SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM
3.11
(ID # 4121)

MEETING DATE:
Tuesday, April 9, 2019

FROM : HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Ratify and approve the Vision Benefits Administration Agreement between the County of Riverside and Medical Eye Services, Inc., effective January 1, 2017 through December 31, 2020, All Districts. [Total Cost - $0, Source of Funds – Employee and retiree premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the Vision Benefits Administration Agreement between the County of Riverside and Medical Eye Services, Inc. to provide voluntary vision benefits for eligible employees and retirees, effective January 1, 2017 through December 31, 2020;
2. Authorize the Chairman of the Board to sign three (3) copies of the Agreement on behalf of the County; and
3. Direct the Clerk of the Board to retain one (1) copy of the Agreement and return two (2) copies of the Agreement to Human Resources for distribution.

ACTION:Policy

Brenda Diederichs
Brenda Diederichs, Assistant CEO / Human Resources Director 3/4/2019

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Spiegel and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	April 9, 2019
xc:	HR

Kecia Harper
Clerk of the Board
By: _____ Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0

SOURCE OF FUNDS: Employee payroll deductions and retiree pension	**Budget Adjustment:** No
	For Fiscal Year: FY 16/17 – FY 20/21

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

On March 12, 2013, Item 3.29, the Board approved the retention of Medical Eye Services, Inc. (MES) to provide voluntary vision benefits to eligible employees covered by the Service Employees International Union, Local 721 (SEIU), Laborer's International Union of North America (LIUNA), Local 777, and employees represented by the Riverside Sheriff's Association Public Safety Unit, effective January 1, 2013 through December 31, 2016.

Effective October 1, 2014, the County contracted with Gerber Life Insurance Company since MES was purchased by Gerber Life Insurance Company, to continue to underwrite and provide vision benefits to County eligible employees and retirees. The modification of the Vision Benefit Agreement was previously approved by the Board on December 13, 2016, Item 3-31.

Attached is the new Vision Benefits Administration Agreement, effective January 1, 2017 through December 31, 2020, with negotiated terms and benefits. As part of the agreement, Human Resources in partnership with AON (benefits consultant) negotiated a 4-year rate guarantee through December 31, 2020.

There is no direct cost to the County for this recommended action. Fees are paid by employee and retiree premiums.

Prev. Agn. Ref.: 12/13/16, Item 3.31 District: All

Impact on Residents and Businesses

There is no direct impact to residents or private businesses in the County of Riverside.

Contract History and Price Reasonableness

The County's contract with Medical Eye Services to provide vision benefits to our active employees and retirees has been in effect since 2004. MES is a fully insured vision plan offered to the County eligible benefitted employees represented by SEIU, LIUNA, and RSA Public Safety. Currently, the County has 10,410 active employees enrolled and approximately 558

retirees enrolled with MES. MES continues to provide quality vision benefits and provides a broad network of providers for member convenience.

ATTACHMENTS:

Attachment A: VISION BENEFITS ADMINISTRATION AGREEMENT BETWEEN THE COUNTY OF RIVERSIDE AND MEDICAL EYE SERVICES, INC.

Irneliza Delos Santos 4/1/2019

Gregory P. Priamos, Director County Counsel 3/29/2019

VISION BENEFITS ADMINISTRATION AGREEMENT
BETWEEN THE COUNTY OF RIVERSIDE AND MEDICAL EYE SERVICES, INC.

This Vision Benefits Administration Agreement ("Agreement") is entered into, effective the 1st day of January, 2017, by and between the County of Riverside, a political subdivision of the State of California, (hereafter "Policyholder"), and Medical Eye Services, Inc., a California corporation, (hereafter "Company").

