

CALIFORNIA VISION INSURANCE POLICY

POLICYHOLDER: CITY OF SAN RAFAEL

POLICY EFFECTIVE DATE: JANUARY 1, 2019

POLICY NUMBER: 291-011

STATE OF DELIVERY: CALIFORNIA

Read Your Policy Carefully

This Policy is a legal contract between the Policyholder and Gerber Life Insurance Company. The consideration for this contract is the application and the payment of premiums as provided hereinafter.

Agreement

This Policy and the attached application is the entire contract between the Policyholder and Us. Oral statements made by the Policyholder, by an Insured, by Our Agent, or by any other person are not part of this Policy. Only Our Executive Officer may make changes for Us. Such changes must be in writing and attached to this Policy. We reserve the right to amend the Policy from time to time. We will pay, with respect to each Insured, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations, and exceptions of this Policy. Persons eligible to be insured include dependents as defined in the Definitions section of the Insurance Certificate. This Policy is governed by the laws of the state shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

Certificates

Gerber Life Insurance Company will furnish to the Policyholder a Certificate for each Insured which will set forth the essential features of the insurance coverage.

Additional Insureds

From time to time, all new employees, members or pupils of the Policyholder eligible to and applying for insurance in such group or class may be added to the group if they meet the eligibility requirements stated in the Insurance Certificate, complete an enrollment form and pay the required premium.

Important Notice

No change in this Policy shall be valid unless: (1) approved in writing by the Policyholder within 60 days advance written notice; and (2) approved by Our Executive Officer and unless approval be endorsed hereon or attached hereto. No agent has the right to change the Policy or to waive any part of its provisions.

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

This Policy is not intended to offer "essential pediatric health (vision) benefits" under the Affordable Care Act and the applicable State Exchanges.

Enrollment and Premium for Internet-Only Groups

- A. Initial Enrollment
 - 1. The Policyholder is responsible for the initial installation of all eligible employees under the Policy online through the MESVision website (www.MESVision.com).
- B. Subsequent Enrollment
 - 1. The Policyholder is responsible to manage the group's eligibility online through the MESVision website. In order to properly maintain benefit eligibility and for accurate information to be reflected on the monthly billing statement, eligibility information must be entered before the 1st of each month.
- C. Premium Payment
 - 1. The Policyholder is responsible to pay the group's premium online through the MESVision website. The Policyholder may elect automatic premium payment deductions from their checking account or credit card each month.

Incorporation Provision

The provisions of the attached Certificate and all Rider(s) issued to amend this Policy after its effective date are made a part of this Policy. This Policy was signed by the Policyholder on the application. We sign here on behalf of Gerber Life Insurance Company at White Plains, NY.

**GROUP INSURANCE POLICY PROVIDING
SCHEDULED VISION CARE INSURANCE
NON-PARTICIPATING**



PRESIDENT & CEO

SECRETARY

COUNTERSIGNATURE OF LICENSED RESIDENT AGENT

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

POLICY OF GROUP INSURANCE

**GROUP INSURANCE POLICY PROVIDING
SCHEDULED VISION CARE INSURANCE**

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

CALIFORNIA VISION INSURANCE CERTIFICATE

This Certificate will take the place of any and all certificates and riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance

This Certificate explains the plan of insurance which is underwritten by Gerber Life Insurance Company. Read it closely to become familiar with Your plan.

Important Notice

Benefits are payable only for expenses incurred while this insurance is in force.

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

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

The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

The Policy under which this Certificate is issued is not intended to offer "essential pediatric health (vision) benefits" under the Affordable Care Act and the applicable State Exchanges.

The Policy under which this Certificate is issued provides vision care insurance only unless a Hearing Benefit Rider to the Vision Policy is selected: it does not provide emergency or other health care services. Services by Participating Providers are rendered at a negotiated discount as shown on this Certificate's Schedule of Benefits.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE

If, for any reason, You are not completely satisfied, You may cancel this coverage by returning this Certificate to Us or to Our Administrator within thirty (30) days of receipt. The coverage shall be void from the beginning and We will promptly refund Your entire premium payment, less any benefits paid.

GROUP INSURANCE CERTIFICATE PROVIDING SCHEDULED VISION CARE INSURANCE



PRESIDENT & CEO



SECRETARY

Countersignature of Licensed Resident Agent (Where Required)

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

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DEFINITIONS

The following terms have specific meaning as used in the Policy

Administrator means: Medical Eye Services, Inc. (MESVision) who is Our administrator for this vision insurance policy.

Covered Services – vision care services and materials which are specified as benefits in the Policy, this Certificate of Coverage, and the Schedule of Benefits herein.

Dependent means any of the following persons:

1. An Insured's legally married spouse;
2. Registered Domestic Partner means any two adults, of the same sex, who meet the definition of the California Insurance Code (reference California Family Code 297) or, if applicable, the insurance code of the Insured's state of residence.
3. Each unmarried or married child, including children, step-children, foster children, or adopted children of registered domestic partners from birth up to age 25 who is primarily dependent upon You for support and maintenance;
4. Each unmarried child at least 19 years of age up to age 25 who is primarily dependent upon You for support and maintenance and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six (6) or more months; or enrolled in a course requiring attendance of 20 or more hours weekly for six (6) or more months; or
5. Each unmarried or married child age 25 or older:
 - a. who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental disability or physical handicap;
 - b. who was so incapacitated and is an Insured under this Policy on his or her 25th birthday; and
 - c. who has been continuously so incapacitated since his or her 25th birthday.

Dependent child coverage may continue beyond the dependent maximum age limit of 25 if the child is and remains both:

- (a) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and
- (b) chiefly dependent upon You for support and maintenance.

