NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
Madison, WI

GROUP VISION CARE INSURANCE CERTIFICATE

Administrator: Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275
1-800-648-1179

Physical Address
226 N. 5th St. 4th Fl.
Columbus, OH 43215

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

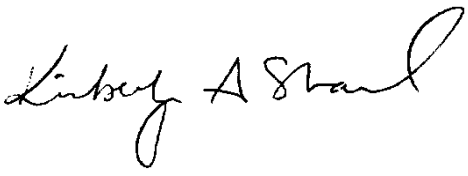
The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

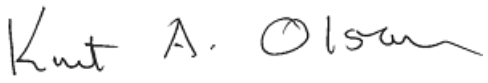
This, together with the Schedule of Benefits, forms Your Certificate of Insurance while an Insured is covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

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.

NEED ASSISTANCE? If you have a question or wish to obtain information about Your coverage, or You require assistance in resolving a complaint, please contact us at 1-800-648-1179.

DISPUTE RESOLUTION: SHOULD A DISPUTE ARISE CONCERNING THIS POLICY OR THE PAYMENT OF A CLAIM HEREUNDER, CONTACT US IN WRITING AT BEAM INSURANCE ADMINISTRATORS LLC, PO BOX 75372, CINCINNATI, OH 45275 OR BY PHONE AT 1-800-648-1179. IF A DISPUTE IS NOT RESOLVED TO YOUR SATISFACTION, YOU MAY CONTACT THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA DEPARTMENT OF INSURANCE AT 300 S. SPRING STREET, LOS ANGELES, CA 90013 OR BY PHONE AT 1-800-927-HELP (1-800-927-4357). The California Department of Insurance web address is www.insurance.ca.gov.





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

NON-PARTICIPATING

THIS CERTIFICATE DOES NOT PROVIDE ESSENTIAL PEDIATRIC VISION HEALTH BENEFITS

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.

This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

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.

Domestic Partner - Two adults who: (1) have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and (2) have on file a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

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 dependent child under age 26, 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 at least 60 days before the child reaches the limiting age, or when You enroll a new disabled child under the plan. We will notify You at least 90 days before the dependent child reaches the limiting age that you must provide the proof described in items a. and b. above. You must provide this proof within 60 days of receipt of notice from us. We will make a determination based on the proof provided. We will notify You of Our decision by the date the dependent child reaches the limiting age.

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.

Low Vision means acuity or visual field loss that cannot be corrected with regular Eyeglass Lenses.

Low Vision Device means a supplemental aid that is prescribed as a result of a Low Vision Evaluation. Low Vision Devices include, but are not limited to, reading telescopes, closed circuit TV reading systems, magnifiers, and bioptic eyewear. Conventional glasses or contacts are not considered Low Vision Devices.

Low Vision Services means the evaluation, diagnosis and prescription of Low Vision Devices by an Optometrist or Ophthalmologist who specializes in Low Vision rehabilitation. Low Vision Evaluation does not include orthoptics or vision training. Low Vision Services includes the initial Low Vision Evaluation and Low Vision Follow-up Visits.

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 Months following the initial effective date.

Rolling Benefit Plan – Benefits begin anew 12 Months from the date of service.

Spouse – Your legally recognized spouse or lawful Domestic Partner in the state where You reside.

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, enrollment will default to the Policyholder's rules.

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.

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.

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 30 days after the date such dependent was acquired. 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 60 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 60 days of the birth in order to continue the coverage beyond the initial 60-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 60 days of the placement in order to continue the coverage beyond the initial 60-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 will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the Employer shall be liable to Us for the payment of the premium accruing for the period the policy continues in force.

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. Coverage is reinstated following failure to pay premium during the Grace Period;
3. 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 Exam and Material, 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.

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

LIMITATIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit and the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. An Insured is eligible to receive benefits under the Contact Lenses and the Eyeglass Frame benefit only after the Eyeglass Lenses benefit Frequency has ended.