WHEREAS, Policyholder has contracted with Gerber Life Insurance Company, a New York corporation, (hereafter "Underwriter") to underwrite a vision benefit policy (hereinafter "Policy") designed to provide vision benefits (hereafter "Benefits") to Policyholder's employees and retirees including their eligible dependents; and

WHEREAS, Company offers a variety of administrative services, as a subcontractor of Underwriter, related to the operation of certain vision benefit plans; and

WHEREAS, Policyholder desires to retain Company to provide certain administrative services in connection with the Policy and Company desires to provide such services; and,

WHEREAS, Policyholder and Company (collectively referred to as the "Parties" and individually referred to as a "Party") are entering into this Agreement for that purpose;

NOW THEREFORE, in consideration of their mutual promises and covenants, the Parties agree as follows:

1.0 DEFINITIONS As used in this Agreement, the following terms shall have the meaning described below:

1.1 Agreement means this Vision Benefits Administration Agreement for the provision of administrative services for the Policy, and all attachments, addendums and amendments hereto.

1.2 Director means the Director of Human Resources for County of Riverside, or his or her designee.

1.3 State means the State of California.

1.4 Policy or Policies refers to the wrap around vision Benefits policies and certificates annually issued by Underwriter and attached hereto as Exhibit A for each of the following plans: Full Service, Eyewear Only, and Retirees.

2.0 RESPONSIBILITIES OF POLICYHOLDER

2.1 Enrollment of Participants; Eligibility Lists; Changes in Status. The Policyholder shall submit to the Company eligibility information in accordance with the applicable Policy attached hereto as Exhibit A.

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2.2 Continuation of Coverage. Policyholder shall, as applicable: (a) determine the occurrence of "qualifying events", as that term is defined, for purposes of continuing coverage under "COBRA" or any similar applicable State laws, (b) notify Participants of their continuing coverage rights under such laws, as applicable, and (c) notify Company of all Participants who have elected continuing coverage, the duration of such coverage, and the termination of such coverage.

3.0 COMPANY RESPONSIBILITIES

3.1 Account Administration. Company shall provide administrative services in accordance with the applicable Policies attached hereto as Exhibit A.

3.2 Payment of Claims. Company shall furnish claims administration services:

3.2.1 Company shall accept claims (each, a "Claim") for Benefits under the Policy, which are made pursuant to procedures established in connection therewith, and do an evaluation of each Claim and any other relevant information available to Company to determine the eligibility of the Participant to whom the Services were provided based on the eligibility information provided by Policyholder.

3.2.2 Company shall maintain a grievance resolution procedure, which shall be made available to a Participant, in writing, upon request. Company may compromise or adjust any Claim properly submitted under such procedure. If there is a change to a determination of a Claim by virtue of the resolution procedure, Company shall make the necessary changes in its records and comply with the final decision.

3.3 Claim Forms. Subject to the requirements of the Policy and this Agreement, Company shall arrange for the printing and publication of, and maintain a supply of, the forms necessary for the administration of the Policy, including without limitation Claim forms, Claim denial forms, and Claim payment forms.

3.4 Records and Information. Company shall maintain and provide records and information necessary to administer the Agreement consistent with all applicable State and federal laws, and continue to comply with all future laws, which may change from time to time, during the term of this Agreement, including any renewal periods. Company shall retain such records for at least ten (10) years from the close of the County's fiscal year in which this Agreement becomes effective. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise. It is agreed that the Policyholder is the owner of all records maintained by Company. At least sixty (60) days prior to destruction of such records, Company shall contact Policyholder in writing and notify Policyholder of the intent to destroy the records in sufficient detail to allow Policyholder to agree to Company's request or to transfer from Company to Policyholder the specified records.

3.5 Licenses. Company shall maintain any and all professional licenses required by the laws of the State of California and applicable Federal laws, if any, at all times while performing services on behalf of Policyholder under this Agreement.

3.6 Insurance Requirements.

3.6.1 Without limiting or diminishing the Company's obligation to indemnify or hold Policyholder harmless, Company shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverages during the term of this Agreement. As respects to the insurance section only, Policyholder herein refers to the County of Riverside, its Agencies, Districts, Special Districts, and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents, or representatives as additional insureds.

3.6.1.1 Workers' Compensation: If the Company has employees as defined by the State of California, the Company shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside.

3.6.1.2 Commercial General Liability: Commercial General Liability insurance coverage, including but not limited to, premises liability, unmodified contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage, covering claims which may arise from or out of Company's performance of its obligations hereunder. Policy shall name Policyholder as additional insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Agreement or be no less than two (2) times the occurrence limit.