We will send a notification to You at least 90 (ninety) days prior to the date the child attains the limiting age. For continuation of benefits for this Dependent, You must submit to the Administrator and to Us documentation that the child meets the criteria for continuation of a disabled Dependent no later than 30 days prior to reaching the maximum age limit (60 days after receiving the 90-day notification). Upon receiving a request by the Insured for continued coverage of a disabled Dependent and proof of the criteria in (a) and (b) above, We will make a determination as to whether the Dependent child is entitled to continue coverage before the child reaches the limiting age. If We fail to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to physical or mental disability, injury, illness or condition.

6. Those individuals in Your immediate family who meet the criteria of the definition of a Dependent as used in the current United States Internal Revenue Code and Regulations of the United States, and who have been enrolled and accepted by Us.

Eligible Vision Expense means expenses for Covered Services shown in the Schedule of Benefits.

Experimental or Investigational means any treatment, therapy, procedure, drug or drug usage, biological product, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which is not demonstrated to be, in accordance with generally accepted professional medical standards, to be safe and effective for use in the treatment of illness, injury or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state government agency, prior to use and where such

approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials or other studies on human patients, shall be considered Experimental or Investigational in nature. "Experimental or Investigational" also includes services, supplies, drugs and procedures that are determined to be educational or the subject of a clinical trial. The fact that a Participating Provider, or medical professional may prescribe, order, recommend, recognize or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device or materials does not in itself make the service or materials non-Experimental or non-Investigational within this definition.

Insured means a person meeting the eligibility requirements of the Policy who is covered for benefits.

Non-Participating Provider means an Ophthalmologist, Optician, or Optometrist who has not contracted with MESVision to accept the terms, conditions, and compensation as set forth by the Schedule of Benefits.

Ophthalmologist means 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.

Optician means a person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an **Optometrist** or an **Ophthalmologist**.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in which his or her services are rendered.

Participating Provider means an Ophthalmologist, Optician, or Optometrist who has contracted with MESVision to accept the terms, conditions, and compensation as set forth by the Schedule of Benefits.

Policy means the Policy issued to the Policyholder.

Policyholder means the entity, named on the Policy's face page, to which We issue the Policy.

Prescription Change means a change of 0.50 diopter or more in one eye, or total in both eyes; or a difference in prism correction greater than 1 degree.

Prior Plan means a group insurance Vision Policy issued to the Policyholder in force immediately prior to the Policy Effective Date and which provided similar benefits of this Policy.

Standard Lenses means any plastic lenses that fit any frame with an eye size less than 61mm; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35. **We, Our, Us** means the Gerber Life Insurance Company.

You, Your, Yours means the Insured.

EFFECTIVE DATE OF COVERAGE

Benefits of this vision Policy become effective at 12:01 A.M. Pacific Time on the eligibility date established by the Policyholder. When the Policyholder pays the full amount of the premiums for You, Your coverage becomes effective automatically. If You contribute toward the cost of Your premiums, You are required to submit a completed enrollment form to the group prior to or within thirty-one (31) calendar days of the date You become eligible in order to have coverage commence on Your eligibility date. If You are a member of an internet-only group, Your coverage automatically becomes effective on the first day of the month following the date You are enrolled.

VISION BENEFITS

We will pay for Covered Services stated in the Schedule of Benefits when We receive proof that Eligible Vision Expenses have been incurred by or on behalf of You or an eligible Dependent. Expenses must be incurred while the Policy is in force and You are covered by the Policy.

For you to be eligible for reimbursement under the Policy, the vision service, device or equipment, must be:

1. performed by a licensed Optometrist or Ophthalmologist who is acting within the scope of his or her license; or
2. supplied by a retail, warehouse, or wholesale optical goods supplier meeting all applicable licensing requirements, if any.

PRINCIPAL BENEFITS AND COVERAGE

We will pay the allowed amount in the Participating Provider Schedule of Benefits for the Covered Services rendered by the Participating Providers less any Deductibles. If Covered Services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of the Non-Participating Schedule of Benefits less any Deductibles.

Deductibles

The Deductible is an amount of charges for Eligible Vision Expense You incur for which no benefits will be paid. The Deductible amount will apply within any 12 consecutive months to You. Provider locations using warehouse pricing will waive the eyewear Deductible. These providers are identified in the Provider Directory at www.mesvision.com.

Examination

1. One comprehensive eye examination in a 12 consecutive month period. A comprehensive examination is a general evaluation of the complete visual system. The comprehensive eye examination constitutes a single service but need not be performed at one session and includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It includes if clinically indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

You are responsible for a Deductible (as stated in the Schedule of Benefits) for the annual comprehensive eye examination and a Deductible for the purchase of frames, lenses, or contact lenses.

Lenses

2. One pair of Standard Lenses in a 24 consecutive month period, or at a 12-month interval if the examination indicates a Prescription Change. "Standard Lenses" (plastic) fit any frame with an eye size less than 61mm; or

3. One pair of contact lenses for cosmetic reasons or for convenience when provided in lieu of other eyewear once in a 24 consecutive month period, or at a 12-month interval if the examination indicates a Prescription Change.

The contact lenses are in lieu of other eyewear benefits. We will pay up to the amount shown in the Schedule of Benefits toward the contact lens evaluation, fitting costs and materials, except when You have a separate fitting benefit; or

4. One pair of non-elective (medically necessary) contact lenses every 24 consecutive month period, or at a 12-month interval if the examination indicates a Prescription Change when required following cataract surgery; or for clinically indicated conditions of Myopia, Hyperopia, or Astigmatism; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus, or 20/60 for certain conditions of Anisometropia. A completed "Non-Elective (Medically Necessary) Contact Lenses Approval Request Form" along with the patient's history from the provider and approval from Us is required. This form can be obtained from the MESVision website at www.MESVision.com. If prior approval is requested, a determination will be made within five (5) business days. If the services have already been rendered, a determination will be made within thirty (30) calendar days.

5. Note: A Prescription Change means any of the following:
 - a. a change in prescription of 0.50 diopter;
 - b. a shift in axis of the cylinder of 15 degrees or less than 15 degrees on a graduated scale as the cylinder power increases over .75 diopter. To confirm that you meet the criterion, please confer with your doctor;
 - c. a difference in prism correction greater than 1 degree; or
 - d. a change in lens type (i.e. single vision to bifocals, bifocals to single vision, etc.)