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

29. Ultra-violet tint or coating
30. Additional cost for contact lenses over the allowance
31. Additional cost for a frame over the allowance
32. Progressive 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.

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:

Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

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. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has vision coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for vision services on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. **Primary Plan**: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced**. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

   c. **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;

      ii. The Plan of the parent with custody of the child;

      iii. The Plan of the Spouse of the parent with custody; and

iv. The Plan of the parent without custody of the child.

d. **Dependent Child/Joint Custody**: If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

f. **Longer/Shorter Length of Coverage**. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART X. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a Grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a Grievance and make a written request for review to:

Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

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

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

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

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

PART XI. GENERAL PROVISIONS

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

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

PART XII. REPLACEMENT OF EXISTING COVERAGE

This provision applies when the Policy replaces coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the Prior Plan. Coverage under this Policy will not be considered as replacement coverage unless the Policyholder's coverage under this Policy takes effect within 60 days after coverage under the Prior Plan ends.

In the absence of this provision, an Insured who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under this Policy because the person is not actively at work or is confined in a hospital.

Each such person will be insured under this Policy if:

(a) the person was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
(b) the prior plan covered more than fifteen (15) people; and
(c) the person is a Member of an Eligible Class under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.

PART XIII. CERTIFICATE SCHEDULE

Insured:	You and Your Eligible Dependents
Certificate Number:	CA09253
Policyholder:	Silicon Valley Mechanical
Policyholder's Address:	2115 Ringwood Ave San Jose, CA 95131
Group Policy Number:	CA09253
Policy/Certificate Effective Date:	January 1st, 2023
Initial Term:	12 Months
Eligible Classes:	Class 1: All Full Time Employees Working At Least 30 Hours Per Week
Waiting Period:	First of the month following 0 Days from the first day of Active Work
Mode of Premium Payment:	Monthly
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART XIV. SCHEDULE OF BENEFITS

Your Certificate is on a Calendar Year Plan Basis

BENEFITS AND ALLOWANCES [1]		
	In-Network	**Out-of-Network**
Comprehensive Eye Exam		
By Ophthalmologist **By Optometrist** **Benefit Frequency:** Once every 12 months	Co-Pay: $10 Covered in Full	Co-Pay: None Allowance: $45
Contact Lenses Evaluation, Fitting and Follow-Up Care:[2]		
Benefit Frequency: Once every 12 months	Co-Pay: $60	Co-Pay: None
Low Vision Supplemental Testing		
Evaluation **Benefit Frequency:** Once every 24 Months	Covered in Full	Allowance per Evaluation: $125
Vision Materials [3]		
Eyeglass Frames [4]		
Benefit Frequency: Once every 12 months	Co-Pay: $10 Allowance: $200	Co-Pay: None Allowance: $70
Eyeglass Lenses – per pair [4]		
Benefit Frequency: Once every 12 months		
Single Vision	Co-Pay: $10 Covered in Full	Allowance: $30
Bifocal	Co-Pay: $10 Covered in Full	Allowance: $50
Trifocal	Co-Pay: $10 Covered in Full	Allowance: $65
Lenticular	Co-Pay: $10 Covered in Full	Allowance: $100

Contact Lenses [5]		
Benefit Frequency: Once every 12 months	Co-Pay: $60 Allowance: $200	Co-Pay: None Allowance: $105
Non-Elective/Visually-Necessary Contact Lenses [5]	Covered in Full	Allowance: $210
Low Vision		
Low Vision Devices **Benefit Frequency:** Once every 24 Months	Maximum Allowance: $1000	Maximum Allowance: $1000

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

[2]Standard Contact Lens Fitting is for an existing contact lens user who wears disposable, daily wear, or extended wear contact lenses. It includes unlimited follow-up visits within 3 months. Specialty Contact Lens Fitting is for an Insured who has never worn contact lenses or who requires a more complex fit for toric,gas permeable, or multi-focal contact lenses. It includes unlimited follow-up visits within 3 months.