3.6.1.3 Vehicle Liability: If vehicles or mobile equipment is used in the performance of the obligations under this Agreement, then Company shall maintain liability insurance for all owned, non-owned, or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Agreement or be no less than two (2) times the occurrence limit. Policy shall name the Policyholder as additional insureds.

3.6.1.4 Professional Liability: Company shall maintain Professional Liability Insurance providing coverage for the Company's performance of work included within this Agreement, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Company's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this

Agreement and Company shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also, known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that Company has Maintained continuous coverage with the same or original insurer. Coverage provided under items 1), 2), or 3) will continue as long as the law allows.

3.6.1.5 General Insurance Provisions - All lines:

3.6.1.5.1 Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California and have an A M BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by Policyholder Risk Manager. If the Policyholder's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.

3.6.1.5.2 The Company must declare its insurance self-insured retention for each coverage required herein. If any such self-insured retention exceeds $500,000 per occurrence each such retention shall have the prior written consent of the Policyholder's Risk Manager before the commencement of operations under this Agreement. Upon notification of self-insured retention unacceptable to the Policyholder, and at the election of the Country's Risk Manager, Company's carriers shall either; 1) reduce or eliminate such self-insured retention as respects this Agreement with the Policyholder, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3.6.1.5.3 Company shall cause Company's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and, 2) if requested to do so orally or in writing by the Policyholder Risk Manager, provide original certified copies of policies including all Endorsements and all attachments thereto, showing such insurance is in full force and effect. Further, said Certificate(s) shall contain the covenant of the insurance carrier(s) that thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. Company shall not commence operations until the Policyholder has been

furnished original Certificate(s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier shall sign the original endorsements for each policy and the Certificate of Insurance.

3.6.1.5.4 It is understood and agreed to by the Parties hereto that the Company's insurance shall be construed as primary insurance, and the Policyholder's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

3.6.1.5.5 If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work; or, the term of this Agreement, including any extensions thereof, exceeds five (5) years; Policyholder reserves the right to adjust the types of insurance and the monetary limits of liability required under this Agreement, if in the Policyholder Risk Manager's reasonable judgment, the amount or type of insurance carried by the Company has become inadequate.

3.6.1.5.6 Company shall pass down the insurance obligations contained herein to all tiers of subcontractors working under this Agreement.

3.6.1.5.7 The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the Policyholder.

3.6.1.5.8 Company agrees to notify Policyholder of any claim by a third party or any incident or event that may give rise to a claim arising from the performance of this Agreement.

3.6.1.6 In addition to the above insurance coverage's, the Company shall also provide a policy(s) of insurance for: (A) Fiduciary Liability in an amount not less than one million dollars ($1,000,000) covering any individual who is construed to be a fiduciary within the meaning of the Employment Retirement Income Security Act of 1974 (ERISA) and all fiduciaries and all persons that handle plan assets, if any, to be bonded as required under the ERISA Act, and; (B) Directors and Officers Liability in an amount not less than one million dollars ($1,000,000). The Directors and Officers policy shall have either: 1) an Extended Reporting endorsement (also known as tail coverage); or 2) Prior Dates Coverage for new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that Company has maintained continuous coverage with the same or original insurer. Coverage provided under items 1), 2), or 3) in this paragraph, will

continue for a period of not less than five (5) years beyond termination of this Agreement.

3.6.1.7 If Company in any manner handles any monies or any form of money, including but not limited to cash, checks, credit cards, debit card, electronic payments and/or transfers, etc., the Company shall provide and maintain at its own cost and expense during the term of this Agreement and any and all extensions thereto, Crime Insurance for: (A) Employee Dishonesty; (B) Forgery or Alteration; (C) Theft, Disappearance and Destruction, (E) Computer Fraud and any other coverage forms necessary to cover any type of loss arising out of/from this Agreement.

4.0 ADMINISTRATIVE FEE

4.1 Underwriter shall be entitled to the premiums described in the Applications for Group Coverage for vision (Full Service, Eyewear Only, and Retirees), which are attached hereto as Exhibit B. Company as a third party administrator is compensated by Underwriter and does not retain premiums nor collect compensation from Policyholder.