Frame

6. One standard frame in a 24 consecutive month period up to the allowed amount shown in the Schedule of Benefits.

The cost difference between the allowed amount and the charges for more expensive frames or unusual lenses, such as oversize, will be Your responsibility. Participating Providers allow a selection from frames that retail up to \$125.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, You are responsible for the additional cost above the \$125.00. If the lenses are 61 millimeters or over, any difference between the allowance and the provider's charge is Your responsibility.

When a Participating Provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance: \$80.19, warehouse allowance: \$83.90. Note that this pricing replaces the retail frame allowance shown in the Schedule of Benefits. If a more expensive frame is selected at a provider location that uses wholesale or warehouse pricing, You are responsible for the additional cost above the wholesale or warehouse pricing. Participating Providers using wholesale or warehouse pricing are identified in the Provider Directory at www.mesvision.com.

LIMITATIONS

(Covered Services paid up to the Schedule of Benefits)

We may limit benefits, as shown in the Schedule of Benefits, for:

1. Contact Lenses, except as specifically provided;
2. Contact Lens Fittings, except as specifically provided;
3. Rigid gas permeable scleral and hybrid contact lenses for advanced keratoconus may be partially covered for patients who meet the Non-Elective Contact Lens Criteria and when other contact lens approaches have been demonstrated to be unsuccessful. The patient will be responsible for the amount of the provider's charge exceeding the benefit allowance. Ocular surface diseases and treatment of underlying ocular pathologies are generally covered under the patient's medical plan.
4. Eyewear when there is no Prescription Change, except when benefits are otherwise available;
5. Charges for non-Standard Lenses or lens options including, but not limited to, polycarbonate, premium progressive, photochromic, polarized, hi-index, occupational, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored, and UV), oversized exceeding the allowance for covered lenses, or other custom lens options will only be covered to the extent there is a dollar value on the schedule and We will only pay up to the amount listed. Any amount for these items above that limit shall be the responsibility of Insured person;
6. Tints, other than pink or rose #1 or #2, except as specifically provided;
7. New-patient intermediate (follow-up) examinations: You should see the same doctor for both the comprehensive and intermediate (follow-up) examinations in order to receive the maximum benefit and to optimize continuity of care. When You elect to have a comprehensive examination and You are eligible for an intermediate (follow-up) examination or select a different provider to perform the intermediate (follow-

up) examination, You will be responsible for the difference between the intermediate (follow-up) examination allowance and the comprehensive examination allowance;

8. Non-prescription (plano) eyewear, except as specifically provided; and
9. Any promotions and/or discounts that are combined with Covered Services under the Policy.

EXCLUSIONS

(Non-Covered Services)

We will not pay benefits for:

1. Any eye examination required by an employer as a condition of employment;
2. Care or treatment of a condition for which benefits are paid to You under any Worker's Compensation Act or similar law;
3. Replacement contact lens insurance offered by providers, care kits, or frame cases;
4. Covered Services which began prior to Your effective date or after benefits have been terminated;
5. Charges for which You are not legally obligated to pay;
6. Covered Services required by any government agency or program, (federal, state, or subdivision thereof);
7. Orthoptics or, vision training or subnormal vision aids;
8. Services that are Experimental or Investigational in nature;
9. Any services provided in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
10. Procedures or expenses that are not included in the Schedule of Benefits;
11. Any charge for services that the appropriate regulatory board determines were provided as a result of a referral prohibited by State Law;
12. Medical or surgical treatment of the eyes, including treatment of any suspected pathology or injury that may be uncovered during the course of a covered vision examination and that may be payable under the medical benefits of the Insured's health plan. In the event that the provider determines that additional diagnostic procedures or treatment plans are indicated to confirm the suspected pathology or injury, the Insured will need to obtain care under her/his medical plan. Insureds who are covered under their medical plan should be referred back to their Primary Care Physician or Participating Medical Group;
13. Any Covered Services provided by another vision Policy, except benefits payable under Coordination of Benefits; and
14. Replacement of lenses or frames which are lost, stolen, or broken, except when benefits are otherwise available.
15. Plan Maximum and Frequency – the Maximum benefits shown in the Schedule of Benefits for which the Insured Person was eligible and received benefits from the Prior Plan, provided that such Prior Plan would have covered substantially the same benefit Deductible and frequency as the initial Prior Plan Policy, had the Prior Plan not been cancelled.

PARTICIPATING PROVIDERS

Certain Ophthalmologists, Opticians and Optometrists have agreed to be Participating Providers. A list of Participating Providers is available from Our Administrator or Us. The most current list of Participating Providers may be downloaded or delivered from the Administrator's website at www.mesvision.com or it can be delivered upon request to an Insured by contacting the Administrator's Customer Service Department at (800) 877-6372. This list may change from time to time, and is updated daily on the website. The Schedule of

Benefits states separately the benefits for Participating Providers and all other providers or Non-Participating Providers.

EXPENSES INCURRED

An Eligible Vision Expense is considered incurred on the date the service is performed, or the order date of the delivered eyewear. Late claim submission for eyewear claims is determined by the eyewear delivery date.

VOLUNTARY TERMINATION OF COVERAGE

If You terminate this insurance and wish to re-enroll for this insurance at a later date, We reserve the right to require a two (2) waiting period. The waiting period will begin on the date You terminate this insurance to such time as you wish to re-enroll.

DEPENDENT COVERAGE

Dependents are covered on the later of:

1. the date Dependent Coverage is first included in Your coverage; or
2. the date the person first qualified as Your Dependent.

NEWBORN INFANT COVERAGE

A Dependent child born while this coverage is in force for an Insured is covered from the moment of birth for Eligible Vision Expense. A notice of birth together with the additional premium must be submitted to Us. This must be done within 31 days after the date of birth in order to continue coverage beyond the 31-day period.

