SCHEDULED VISION CARE INSURANCE

POLICYHOLDER: **COUNTY OF VENTURA**

POLICY EFFECTIVE DATE: **JANUARY 1, 2015**

POLICY NUMBER: **290-004**

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 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 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.

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

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

SCHEDULED VISION CARE
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.

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 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

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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SCHEDULE OF BENEFITS

PARTICIPATING PROVIDERS

If covered services and materials are provided by a participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of prevailing fees[1], but not to exceed the following Schedule of Allowances:

Deductible Amounts[2]: The deductible amount will apply any 12 consecutive months to You.

Exam	$20.00
Materials	$20.00

BENEFITS	ALLOWANCES
Exam: One comprehensive examination in any 12 consecutive months.	
Comprehensive Examination	100%
Lenses: One pair of standard lenses in any 12 consecutive months. "Standard" lenses (plastic) fit any frame with an eye size less than 61mm.	
Single Vision	100%
Bifocal	100%
Trifocal	100%
Aphakic/Lenticular Monofocal	100%
Aphakic/Lenticular Multifocal	100%
High Power of 7.25 Diopters or more (per lens)	100%
Progressive[3]	$89.50
Polycarbonate for children up to age 19[3]	
Single	$85.00
Bifocal	$85.00
Contact Lenses: One pair of contact lenses every 12 consecutive months.[4]	
Non-elective contact lenses are a fully covered benefit. Non-elective contact lenses are lenses following cataract surgery; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus or Anisometropia; or for certain conditions of Myopia 12 Diopters, Hyperopia 7 Diopters, or Astigmatism 3 Diopters. A report from the provider an approval from Medical Eye Services is required.	100%
Elective/Costmetic[4]	$105.00
Frame: One standard frame in any 24 consecutive months.[5]	
Selection up to retail amount of	$100.00

[1] Prevailing Fees means a fee which falls within a range of charges, as submitted to Medical Eye Services by providers within a geographical area.

[2] The Deductible is an amount of covered Vision charges You incur for which no benefits will be paid.

[3] Some Policies do not cover this service. Any difference between the allowance and the provider's charge is the patient's responsibility.

[4] The allowance is in lieu of other eyewear. The allowance includes the contact lens evaluation, fitting costs, and materials. Any difference between the allowance and the provider's charge is a patient responsibility. Disposable contact lenses should be purchased up to the maximum allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement.

[5] 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.

SCHEDULE OF BENEFITS

NON-PARTICIPATING PROVIDERS

If covered services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of the following Schedule of Allowances. Any difference between the allowance and the provider's charge is the patient's responsibility.

Deductible Amounts: The Deductible is an amount of covered Vision charges You incur for which no benefits will be paid. The deductible amount will apply any 12 consecutive months to You.

Exam	$20.00
Materials	$20.00

BENEFITS	**ALLOWANCES**
Exam: One comprehensive examination in any 12 consecutive months.	
Ophthalmologic Examination	$40.00
Optometric Examination	$40.00
Lenses: One pair of standard lenses in any 12 consecutive months. "Standard" lenses (plastic) fit any frame with an eye size less than 61mm.	
Single Vision	$30.00
Bifocal	$50.00
Trifocal	$65.00
Aphakic/Lenticular Monofocal	$125.00
Aphakic/Lenticular Multifocal	$125.00
Progressive[1]	$65.00
Polycarbonate for children up to age 19[1]	
Single	$55.00
Bifocal	$55.00
Contact Lenses: One pair of contact lenses every 12 consecutive months.[2]	
Non-elective contact lenses are a fully covered benefit. Non-elective contact lenses are lenses following cataract surgery; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus or Anisometropia; or for certain conditions of Myopia 12 Diopters, Hyperopia 7 Diopters, or Astigmatism 3 Diopters. A report from the provider an approval from Medical Eye Services is required.	Up to $250.00
Elective/Costmetic[2]	$100.00
Frame: One standard frame in any 24 consecutive months.	
Selection up to retail amount of	$40.00

[1] Some Policies do not cover this service. Any difference between the allowance and the provider's charge is the patient's responsibility.