5.0 PROPRIETARY RIGHTS

5.1 Proprietary Nature of Information. Policyholder and Company agree to treat all Member patient information provided by Company or Policyholder as confidential. Policyholder and Company shall maintain the confidentiality of all such information and shall make disclosures to third parties only upon the advance written consent of the Member, or when allowed by applicable law. Company shall safeguard the confidentiality of Member health records and treatment in accordance with all applicable State and federal laws, and regulations.

5.2 Use of Trademarks and Copyrights. Policyholder and Company each reserve the right to control the use of its name, symbols, trademarks, or other marks currently existing or later established. However, either Party may use the other Party's symbol, trademarks, or other marks with the prior written approval of the other Party. Policyholder shall be allowed to use the name of Company in its promotional activities and marketing campaign.

5.3 Company Advertising. Prior to listing or otherwise referencing Policyholder in any promotional or advertising brochures, media announcements or other advertising or marketing material, Company shall first obtain the prior written consent of the Director.

6.0 TERM AND TERMINATION

6.1 The term of this Agreement shall become effective on January 1, 2017 and continue in effect for four years through December 31, 2020, unless terminated earlier as provided herein.

6.2 Causes for Immediate Termination of Agreement by Policyholder. The following shall constitute cause for immediate termination of this Agreement by Policyholder:

i) Breach of Material Term and Failure to Cure – Company's breach of any material term, covenant, or condition and subsequent failure to cure such breach within thirty (30) days following written notice of such breach.
ii) Failure to Provide Services – Failure of Company to provide services in accordance with this Agreement.
iii) Preservation of the Safety, Health and/or Welfare of Members – Determination by Policyholder that Company places the safety, health and/or welfare of Members in danger.
iv) Loss of Licensing – Failure by Company to secure and maintain the necessary governmental licenses, accreditation or certification required for the performance of duties hereunder.
v) Loss of Insurance Coverage – Failure by Company to maintain adequate general and professional liability insurance coverage, as provided herein.
vi) Insolvency of Company – Failure of the Company to remain solvent, including the filing of bankruptcy of Company.

6.3 Termination Without Cause. After the end of the first year of this Agreement, either Party may terminate this Agreement without cause. In the event either Party desires to terminate this Agreement without cause, the terminating Party shall give the other Party at least sixty (60) days written notice of termination.

7.0 MUTUAL INDEMNIFICATION

7.1 Each Party shall indemnify and hold harmless the other Party, its respective directors, officers, employees, agents and representatives from any liability to a third party based on breach of this Agreement by the indemnifying Party or the indemnifying Party's reckless conduct in the provision of services under this Agreement, but only to the extent such third party claim is not covered by any insurance coverage of the indemnified party.

8.0 MISCELLANEOUS

8.1 Relationship of Parties; Expenses. The relationship between Company and Policyholder is an independent contractor relationship. Neither Company nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Policyholder. Policyholder nor any employee(s) and/or agent(s) of Policyholder shall be considered to be an employee(s) and/or agent(s) of Company. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the Parties other than that of independent Parties contracting for the purposes of effectuating this Agreement. Except

as expressly set forth herein, each Party shall bear all expenses it may occur in connection with the execution, delivery and performance of this Agreement.

8.2 Legal Requirements. If at any time any federal, State or local law requires agreements of this type to include any provision, which is not already included in this Agreement, the Parties shall amend this Agreement to include such provision promptly following the request of either Party. In addition, if (a) there is (i) any change in any federal, State or local statute, law, regulation, legislation, rule, policy or general instruction or guideline, or (ii) any ruling, judgment, decree or interpretation by any court, agency or other governing body having jurisdiction over either Party (in any such case, for purposes of this section, a "Regulatory Matter"), and (b) such Regulatory Matter materially and adversely affects, or is reasonably likely to affect, the manner in which either Party is to perform or be compensated for its services under this Agreement or which shall make this Agreement unlawful, the Parties shall immediately use their best efforts to enter into a new arrangement that complies with such Regulatory Matter and approximates as closely as possible the position of the Parties under this Agreement, economically and otherwise, prior to such Regulatory Matter. If the Parties are unable to reach a new agreement within a reasonable period of time following the date upon which such Regulatory Matter arises or it becomes reasonably certain that such Regulatory Matter will arise, then either Party may terminate this Agreement pursuant to Section 6.3 (Termination Without Cause). If termination is not feasible, either Party may submit the issue to binding arbitration before the American Arbitration Association ("AAA") in accordance with the AAA's then-current commercial arbitration rules for a single arbitrator. All arbitration hearings shall be held in the State of California. Arbitration proceedings shall be initiated with appropriate written notice to the other Party and to AAA. The decision of the arbitrator shall be final, and judgment on such decision may be entered in any State or federal court of competent jurisdiction within the State of California. All costs and expenses of arbitration shall be borne by the Parties as determined by the arbitrator.