ADOPTED CHILDREN COVERAGE

A Dependent child placed with You for adoption while this coverage is in force shall be covered from the date of placement for purpose of adoption by You. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement. A notice of placement for adoption together with the additional premium must be submitted to Us. This must be done within 31 days after the date of such placement in order to continue coverage beyond the 31-day period.

COORDINATION OF BENEFITS

If You or any of Your Dependents are also covered under one or more other Policies, the benefits payable under this Policy will be coordinated with the benefits payable under all other Policies.

DEFINITIONS

The following definitions apply only to this Coordination of Benefits section.

1. The term "Policy" means coverage providing hospital, medical or vision benefits or services by:
 - a) group or blanket insurance coverage, except school accident coverage;
 - b) group practice or other prepayment coverage on a group basis; or
 - c) any coverage under a labor-management trust Policy, union welfare Policies, employer organization, or employee benefit Policies.

The term "Policy" will be construed separately for a policy, contract or other arrangement for benefits or services that reserves the right to take the benefits or services of other Policies into consideration in determining its benefits, or separately for that portion which does not reserve the right.

2. The term "Covered Expense" means any necessary, reasonable, and customary item of expense, all or part of which is covered under one of the Policies.

When a Policy provides benefits in the forms of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both a Covered Expense and a benefit paid.

3. The term "Claim Period" means a calendar year or a portion of a calendar year for a claim on anyone covered under this Policy.

ORDER OF BENEFITS DETERMINATION

The order of benefit determination rules govern the order in which each Policy will pay a claim for benefits. The Policy that pays first is called the Primary policy. The Primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another Policy may cover some expenses. The Policy that pays after the Primary policy is the Secondary policy. The Secondary policy may reduce the benefits it pays so that payments from all Policies do not exceed 100% of the total Covered Expense.

The rules establishing the order of benefit determination are:

1. The Primary policy pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other policy.
2. a) Except as provided in paragraph (b) below, a Policy that does not contain a coordination of benefits (COB) provision that is consistent with this provision is always primary unless the provisions of both Policies state that the complying policy is primary.
b) Coverage obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Policy provided by the Policy holder. An example of this type of situation is coverage written in connection with a closed panel policy to provide out-of-network benefits.
3. A Policy may consider the benefits paid or provided by another Policy in calculating payment of its benefits only when it is secondary to this Policy.
4. Each Policy determines its order of benefits using the first of the following rules that apply:
 - a) Non-Dependent or Dependent. The Policy that covers the Insured other than as a Dependent, for example as an employee, is the Primary policy and the Policy that covers the Insured as a Dependent is the Secondary policy. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Policy covering the Insured as a Dependent, and primary to the Policy covering the Insured as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Policies is reversed so that the Policy covering the Insured as an employee is the Secondary policy and the other Policy is the Primary policy.
 - b) Dependent covered under more than one Policy. Unless there is a court decree stating otherwise, when a Dependent is covered by more than one Policy the order of benefits is determined as follows:
 - 1) For a Dependent whose parents are married or are living together, whether or not they have ever been married:
 - a. The Policy of the parent whose birthday falls earlier in the calendar year is the Primary policy; or
 - b. If both parents have the same birthday, the Policy that has covered the parent the longest is the Primary policy.
 - 2) For a Dependent whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a. If a court decree states that one of the parents is responsible for the Dependent's health care expenses or health care coverage and the Policy of that parent has actual knowledge of those terms, that Policy is primary. This rule applies to policy years commencing after the Policy is given notice of the court decree;

- b. If a court decree states that both parents are responsible for the Dependent's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
 - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent, the provisions of subparagraph (a) above shall determine the order of benefits; or
 - d. If there is no court decree allocating responsibility for the Dependent's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - A. The Policy covering the custodial parent;
 - B. The Policy covering the spouse of the custodial parent;
 - C. The Policy covering the noncustodial parent; and then
 - D. The Policy covering the spouse of the noncustodial parent.
- 3) For a Dependent covered under more than one Policy of individuals who are not the parents of the Dependent, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the Dependent's parent.
- c) The Policy that covers an Insured as an employee, who is neither laid off nor retired (or as that employee's Dependent), is the Primary policy. The Policy covering the same Insured as a laid-off or retired employee (or as that employee's Dependent) is the Secondary policy. If the other Policy does not have this rule, and if, as a result, the Policies do not agree on the order of benefits, this rule (c) is ignored. This rule does not apply if rule 4(a) can determine the order of benefits.
 - d) If an Insured whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Policy, the Policy covering the person as an employee, member, subscriber, or retiree or covering the insured as a Dependent of an employee, member, subscriber or retiree is the Primary policy and the COBRA or state or other federal continuation coverage is the Secondary policy. If the other Policy does not have this rule, and as a result, the Policies do not agree on the order of benefits, this rule (d) is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
 - e) Longer or shorter length of coverage. The Policy that covered the Insured as an employee, member, policyholder, subscriber, or retiree longer is the Primary policy and the Policy that covered the Insured the shorter period of time is the Secondary policy.
 - f) If the preceding rules do not determine the order of benefits, the Covered Expenses shall be shared equally between the Policies meeting the definition of Policy. In addition, this Policy will not pay more than it would have paid had it been the Primary policy.

EFFECTS ON THE BENEFITS OF THIS POLICY

1. When this Policy is secondary, it may reduce its benefits so that the total benefits paid or provided by all policies during a policy year are not more than the total Covered Expenses. In determining the claims payment, the Secondary policy will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Covered Expense under its Policy that is unpaid by the Primary policy. The Secondary policy may then reduce its payment by the amount so that, when combined with the amount paid by the Primary policy, the total benefits paid or provided by all policies for the claim do not exceed the total Covered Expense for that claim. In addition, the Secondary policy shall credit to its policy deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
2. If an Insured is enrolled in two or more closed panel policies and if, for any reason, including the provision of service by a Non-Participating Provider, benefits are not payable by one closed panel policy, COB shall not apply between this Policy and other closed panel policies.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Policy and other policies. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Policy and other policies covering the Insured claiming benefits. We need not tell, or get the consent of, any person to do this. Each Insured claiming benefits under this Policy must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another policy may include an amount that should have been paid under this Policy. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Policy. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If Our payment is more than We should have paid under this COB provision, We may recover the excess from one or more of the Insureds paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured.