[2] The contact lens allowance is in lieu of other eyewear benefits. The allowance includes the contact lens evaluation, fitting costs, and materials. Any difference between the allowance and the provider's charge is a patient responsibility. Disposable contact lenses should be purchased up to the maximum allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement.

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, P.O. Box 25209, Santa Ana, CA 92799.

LIMITATIONS

(Paid up to the Schedule of Benefits)

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

1. Contact Lenses;
2. Contact Lens Fittings;
3. Eyewear when there is no Prescription Change, except when benefits are otherwise available;
4. Non-standard lenses including, but not limited to, polycarbonate, progressive, photochromic, hi-index, occupational, beveled, faceted, coated (anti-reflective, scratch, mirrored, and UV), or oversized exceeding the allowance for covered lenses;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. Polarized lenses;
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 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; and
8. Non-prescription (plano) eyewear.

EXCLUSIONS

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 You are entitled to or eligible for benefits 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. Covered services performed by a close relative or by an individual who ordinarily resides in the insured's home;
8. Orthoptics, vision training or subnormal vision aids;
9. Services that are Experimental or Investigational in nature;
10. 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;
11. Procedures that are not included in the Schedule of Benefits;
12. Any charge for services that the appropriate regulatory board determines were provided as a result of a referral prohibited by State Law;
13. Medical or surgical treatment of the eyes;
14. Any covered services provided by another vision Policy; and
15. Replacement of lenses or frames which are lost, stolen, or broken, except when benefits are otherwise available.

DEFINITIONS

The following items have specific meaning as used in the Policy.

Administrator means: Medical Eye Services, Inc., P.O. Box 25209, Santa Ana, CA 92799-5209; (800) 877-6372 / TDD Line (877) 735-2929 / www.mesvision.com.

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 child, including children, step-children, foster, or adopted children of registered domestic partners from birth to age 26 who is primarily dependent upon You for support and maintenance;
4. Each unmarried or married child age 19 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 19th birthday; and
   c. who has been continuously so incapacitated since his or her 19th birthday.

   Dependent child coverage may continue beyond the dependent maximum age limit of 26 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.
5. 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 vision 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 determined not to have been demonstrated in accordance with generally accepted professional medical standards as being 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.

Policy means the Policy issued to the Policyholder.

Policyholder means the employer or group.

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.

Scheduled Benefit means the specific benefit for each particular vision procedure shown in the Schedule of Benefits.

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 your employer. When Your employer 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.

VISION BENEFITS

We will pay the Scheduled Benefits 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 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 than any Copayments. 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 Copayments.

Examination

1. One comprehensive eye examination in a 12 consecutive month. 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 copay (as stated in the Schedule of Benefits) for the annual comprehensive eye examination and a copy for the purchase of frames, lenses, or contact lenses.

Lenses

2. One pair of lenses in a 12 consecutive month period; or

3. One pair of contact lenses for cosmetic reasons or for convenience when provided in lieu of other eyewear once in a 12 consecutive month period;

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.

Disposable Contact Lenses should be purchased up to the maximum allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement; or

4. One pair of non-elective (medically necessary) contact lenses every 12 consecutive month period 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.

Frame

5. One 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 $100.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, You are responsible for the additional cost above the $100.00. 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: $66.04, warehouse allowance: $69.09. 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.

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) year 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 Expenses, including conditions due to congenital malformation. 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.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. The benefits that would be payable under this Policy in the absence of coordination; and
2. The benefits that would be payable under all other Policies in the absence of provisions for coordination on those Policies;

would exceed those Covered Expenses.