8.3 No Third Party Benefit. This Agreement is intended for the exclusive benefit of the Parties and their respective successors and assigns, and nothing contained in this Agreement shall be construed as creating any rights or benefits in or to any third party.

8.4 Assignment; Successors. This Agreement shall be binding upon and shall inure to the benefit of all transferees, assigns and successors in interest of any kind of the Parties hereto, but no transfer or assignment of any duties or responsibilities of this Agreement may be made without the prior written permission of the other Party. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void.

8.5 Notices. Any notice required to be given under this Agreement shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other addresses as the Parties may hereafter designate:

If to Policyholder:

County of Riverside/Human Resources
Attn: Stacey M. Beale, Human Resources Division Manager
4080 Lemon Street, 1st Floor
Riverside, CA 92502-1569

If to Company:

Medical Eye Services, Inc.
Compliance Department
345 Baker Street
Costa Mesa, CA 92626-4518

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

8.6 Entire Agreement; Modification or Amendment. This Agreement and its attached exhibits represent the full and final understanding of the Parties with respect to the subject matter described herein and supersedes any and all prior agreements or understandings, written or oral, express or implied. Policyholder and Company pursuant to mutual written amendments may modify this Agreement. Amendments shall require the formal approval of the Board of Supervisors for County of Riverside to be effective, except as expressly provided herein.

Amendments that shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments to, the policies and procedures, plan documents, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Director.

8.7 Attachments and Exhibits. Any Attachments or Exhibits attached hereto are incorporated herein by reference and made an integral part of this Agreement.

8.8 Captions. The captions of the various articles and sections of this Agreement are not part of the context of this Agreement, are only labels to assist in locating and reading those sections, and shall be ignored in construing this Agreement.

8.9 Severability. The intention of the Parties is to comply fully with all applicable laws and public policies, and this Agreement shall be construed consistently with all laws and public policies to the extent possible. If and to the extent that any court of competent jurisdiction determines that it is impossible to construe any provision of this Agreement consistently with any law or public policy and consequently holds that provision to be invalid, such holding shall in no way affect the validity of the other provisions of this Agreement, which shall remain in full force and effect. With respect to any provision in this Agreement finally determined by such a court to be invalid or unenforceable, such

court shall have jurisdiction to reform this Agreement (consistent with the intent of the Parties) to the extent necessary to make such provision valid and enforceable, and, as reformed, such provision shall be binding on the Parties.

8.10 Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either Party in such manner as to cause serious financial hardship to such Party, the Party so affected shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other Party.

8.11 Waiver of Breach. Failure of either Party hereto to require the performance by the other Party hereto of any obligation under this Agreement shall not affect its right subsequently to require performance of that or any other obligation. Any waiver by any Party hereto of any breach of any provision of this Agreement shall not be construed as a continuing waiver of any such provision or a waiver of any succeeding breach or modification of any other right under this Agreement.

8.12 Governing Law; Venue. This Agreement shall be governed and construed by the laws of the State of California without regard to its conflict of laws principles. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the State and federal (if permitted by law and a Party elects to file an action in federal court) courts located in the County of Riverside, State of California.

8.13 Disputes. Policyholder and Company agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement, prior to the filing of a claim under the Government Claims Act (Government Code section 900 et. seq.) and prior to the initiation of any litigation by either Party.