BENEFITS SUBJECT TO COORDINATION

All benefits provided under the Policy are subject to coordination.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate, the Policy, the application of the Policyholder and any applicable state rider or endorsement, constitute(s) the entire contract between the Policyholder and Us, and any statement made by the Policyholder or by any Insured person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application.

No change in the Policy shall be valid unless: (1) approved in writing by the Policyholder within 30 days advance written notice; and (2) approved by Our Executive Officer and unless such approval be endorsed herein or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After two years (2) from the date of issue of the Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in this application shall be used to void the Policy; and after two (2) years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after expiration of such two (2) years.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

CONFORMITY TO LAW

Any provision of the Policy, which, on its Effective Date is in conflict with the statutes of the State of California, is changed to conform to the minimum standards of those statutes.

NON-PARTICIPATION

The Policy will not share in Our surplus or earnings.

CLAIMS PROVISIONS

DISCLOSURE OF COVERAGE; CLAIMS

Participating Providers have agreed to bill Our Administrator directly. It is Your responsibility to identify yourself as having vision coverage at the time of service. If You do not, You may be required to pay for services and/or materials at the time of the visit, and any submitted claim will be paid to the Participating Provider. The Participating Provider is required to refund the amount paid by You, less any Deductibles or payments for non-covered services. If You do not inform the Participating Provider or, if You obtain services from a Non-Participating Provider the "Notice of Claim" provision shall be applicable.

NOTICE OF CLAIM

Written notice of claim must be given to Our Administrator within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. The notice should include sufficient information to identify the Insured. Claim forms may be obtained from a Participating Provider, Our Administrator, Policyholder, or Us. When the Administrator receives the notice of the claim, the Administrator will send the forms for filing a vision claim. The forms will be sent within fifteen (15) days of the request from the claimant.

CLAIM FORM

Upon receipt of a written notice of claim, We will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS (CLAIM SUBMISSION)

Written proof of loss must be furnished to Our Administrator, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within ninety (90) days after the termination of the period for which We are liable, and in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, proof must be sent no later than one (1) year from the date of service (date of service means the calendar date on which Covered Services were provided).

TIME OF PAYMENT OF CLAIMS

Subject to due written proof of loss, all benefits due under the Policy will be paid to or on behalf of the Insured as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured immediately upon receipt of due written proof.

PAYMENT OF CLAIMS

If the Policy provides coverage of a claimant as a Dependent of a parent who has legal responsibility for the Dependent's medical care and such parent does not have custody of the Dependent, We may, upon request of the custodial parent, make the payments directly to the provider of care or the non-covered custodial parent. Any payments so made will release Us from all further liability to the Insured to the extent of the payments made.

Benefits for other losses are paid to the Participating Provider or, if services are rendered by a Non-Participating Provider, the payment will be made to the Insured. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

Requests for payment adjustments should be made within 180 days of payment or denial. Payment may require approval prior to additional payment and may be subject to the claim submission deadline.

ADMINISTRATIVE PROVISIONS

PREMIUMS

DUE DATE AND METHOD OF PAYMENT

Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premiums are due on the first day of each month. If We agree to change the method of paying premiums, any pro rata adjusted premium required will be payable.

GRACE PERIOD

A grace period of thirty-one (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 Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force. If a premium is not paid by the end of the grace period, Your coverage will terminate at the end of the grace period.

PAYMENT OF PREMIUMS

Premiums are payable at Our office in White Plains, New York, or to Our Administrator. The first premium for each Insured is due on the Certificate Effective Date. Each monthly payment will pay for the insurance then in force under the Policy for a period of one month. If the method of paying premiums is changed by agreement as indicated above, each premium payment will pay for the insurance then in force under the Policy for the agreed upon period.

REINSTATEMENT

There shall be no provision in a group disability policy relative to reinstatement of the Policy after lapse because of default in the payment of premium.

CHANGE IN PREMIUM RATES AND BENEFITS

We have the right to change the premiums upon renewal. We will not change the premium rates during any rate guarantee period following Your Effective Date. We shall not increase premiums, reduce or eliminate benefits, or restrict eligibility for coverage without providing You, Your insurance producer, and any administrator at least 60 days advance written notice of any such change.

PROTECTED HEALTH INFORMATION

We maintain physical, electronic, and administrative safeguards that meet federal and state requirements. The Use and Disclosure of Protected Health Information (PHI) is limited to persons who need the information for authorized business purposes. We will not use PHI for marketing purposes. If you would like to obtain a copy of our "Notice of Privacy Practices", which explains your rights in relation to PHI, please submit your written request to:

Privacy Compliance Office / Legal Department
Gerber Life Insurance Company
1311 Mamaroneck Avenue
White Plains, NY 10605

INTERNAL GRIEVANCE PROCEDURE

The Insured, or the Insured's representative, has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with Us. If an Insured's claim is denied in whole or in part, he/she will receive written notification of the denial. If the Insured is not satisfied with a determination made by Us, the Insured is entitled to an appeal process or "Grievance" as described. A Grievance must be filed no later than 180 calendar days after the occurrence.