[3]The Vision Materials Allowance includes Frames, Lenses, Lens Options and Contact Lenses.

[4]Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

[5] Contact Lenses are payable in lieu of Eyeglass Lenses and Frames.

JOINT NOTICE OF PRIVACY PRACTICES

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

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

How We May Use or Disclose Your Health Information

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** We may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. **Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

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

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Our Obligations Under This Notice

We are required by law to:

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

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

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

Privacy Officer
Beam Insurance Administrators, LLC
PO Box 75372
Cincinnati, OH 45275

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

Effective Date of This Notice: April 25, 2016.

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.**

Appendix A

Privacy Information for California Residents

Effective Date: June 1, 2020

This Appendix discusses how National Guardian Life Insurance Company ("we," "us," or "our") collects personal information of California residents. This Appendix applies solely to individuals who reside in the State of California ("consumers" or "you"). This Appendix complies with the California Consumer Privacy Act of 2018 ("CCPA") and any terms defined in the CCPA have the same meaning when used in this Appendix. This Appendix does not apply to personal information outside the scope of the CCPA, including without limitation:

- Personal information collected, processed, sold, or disclosed pursuant to the Gramm-Leach-Bliley Act, and implementing regulations, or the California Financial Information Privacy Act.

- Personal information bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living as set forth in the Fair Credit Reporting Act.

- Personal health information collected, processed, or disclosed pursuant to the Health Insurance Portability and Accountability Act.

1. *National Guardian Life Insurance Company as a Service Provider*

When we act as a service provider for our customers, we collect personal information on behalf of our customers subject to our contractual obligations. When we act as a service provider, we follow the instructions of our customer on how to process personal information on our customer's behalf. The provisions of this Appendix do not apply to the personal information that we process on behalf of our business customers.

2. *What Personal Information We Collect and How We Share it*

The below chart lists the categories of personal information that we may collect and have collected in the past 12 months and how we share such information. We will share personal information with parties to whom you have directed or authorized us to share with.

Categories of Personal Information	Categories of Service Providers and Third Parties with whom Personal Information is Shared
Identifiers. This may include a real name, alias, address, email address, phone number, Social Security Number, driver's license number, online identifier, IP address, account username and password, job title, or other similar identifiers.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; data analytics providers; prospective purchasers of our business; and outside auditors and lawyers.

Internet and network information. This may include information on your interaction with a website, application, or advertisement, such as browsing history and how you use your account.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; and data analytics providers.
Device information. This may include the operating system of your device, device identifier, the type of device you are using, or your geolocation information.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; and data analytics providers.
Other information you submit to us. This may include requests or communications you submit to us, including emails, ratings, or customer service call recording.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; prospective purchasers of our business; and outside auditors and lawyers.
Research or survey information. This may include survey results, social media data, and other information about your participation in consumer research.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; prospective purchasers of our business; and outside auditors and lawyers.
Inferences we draw about you. This may include information about your preferences, characteristics, predispositions, behavior, or other trends that help us identify which products you may be interested in.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; and data analytics providers.

3. *How We Use Personal Information*

We may use personal information in the following ways:

- To provide you with information, products, or services;
- To improve our services and products;
- To secure and monitor our websites;
- For audit or research purposes;
- To resolve grievances;
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue;
- To respond to requests from law enforcement or other government authorities as required by law; or
- For our own legal obligations and business needs.

4. *Sale of Personal Information*

CCPA defines a "sale" of personal information broadly to include more than exchanges for monetary purposes. A sale can include personal information shared with a third party for "valuable consideration," or information shared with a third party (even if they are performing services on our behalf) if they are permitted to use the information for their own purposes.

We do not and have not sold any personal information in the previous 12 months.

5. *California Residents' Rights and Choices*

The CCPA provides California residents with specific rights regarding their personal information, described below. Below are your CCPA rights and how to exercise those rights.

a. *Access to Specific Information and Data Portability Rights ("Right to Know")*

You have the right to request that we disclose certain information to you about our collection and use of your personal information over the past 12 months. You could request:

- The categories of personal information we collected about you;
- The categories of sources of the personal information we collected about you;
- Our business or commercial purpose for collecting that personal information;
- The categories of third parties with whom we share that personal information; or
- The specific pieces of personal information we collected about you.