8.14 Time is of the Essence. Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

8.15 Conflict of Interest. The Parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

8.16 Health Insurance Portability and Accountability Act (HIPAA). The Company in this Agreement is subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 (HITECH), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto. The Company hereto agrees to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA and HITECH. The Company further agrees that it shall be in compliance, and shall remain in compliance with the requirement of HIPAA,

HITECH and the laws and regulations promulgated subsequent hereto, as may be amended from time to time. The Parties shall adhere to all terms and conditions as outlined and specified in Exhibit C, HIPAA Business Associate Addendum, attached hereto and incorporated herein by this reference.

8.17 Force Majeure. Neither Party shall be liable to the other Party or be deemed to have breached this Agreement for any failure or delay in the performance of all or any part of its obligations under this Agreement if such failure or delay is due to any contingency beyond its reasonable control (a "Force Majeure"). Without limiting the generality of the foregoing, such contingency includes, but is not limited to, acts of God, fires, floods, pandemics, storms, earthquakes, riots, boycotts, strikes, lock-outs, acts of terror, wars and war operations, restraints of government, power or communication line failure or other circumstance beyond such Party's reasonable control, or by reason of a judgment, ruling or order of any court or agency of competent jurisdiction or change of law or regulation subsequent to the execution of this Agreement. Both Parties are obligated to provide reasonable back-up capability to avoid the potential interruptions described above. If a Force Majeure occurs, the Party delayed or unable to perform shall give immediate notice to the other Party. Policyholder acknowledges that the foregoing provision does not apply to Policyholder's obligation to make timely payment of any fees due Company, and that Company shall be entitled to all remedies set forth in this Agreement and those allowed by law for Policyholder's failure to timely pay such fees.

8.18 Government Claims Act. The provisions of the Government Claims Act (Government Code section 900 et seq.) must be followed first for any disputes arising under this Agreement.

8.19 Certification of Authority to Execute This Agreement. Company certifies that the individual signing herein has authority to execute this Agreement on behalf of Company, and may legally bind Company to the terms and conditions of this Agreement, and any attachments hereto.

[Intentionally Left Blank; Signature Page Follows]

IN WITNESS WHEREOF, the Parties hereto have caused their duly authorized representatives to execute this Agreement:

COUNTY OF RIVERSIDE, a political subdivision of the State of California

By: _____
Kevin Jeffries
Chairman, Board of Supervisors

Date: APR 09 2019

MEDICAL EYE SERVICES, INC., a California corporation

By: _____
Charles Kupfer
Chief Financial Officer

Date: 03/07/19

ATTEST:
Clerk of the Board
Kecia Harper

By: _____, Deputy

APPROVED AS TO FORM:
Gregory P. Priamos
County Counsel

By: _____
David M. McCarthy
Deputy County Counsel

Date: 20 MAR 2019

EXHIBIT A

GROUP VISION INSURANCE POLICY & CERTIFICATES

- Full Service
- Eyewear Only
- Retirees

CALIFORNIA VISION INSURANCE POLICY

POLICYHOLDER: **COUNTY OF RIVERSIDE (FULL SERVICE)**

POLICY EFFECTIVE DATE: **JANUARY 1, 2017**

POLICY NUMBER: **383-088**

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 120 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.

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

Kyle O'Reilly
PRESIDENT & CEO

Ayana Gordon
SECRETARY

Gerber Life Insurance Company
A Stock Company
Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

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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. Eyewear when there is no Prescription Change, except when benefits are otherwise available;
4. Charges for non-Standard Lenses or lens options including, but not limited to, polycarbonate, progressive, photochromic, polarized, hi-index, occupational, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored, and UV), or 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;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. 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
7. Non-prescription (plano) eyewear, except as specifically provided.

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, 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;
13. Any Covered Services provided by another vision Policy; and

14. Replacement of lenses or frames which are lost, stolen, or broken, except when benefits are otherwise available.

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 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 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 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.

Non-Participating Provider means an Ophthalmologist, Optician, or Optometrist who has not elected to join the MESVision network of Participating Providers and who is not listed in the Participating Provider directory.

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 elected to join the MESVision network of Participating Providers and who is listed in the Participating Provider directory.

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.

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 56/61mm; 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 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 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.

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.

Lenses

2. One pair of Standard 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, except when You have a separate fitting benefit; 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.