You (the Insured) or Insured's authorized representative can file a Grievance on the website (www.MESVision.com), by fax, by telephone, or by mail. To file a Grievance please contact Our Administrator:

Medical Eye Services, Inc.
Attn: Benefit Resolutions Department
P.O. Box 25209
Santa Ana, CA 92799

Website: www.MESVision.com
Telephone #: 800-877-6372
Fax #: 714-619-4662

If you need the help of the California Department of Insurance (CDI) with a complaint involving a grievance that has not been satisfactorily resolved by the Administrator and/or Gerber Life Insurance Company, you may file a complaint online (<http://www.insurance.ca.gov>), call the CDI's toll free number at 1-800-927-4357, or write to:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

CANCELLATION OF INSURANCE

We may cancel the Policy at any time by written notice delivered to the Policyholder, or mailed to the Policyholder's last address as shown on Our records, stating when, not less than 31 days thereafter, such cancellation shall be effective. After the Policy has been continued beyond its original term the Policyholder may cancel the Policy at any time by written notice delivered or mailed to Us, effective on receipt or on such later date as may be specified in the notice. If the Policy is cancelled, the Policyholder shall be entitled to a pro rata refund of the paid Policy fee for the unexpired term, less a \$50 administrative fee and all costs for Eligible Vision Expenses incurred by Us subsequent to such cancellation effective date. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on pro rata basis the earned premium which has not been paid. In computing the pro rata premium to be returned or to be paid by Us or to be paid by the Policyholder, any discounts in premium or premium rate actually allowed to the Policyholder because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the pro rata return or payment of premium will be computed upon the basis of Our regular and customary premium or premium rate for the coverage of the Policy. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

TERMINATION OF INSURANCE

We may terminate the Policy on any premium due date. We will give the Policyholder, the insurance producer, and any administrator at least 60 days advance written notice of such termination, except for non-payment of premiums when the grace period will apply. The Policyholder may terminate the Policy at any time by giving 30 days prior written notice to the Administrator. The Policy will then terminate on the requested termination date or some later date on which the Policyholder and the Administrator have agreed. The Policyholder remains responsible for the payment of premiums to the date of termination. If 30 days written notice of termination is not provided to the Administrator, the termination date shall be effective on the last day of the month after any date(s) of the service rendered to any Insured person or the Policyholder's requested termination effective date, whichever is later, subject to the Insured notification requirements.

If nonemployee certificate holders or employees of more than one employer are covered under the Policy, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and Dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

The coverage on any Insured will end automatically on the earliest of the following dates:

1. The last day of the month in which the Insured ceases to be eligible for coverage;
2. Subject to the "Grace Period" provision, the last day of the month for which the required premium has been paid; and
3. The date the Policy is terminated or discontinued.

The coverage of any Dependent will end automatically on the earliest of the following dates:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent;
2. Subject to the "Grace Period" provision, the last day of the month for which the required premium has been paid; and
3. The date the Policy is terminated or discontinued.

Termination of coverage will not prejudice any existing claim.

MILITARY REINSTATEMENT

Members of the United States Military Reserve and The National Guard who are called to active duty on or after January 1, 2007 will be reinstated upon payment of premium as a covered Insured without a waiting period or exclusions of coverage for pre-existing conditions.

INDIVIDUAL CONTINUATION OF BENEFITS

Applicable to Insureds when the group is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (groups of 20 or more eligible employees) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA) (groups of 2 to 19 eligible employees). The group should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), an Insured will be entitled to elect to continue group coverage under this Policy if the Insured would otherwise lose coverage because of a Qualifying Event that occurs while the group is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Insured if the Qualifying Event had not occurred (including any changes in such coverage).

Note: The Insured will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Insured is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health group that provides coverage without exclusions or limitations with respect to any Pre-existing condition. Under COBRA, the Insured will not be entitled to benefits if at the time of the qualifying event such Insured is entitled to Medicare.

A. QUALIFYING EVENT

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the subscriber:
 - a) the termination of employment (other than by reason of gross misconduct); or
 - b) the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the subscriber, or subscriber's Dependent spouse or Domestic Partner, during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the group is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

*Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

- a) the death of the subscriber; or
- b) the termination of the subscriber's employment (other than by reason of such subscriber's gross misconduct); or
- c) the reduction of the subscriber's hours of employment to less than the number of hours required for eligibility; or
- d) the divorce or legal separation of the subscriber from the Dependent spouse or termination of the domestic partnership; or
- e) the subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
- f) a Dependent child's loss of Dependent status under the Policy.

3. For COBRA only, with respect to a subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the group's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

B. NOTIFICATION OF A QUALIFYING EVENT

1. With respect to COBRA Insureds:

The Insured must notify the group, in writing, of all qualifying events (divorce, legal separation, termination of a domestic partner or a child's loss of Dependent status) within 60 days of the date of the qualifying event. If the Insured fails to make the notification to the group within the required 60 days, the Insured will be disqualified from receiving continuation coverage. The Insured must elect continuation coverage within the 60 days of either (1) the date that the Insured's coverage under the Contract terminated or will terminate by reason of a qualifying event, or (2) the date the Insured was sent the notice of the required benefit information, premium information, enrollment forms, and disclosures to allow the qualified beneficiary to formally elect continuation coverage, whichever is later.

The group is responsible for notifying its COBRA administrator (or group administrator if the group does not have a COBRA administrator) of the Insured's death, termination, or reduction of hours of employment, the subscriber's Medicare entitlement or the group's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Insured by first class mail of his or her right to continue group coverage under this Policy. The Insured must then notify the COBRA administrator within 60 days of the later of: (1) the date of the notice of the Insured's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Insured does not notify the COBRA administrator within 60 days, the Insured's coverage will terminate on the date the Insured would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA Insureds:

The Insured is responsible for notifying the group in writing of the Employee's/subscribers death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a child's loss of Dependent status under this Policy. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Policy because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Insured from receiving continuation coverage under Cal-COBRA.

The group is responsible for notifying the vision plan Administrator in writing of termination or reduction of hours of employment within 30 days of the Qualifying Event.

When the vision plan Administrator is notified that a Qualifying Event has occurred, the vision plan Administrator will, within 14 days, provide written notice to the Insured by first class mail of his or her right to continue group coverage under this Policy. The Insured must then give the group notice in writing of the Insured's election of continuation coverage within 60 days of the later of: (1) the date of the notice of the Insured's right to continue group coverage, and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to the vision plan Administrator by first-class mail or other reliable means.