Our employees and employees of our business partners and service providers also do not have a Right to Know.

b. *Deletion Request Rights ("Right to Deletion")*

You have the right to request that we delete some or all of the personal information that we have collected from you and retained, subject to a number of exceptions. We are not required to delete personal information that is: (a) necessary to complete a transaction with you or for warranty or product recalls; (b) used for security purposes, to prevent fraud, to fix errors, or to comply with law; (c) reasonable for us to use for internal purposes given our relationship with you; or (d) compatible with the context in which you provided the information. The list of exceptions above is not exhaustive, and we may also deny a deletion request as otherwise permitted by law.

Our employees and employees of our business partners and service providers do not have a Right to Deletion.

c. *Exercising Your Rights*

To exercise your rights described above, please submit a verifiable consumer request to us by either:

- Calling us at 800-548-2962.
- Request a form to be completed by writing to us at:

  National Guardian Life Insurance Company
  PO Box 1191
  Madison, WI 53701

Only you, or a person or entity that you authorize to act on your behalf, may make a verifiable consumer request related to your personal information. You may also make a verifiable consumer request on behalf of your minor child. If you are making a request on behalf of another person, you must provide written legal documentation that you are authorized to act on behalf of that individual.

You may only make a verifiable consumer request for access or data portability twice within a 12-month period. The verifiable consumer request must:

- Provide sufficient information that allows us to reasonably verify you are the person about whom we collected personal information or an authorized representative; and
- Describe your request with sufficient detail that allows us to properly understand, evaluate, and respond to it.

We may not be able to fulfill your request or provide you with personal information if we cannot verify your identity or authority to make the request and confirm the personal information relates to you. To verify your identity, we may request up to three pieces of personal information about you, and we reserve the right to take additional steps, as necessary, to verify your identity if we have reason to believe a request is fraudulent.

d. *Response Timing and Format*

We endeavor to respond to a verifiable consumer request within 45 days of its receipt. If we require more time (up to 90 days), we will inform you of the reason and extension period in writing.

Any disclosures we provide will only cover the 12-month period preceding the date we received your verifiable consumer request. The response we provide will also explain the reasons we cannot comply with a request, if applicable. For data portability requests, we will select a format to provide your personal information that is readily useable and should allow you to transmit the information from one entity to another entity without hindrance.

We do not charge a fee to process or respond to your verifiable consumer request unless it is excessive, repetitive, or manifestly unfounded. If we determine that the request warrants a fee, we will tell you why we made that decision and provide you with a cost estimate before completing your request.

e. *Non-Discrimination*

You have the right to not be discriminated against for exercising any of your CCPA rights. Unless permitted by the CCPA, we will not:

- Deny you goods or services;
- Charge you different prices or rates for goods or services, including through granting discounts or other benefits, or imposing penalties;
- Provide you a different level or quality of goods or services; or

- Suggest that you may receive a different price or rate for goods or services or a different level or quality of goods or services.

6. Other California Privacy Rights

California's "Shine the Light" law (Civil Code Section § 1798.83) permits users of our Website that are California residents to request certain information regarding our disclosure of personal information to third parties for their direct marketing purposes. To make such a request, please contact us through the information provided above.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P. O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
c/o TPA Name
TPA Address
TPA Telephone Number

You should always contact the Company or agent first. If your discussions with the insurer or agent fail to provide a satisfactory resolution to your problem or concern, you may then contact the California Department of Insurance, Consumer Communications Bureau.

You can contact the **Consumer Communications Bureau** by:

Visiting their website at: www.insurance.ca.gov

Writing to:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Calling:

1-800-927-Help (4357) or
1-213-897-8921

TDD Number
1-800-482-4TDD (4833)

Form 2356-CA 04/18