5. Note: A Prescription Change means any of the following:
   a) A change in prescription of 0.50 diopter or more in one eye or total in both eyes;
   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 frame in a 12 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 $75.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, You are responsible for the additional cost above the $75.00. 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: $47.17, warehouse allowance: $49.35. 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.

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, 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 60 days after the date of birth in order to continue coverage beyond the 60-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 60 days after the date of such placement in order to continue coverage beyond the 60-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 State of California, 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 (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 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 180-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 31-60 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, 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.

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 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 group 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.

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. NOTIFICATION REQUIREMENTS OF CAL-COBRA EXTENSION

The group or its COBRA administrator is responsible for notifying COBRA Insureds of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA Insured should contact the group for more information about continuing coverage. If the Insured elects to apply for continuation of coverage under Cal-COBRA, the Insured must notify the group at least 30 days before COBRA termination.

E. 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.

F. 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.

G. 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.

H. 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 fees[1], 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 Amounts[2]:

Exam	$0.00
Material	$0.00

COVERED SERVICES & BENEFITS	ALLOWANCES	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Exam:		
Comprehensive Examination	Covered in Full	$50.00
Lenses:		
Single Vision	Covered in Full	$43.00
Bi-focal	Covered in Full	$60.00
Blended Segment	$72.50	$60.00
Tri-focal	Covered in Full	$75.00
Aphakic/Lenticular Monofocal	Covered in Full	$120.00
Aphakic/Lenticular Multifocal	Covered in Full	$200.00
High Power of 7.25 Diopters or more additional (per lens)	Covered in Full	$0[6]
Prism 1 ½ to 4 diopters (per lens)	Covered in Full	$0[6]
Prism 4 ½ to 10 diopters (per lens)	Covered in Full	$0[6]
Slab-off prism (per lens)	Covered in Full	$0[6]
Progressive	$89.50	$75.00
Polycarbonate for children up to age 19		
Single Vision	$0.00	$0.00
Bi-focal	$0.00	$0.00
Contact Lenses[3]:		
Non-Elective/Medically Necessary (one pair)	Covered in Full	$250.00
Elective/Cosmetic	$100.00	$100.00
Frame[4]:		
Selection up to retail amount of	$75.00	$40.00

[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.

[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.

[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.

[6] If the dollar amount related to a benefit/service is "0", this Policy does not cover the service. Any difference between the allowance and the provider's charge is the patient's responsibility.

[7] For groups with optional tint benefits, tints other than Pink or Rose #1 or #2 are paid according to the patient's benefit allowance. The balance of the charge for standard tints (any solid tint) exceeding the allowance is a provider fee adjustment. The balance of non-standard tints or coatings (such as gradient or double gradient and mirrored) is a patient responsibility.

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: RIVERSIDE COUNTY OF (EYEWEAR ONLY)

POLICY EFFECTIVE DATE: JANUARY 1, 2017

POLICY NUMBER: 383-088

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 120 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.

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

Kevin O'Reilly

PRESIDENT & CEO

SECRETARY

Gerber Life Insurance Company
A Stock Company
Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

PROVISION **PAGE**

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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. Eyewear when there is no Prescription Change, except when benefits are otherwise available;
4. Charges for non-Standard Lenses or lens options including, but not limited to, polycarbonate, progressive, photochromic, polarized, hi-index, occupational, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored, and UV), or 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;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. 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
7. Non-prescription (plano) eyewear, except as specifically provided.

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, 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;
13. Any Covered Services provided by another vision Policy; and

14. Replacement of lenses or frames which are lost, stolen, or broken, except when benefits are otherwise available.

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 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 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 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.

Non-Participating Provider means an Ophthalmologist, Optician, or Optometrist who has not elected to join the MESVision network of Participating Providers and who is not listed in the Participating Provider directory.

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 elected to join the MESVision network of Participating Providers and who is listed in the Participating Provider directory.

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.

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 [56/61mm]; 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 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 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.

Lenses

2. One pair of Standard Lenses in a 12 consecutive month period.

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, except when You have a separate fitting benefit; 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.