If the Insured does not notify the vision plan Administrator within 60 days, the Insured's coverage will terminate on the date the Insured would have lost coverage because of the Qualifying Event.

If this Policy replaces a previous Policy that was in effect with the group's, and the Insured had elected Cal-COBRA continuation coverage under the previous group, the Insured may choose to continue to be covered by this Policy for the balance of the period that the Insured could have continued to be covered under the previous group, provided that the Insured notify the vision plan Administrator within 30 days of receiving notice of the termination of the previous group.

C. DURATION OF CONTINUATION OF GROUP COVERAGE

Cal-COBRA Insureds will be eligible to continue coverage under this Policy for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA Insureds will be eligible to continue coverage under this Policy for 18, 29, or 36 months depending on the type of Qualifying Event. Contact your group for more information.

COBRA Insureds who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Insured's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA Insureds must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Insured to continue group coverage under this Policy.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

D. PAYMENT OF PREMIUMS

Premiums for the Insured continuing coverage shall be 102 percent of the applicable group premium rate if the Insured is a COBRA Insured, or 110 percent of the applicable group premiums rate if the Insured is a Cal-COBRA Insured, except for the Insured who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 shall be 150 percent of the applicable group premium rate.

Note: For COBRA Insureds who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, premiums for Cal-COBRA coverage shall be 110 percent of the applicable group premiums rate for months 30 through 36.

If the Insured is enrolled in COBRA and is contributing to the cost of coverage, the group shall be responsible for collecting and submitting all premium contributions in the manner and for the period established under this Policy.

Cal-COBRA Insureds must submit premiums directly to the Vision Plan Administrator. The initial premiums must be paid within 45 days of the date the Insured provided written notification to the Vision Plan Administrator of the election to continue coverage and be sent to the Vision Plan Administrator through the MESVision website at (www.MESVision.com) or by first-class mail or other reliable means. The premiums payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Insured from continuation coverage.

E. EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE

The continuation of coverage will begin on the date the Insured's coverage under this Policy would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as premiums are timely paid.

F. TERMINATION OF CONTINUATION OF GROUP COVERAGE

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this group vision insurance Policy (if the group continues to provide any group benefit for subscribers, the Insured may be able to continue coverage);
2. failure to timely and fully pay the amount of required premiums as applicable. Coverage will end as of the end of the period for which premiums were paid;
3. the Insured becomes entitled to Medicare;
4. the Insured no longer resides in California;
5. the Insured commits fraud or deception in the use of the benefits of this Policy.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

G. NOTIFICATION REQUIREMENTS

The group must notify a qualified beneficiary during the 180 days prior to the expiration of continuation coverage of (1) the date continuation coverage will terminate and (2) the availability of any conversion coverage that is available.

SCHEDULE OF BENEFITS FOR COVERED SERVICES

If Covered Services are provided by a participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of prevailing fees¹, but not to exceed the "Participating Provider" allowances. If Covered Services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, any difference between the allowance and the provider's charge is the patient's responsibility.

Deductible Amounts²:

Exam	\$10.00
Material	\$10.00

COVERED SERVICES & BENEFITS

ALLOWANCES

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Exam:		
Comprehensive Examination	Covered in Full	\$40.00
Lenses:		
Single Vision	Covered in Full	\$30.00
Bifocal	Covered in Full	\$50.00
Blended Segment	\$72.50	\$50.00
Trifocal	Covered in Full	\$65.00
Aphakic/Lenticular Monofocal	Covered in Full	\$125.00
Aphakic/Lenticular Multifocal	Covered in Full	\$125.00
High Power of 7.25 Diopters or more additional (per lens)	Covered in Full	\$0 ⁵
Prism 1 ½ to 4 diopters (per lens)	Covered in Full	\$0 ⁵
Prism 4 ½ to 10 diopters (per lens)	Covered in Full	\$0 ⁵
Slab-off prism (per lens)	Covered in Full	\$0 ⁵
Standard Progressive ⁶	Covered in Full	\$65.00
Progressive Premium ⁶	\$89.50	\$65.0
Polycarbonate for children up to age 19:		
Single	\$85.00	\$55.00
Bifocal	\$85.00	\$55.00
Contact Lenses³:		
Non-Elective/Medically Necessary (one pair)	Covered in Full	\$250.00
Elective/Cosmetic	\$105.00	\$105.00
Frame⁴:		
Selection up to a retail amount of	\$125.00	\$75.00

- 1 Prevailing Fees means a fee which falls within a range of charges, as submitted to Medical Eye Services, Inc. by providers within a geographical area.
- 2 The Deductible is an amount of charges for Eligible Vision Expenses: (a) that You incur and (b) for which no benefits will be paid. Provider locations using warehouse pricing will waive the eyewear Deductible. These providers are identified in the Provider Directory at www.mesvision.com.
- 3 The contact lens allowance is in lieu of other eyewear. The allowance includes the contact lens evaluation, fitting costs, and materials, except when the Insured has a separate fitting benefit. Any difference between the allowance and the provider's charge is a patient responsibility. Please refer to the Limitations section of this Certificate.
- 4 The difference between the benefit amount and the charges for more expensive frames or unusual lenses, such as oversize, will be a patient responsibility. The retail frame allowance is reduced 30%-35% at provider locations employing wholesale or warehouse pricing. These provider locations are identified in the Participating Provider directory at www.mesvision.com. Some designer frames may be restricted by the manufacturer.
5. If the dollar amount related to a benefit/service is "0", this Policy does not cover the service.
6. Standard progressive lenses (also referred to as no-line bifocals) allow you to see distance, mid-range and near clearly; however, there may be some peripheral distortion. Standard progressive lenses also need to be a minimum height in order to transition properly between distance and near vision. Premium progressive lenses are digitally surfaced so they provide a wider reading area, less peripheral distortion and less height restrictions, than standard progressive lenses. Premium progressive lenses with higher levels of customization, including high definition lenses, are not a covered-in-full benefit; the patient is responsible for the balance between the maximum plan benefit and the provider's usual, customary, and reasonable charge.

