered Not Covered
Tint **Gradient** Single Vision Multifocal	 Covered in Full Covered in Full	 Covered in Full Covered in Full	 Not Covered Not Covered
Oversize Lenses Single Vision Multifocal	 Covered in Full Covered in Full	 Covered in Full Covered in Full	 Not Covered Not Covered
Scratch Resistant Coating Single Vision Multifocal	 Covered in Full Covered in Full	 Covered in Full Covered in Full	 Not Covered Not Covered
Anti-Reflective (AR) Coating Tier 1	 Covered in Full	 Covered in Full	 Not Covered

Contact Lenses [2]			
Elective **Benefit Frequency:** Once every 12 Months	Allowance: up to $105	Allowance: up to $150	Allowance: up to $150
Non-Elective/Visually-NecessaryContact Lenses [2, 3]	Covered in Full	Covered in Full	Allowance: up to $210

[1] Where an “Allowance” is shown, You are responsible for paying any charges in excess of the Allowance.

[2] Contact Lenses are payable in lieu of Eyeglass Lenses.

[3] Prior Authorization Required

Privacy Notice

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

Types of Information We Collect:
We collect most information directly from you on applications or from other communications with you during the application process.
Types of Information we could collect include, but not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics
- phone number
- email

We also may keep information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- Other insurance companies
- agents
- employers
- public records
- consumer reporting agencies
- service providers
- Google analytics
- website hosts

How We Disclose Your Information:
Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

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

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

Access to and Correction of Your Information:

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

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

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

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

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

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

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