Except as provided in the following paragraph, when Coordination of Benefits applies to the benefits payable to an individual for any Claim Period, the benefits that would be payable for Covered Expenses under this Policy in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Covered Expenses under all other Policies will not exceed the total of those Covered Expenses. Benefits payable under all other Policies include the benefits that would have been payable had claim been properly made for them.
The rules establishing the order of benefit determination are:

1. The benefits of a Policy which covers the individual, for whom claim is made, other than as a Dependent, will be determined before the benefits of a Policy which covers that individual as a Dependent.
2. Except as stated in (3) below, when this Policy and another Policy cover the same child as a Dependent of different parents:
   a. the benefits of the Policy of the parent whose birthday falls earlier in a year are determined before those of the Policy of the parent whose birthday falls later in the year; but
   b. if both parents have the same birthday, the benefits of the Policy which covered the parent longer are determined before those of the Policy which covered the other parent for a shorter period of time. However, if the other Policy does not have the rule described in (a) above, but instead uses a different method and if, as a result, the Policies do not agree on the order of benefits, the rule in the other Policy will determine the order of benefits.
3. If two or more Policies cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. first, the Policy of the parent with custody of the child;
   b. then, the Policy of the spouse of the parent with custody of the child; and
   c. finally, the Policy of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Policy of that parent has actual knowledge of those terms, the benefits of that Policy are determined first. This paragraph does not apply with respect to any Claim Period or Policy year during which any benefits are actually paid or provided before the entity has that actual knowledge.
4. The benefits of a Policy which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Policy which covers that person as a laid-off or retired employee (or as that employee's Dependent). 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 (4) is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a Policy which has covered the individual for whom claim is made for the longer period of time will be determined before the benefits of a Policy which has covered the individual the shorter period of time.

If We are responsible for secondary coverage for Covered Benefits, We will not deny coverage or payment of the amount We owe as secondary payor solely on the basis of the failure of another group contract responsible for primary coverage to pay for those Covered Expenses. This will not require Us to pay the obligations of the primary payor.

For the purpose of administering the above provisions of this Policy or any provision of similar purpose of other Policies, We may release to or obtain from any other insurance company, organization or individual any information, with respect to

any person, which We deem to be necessary for such purposes. Any individual claiming benefits under this Policy will furnish Us with any information necessary to implement this provision.

Whenever payments, which should have been made under this Policy in accordance with the above provisions, have been made under any other Policies, We will have the right to pay any organizations making these payments any amount We determine to be warranted in order to satisfy the intent of this provision. Amounts paid in this manner will be considered to be benefits paid under this Policy and, to the extent of these payments, We will be fully discharged from liability under this Policy.

Whenever payments have been made by Us for Covered Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, We will have the right to recover the excess from one or more of the following:

1. other insurance companies;
2. other organizations; or
3. individuals to or from whom payments were made.

BENEFITS SUBJECT TO COORDINATION All benefits provided under the Policy are subject to coordination.

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.

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 parties, 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 this Policy shall be valid unless: approved by Our Executive Officer and unless such approval be endorsed herein or attached hereto. No agent has authority to change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After three years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in this application shall be used to void the Policy; and after three 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 three years.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three 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 jurisdiction in which it was issued, is changed to conform to the minimum standards of those statutes.

NON-PARTICIPATION

This 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 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 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 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this 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 this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 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, later than one year from the time proof is otherwise required. Please be aware that there is a 12-month claim submission deadline from the date of service.

TIME OF PAYMENT OF CLAIMS

Subject to due written proof of loss, all benefits due under this 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 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 as of the last date to which premiums have been paid.

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 nor shall there be any provision therein prior to the reinstatement relative to when the insurance coverage becomes effective again after such lapse and reinstatement.

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:

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

Website: www.MESV*ision*.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 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 this policy at any time by written notice delivered to the employer, or mailed to the employer's last address as shown on Our records, stating when, not less than 31 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the employer may cancel this 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. In the event of such cancellation by either Us or the employer, We shall promptly return on a prorata basis the unearned premium paid, if any, and the employer shall promptly pay on prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned or to be paid by Us or to be paid by the employer, any discounts in premium or premium rate actually allowed to the employer 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 prorata return or payment of premium will be computed upon the basis of Our regular and customary premium or premium rate for the coverage of this 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 group 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 group Policy at any time by giving 30 days prior written notice to the Administrator. The group 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 above, 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 above, 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.

CONTINUATION OF COVERAGE NOTICE

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

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. The group should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, 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.

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: 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 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.

   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.

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.

C. DURATION OF CONTINUATION OF GROUP COVERAGE

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.

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.

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, 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.

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.

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 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.

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.

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