You may also refer to the website at www.MESVision.com for benefit eligibility and claim history information or call 1-800-877-6372 to speak to a representative. Written inquiries may be forwarded to: Medical Eye Services, Inc., P.O. Box 25209, Santa Ana, CA 92799.

NOTICE OF AVAILABILITY CALIFORNIA LANGUAGE ASSISTANCE SERVICES

We are pleased to help you obtain vision care services in the language you understand at no charge to you.

INTERPRETER SERVICES

If you or a family member have limited English speaking skills and need verbal interpreter services or assistance arranging vision care services, the vision Policy administrator can assist you:

CALL **1-800-877-6372** for assistance with interpreter services; or

CALL the TTY/TDD LINE at **1-877-735-2929** for the hearing and speech impaired.

Hours of Operation: **Monday – Friday, 8:00 am – 5:00 pm Pacific Time**

TRANSLATION OF WRITTEN INFORMATION TO INSUREDS

The language most frequently requested to be translated among our membership is referred to as the “threshold language”, which is currently Spanish. Upon your request, the administrator will translate written information that impacts your vision care coverage into the threshold language(s). To request translation of vision benefit documents:

CALL **1-800-877-6372**, Customer Service; or

CALL the TTY/TDD LINE at **1-877-735-2929** for the hearing and speech impaired.

Hours of Operation: **Monday – Friday, 8:00 am – 5:00 pm Pacific Time**

If unable to reach us, please contact the Department of Insurance Consumer Communications Bureau toll-free number at **1-800-927-HELP (4357) or TDD 1-800-482-4833**. Telephone lines are open from **8:00 a.m. to 5:00 p.m. Pacific Time, Monday through Friday**, except state holidays.

Gerber Life Insurance Company

1311 Mamaroneck Avenue
White Plains, New York 10605

NOTICE

This notice is added to and made part of the Policy or Certificate to which it is attached in compliance with Federal law.

THE POLICY AND THE CERTIFICATES ISSUED UNDER IT PROVIDE VISION-ONLY INSURANCE. THE COVERAGE PROVIDED UNDER THE POLICY IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Nothing contained herein shall be deemed to alter or affect any of the provisions of the Policy.

Signed by the Company:


President & CEO

**GROUP INSURANCE CERTIFICATE PROVIDING
SCHEDULED VISION CARE INSURANCE**

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

Administrator

Medical Eye Services, Inc.

P.O. Box 25209

Santa Ana, CA 92799-5209

(800) 877-6372/TDD Line (877) 735-2929/www.mesvision.com

CALIFORNIA VISION INSURANCE POLICY

POLICYHOLDER: CITY OF SAN RAFAEL

POLICY EFFECTIVE DATE: JANUARY 1, 2019

POLICY NUMBER: 291-011

STATE OF DELIVERY: CALIFORNIA

Read Your Policy Carefully

This Policy is a legal contract between the Policyholder and Gerber Life Insurance Company. The consideration for this contract is the application and the payment of premiums as provided hereinafter.

Agreement

This Policy and the attached application is the entire contract between the Policyholder and Us. Oral statements made by the Policyholder, by an Insured, by Our Agent, or by any other person are not part of this Policy. Only Our Executive Officer may make changes for Us. Such changes must be in writing and attached to this Policy. We reserve the right to amend the Policy from time to time. We will pay, with respect to each Insured, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations, and exceptions of this Policy. Persons eligible to be insured include dependents as defined in the Definitions section of the Insurance Certificate. This Policy is governed by the laws of the state shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

Certificates

Gerber Life Insurance Company will furnish to the Policyholder a Certificate for each Insured which will set forth the essential features of the insurance coverage.

Additional Insureds

From time to time, all new employees, members or pupils of the Policyholder eligible to and applying for insurance in such group or class may be added to the group if they meet the eligibility requirements stated in the Insurance Certificate, complete an enrollment form and pay the required premium.

Important Notice

No change in this Policy shall be valid unless: (1) approved in writing by the Policyholder within 60 days advance written notice; and (2) approved by Our Executive Officer and unless approval be endorsed hereon or attached hereto. No agent has the right to change the Policy or to waive any part of its provisions.

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

This Policy is not intended to offer "essential pediatric health (vision) benefits" under the Affordable Care Act and the applicable State Exchanges.

Enrollment and Premium for Internet-Only Groups

- A. Initial Enrollment
 - 1. The Policyholder is responsible for the initial installation of all eligible employees under the Policy online through the MESVision website (www.MESVision.com).
- B. Subsequent Enrollment
 - 1. The Policyholder is responsible to manage the group's eligibility online through the MESVision website. In order to properly maintain benefit eligibility and for accurate information to be reflected on the monthly billing statement, eligibility information must be entered before the 1st of each month.
- C. Premium Payment
 - 1. The Policyholder is responsible to pay the group's premium online through the MESVision website. The Policyholder may elect automatic premium payment deductions from their checking account or credit card each month.

Incorporation Provision

The provisions of the attached Certificate and all Rider(s) issued to amend this Policy after its effective date are made a part of this Policy. This Policy was signed by the Policyholder on the application. We sign here on behalf of Gerber Life Insurance Company at White Plains, NY.

**GROUP INSURANCE POLICY PROVIDING
SCHEDULED VISION CARE INSURANCE
NON-PARTICIPATING**



PRESIDENT & CEO

SECRETARY

COUNTERSIGNATURE OF LICENSED RESIDENT AGENT

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

POLICY OF GROUP INSURANCE

**GROUP INSURANCE POLICY PROVIDING
SCHEDULED VISION CARE INSURANCE**

Gerber Life Insurance Company

A Stock Company

Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605