5. Note: A Prescription Change means any of the following:
   a) A change in prescription of 0.50 diopter or more in one eye or total in both eyes;
   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 frame in a 12 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 $75.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, You are responsible for the additional cost above the $75.00. 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: $47.17, warehouse allowance: $49.35. 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 Expense, 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 State of California, 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 (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 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 31-60 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, 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.

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 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 group 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.

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. NOTIFICATION REQUIREMENTS OF CAL-COBRA EXTENSION

The group or its COBRA administrator is responsible for notifying COBRA Insureds of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA Insured should contact the group for more information about continuing coverage. If the Insured elects to apply for continuation of coverage under Cal-COBRA, the Insured must notify the group at least 30 days before COBRA termination.

E. 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.

F. 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.

G. 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.

H. 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 fees[1], 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 Amounts[2]:

Material	$0.00

COVERED SERVICES & BENEFITS	ALLOWANCES	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Lenses:		
Single Vision	Covered in Full	$43.00
Bi-focal	Covered in Full	$60.00
Blended Segment	$72.50	$60.00
Tri-focal	Covered in Full	$75.00
Aphakic/Lenticular Monofocal	Covered in Full	$120.00
Aphakic/Lenticular Multifocal	Covered in Full	$200.00
Lenticular Monofocal	Covered in Full	$125.00
Lenticular Multifocal	Covered in Full	$125.00
High Power of 7.25 Diopters or more additional (per lens)	Covered in Full	$0[6]
Prism 1 ½ to 4 diopters (per lens)	Covered in Full	$0[6]
Prism 4 ½ to 10 diopters (per lens)	Covered in Full	$0[6]
Slab-off prism (per lens)	Covered in Full	$0[6]
Progressive	$89.50	$75.00
Polycarbonate for children up to age 19		
Single Vision	$0.00	$0.00
Bi-focal	$0.00	$0.00
Contact Lenses[3]:		
Non-Elective/Medically Necessary (one pair)	Covered in Full	$250.00
Elective/Cosmetic	$100.00	$100.00
Frame[4]:		
Selection up to retail amount of	$75.00	$40.00

[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.

[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.

[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.

[6] If the dollar amount related to a benefit/service is "0", this Policy does not cover the service. Any difference between the allowance and the provider's charge is the patient's responsibility.

[7] For groups with optional tint benefits, tints other than Pink or Rose #1 or #2 are paid according to the patient's benefit allowance. The balance of the charge for standard tints (any solid tint) exceeding the allowance is a provider fee adjustment. The balance of non-standard tints or coatings (such as gradient or double gradient and mirrored) is a patient responsibility.

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: **COUNTY OF RIVERSIDE (RETIREES)**

POLICY EFFECTIVE DATE: **JANUARY 1, 2017**

POLICY NUMBER: **383-088**

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 120 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.

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 & CEO

SECRETARY

Gerber Life Insurance Company
A Stock Company
Home Office: 1311 Mamaroneck Avenue, White Plains, New York 10605

PROVISION **PAGE**

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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. Eyewear when there is no Prescription Change, except when benefits are otherwise available;
4. Charges for non-Standard Lenses or lens options including, but not limited to, polycarbonate, progressive, photochromic, polarized, hi-index, occupational, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored, and UV), or 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;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. 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
7. Non-prescription (plano) eyewear, except as specifically provided.

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, 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;
13. Any Covered Services provided by another vision Policy; and

14. Replacement of lenses or frames which are lost, stolen, or broken, except when benefits are otherwise available.

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 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 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 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.

Non-Participating Provider means an Ophthalmologist, Optician, or Optometrist who has not elected to join the MESVision network of Participating Providers and who is not listed in the Participating Provider directory.

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 elected to join the MESVision network of Participating Providers and who is listed in the Participating Provider directory.

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.

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 56/61mm; 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 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 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.

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.

Lenses

2. One pair of Standard 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, except when You have a separate fitting benefit; 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 12 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 $120.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, You are responsible for the additional cost above the $120.00. 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: $75.47, warehouse allowance: $78.96. 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.

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, 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 60 days after the date of birth in order to continue coverage beyond the 60-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 60 days after the date of such placement in order to continue coverage beyond the 60-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 State of California, 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 (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 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 180-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 31-60 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, 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.

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 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