



National Guardian Life Insurance Company

Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191
(called We, Our and Us)

**Group Vision Care
Certificate of Coverage**

Administrator: Avesis Third Party Administrators, Inc.
Phoenix, Arizona 85012

Vision Benefits Manager: Avesis Incorporated
Phoenix, Arizona 85012

This certificate explains the plan of insurance underwritten by National Guardian Life Insurance Company, and accompanies the Identification Card that is needed to use benefits. The Insured's are entitled to the vision care services described in the group Policy. This certificate is provided as a summary of the group Policy to explain the Insured's vision care benefits and describe the procedure for using these benefits. However, the group Policy alone is the contract of insurance and determines the coverage and benefits. **Please read this certificate carefully to become familiar with its coverage.**

Important Notice

Benefits are payable only for expenses incurred while an Insured's coverage is in force. No agent has the right to change the Policy or to waive any part of it.

The Policy, under which this Certificate is issued, may be amended or canceled at any time 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 Worker's Compensation or a similar type of insurance.

Signed for by National Guardian Life Insurance Company:

Sherri Kliczak, Secretary

John Larson, President

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DEFINITIONS

Calendar Year Plan - means benefits begin anew on January 1 of each Calendar Year. For persons enrolled other than on January 1, of a given Calendar Year, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Calendar Year with full 12-month benefits becoming effective January 1 of the next Calendar Year.

Claim Form - A form provided by Us for the purpose of determining eligibility and claim payment.

Copay Amount - An Insured's share of costs, paid to the Contracting Provider at the time the services are rendered. Copay Amounts that apply to the various vision benefits are listed in the Certificate of Coverage Benefits Summary.

Elective Plan - A plan in which individual Employees may elect whether they choose to participate.

Employee - The individual employed by the Policyholder.

Employer - The entity for whose Employees or Members vision care benefits are being provided.

Group - The aggregate of Employees which is eligible to be the recipient of benefits under the Policy.

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

Initial Term - The [24 month] period following the group's initial effective date. Rates are guaranteed not to change during this period.

Insured - The Member and Insured Dependents if dependent coverage is provided by the Employer participating in the program.

Late Entrant - Is any active eligible employee or eligible dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits are limited for Late Entrants under Limitations.

Materials - Eyeglass lenses, frames, contact lenses.

Member - An Employee who became insured under the policy.

Network or Contracting Provider - An Ophthalmologist, Optician or Optometrist who has elected to enter into a contract with the Vision Benefit Manager and who is listed in the Provider Directory.

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

Optical Necessity - Situation when a prescription or a change of prescription is required to correct visual function.

Optician - 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, who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optometrist - A person licensed to practice optometry as defined by the laws of the state in which his or her services are rendered, who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Orthoptics - The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Out-of – Network Provider - An Ophthalmologist, Optician or Optometrist who has elected not to enter into a contract with the Vision Benefits Manager and who is not listed in the Provider Directory.

Plan - The coverage and benefits provided by the Policy to the Insured.

Policyholder - The entity that contracts with Us on behalf of its Members.

Policy Year Plan - means benefits begin immediately on the Policyholder's effective date and renew 12 months following the initial effective date. For persons enrolled on other than the Policyholder's initial effective date or a subsequent Plan anniversary, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Plan Year with full 12-month benefits becoming effective on the next Plan anniversary of the next Calendar Year.

Professional Service - Examination, material selection, fitting of glasses, related adjustments, etc.

Re-enrollee - Any active Member or dependent who was covered under the policy, terminated his coverage, and then subsequently re-enrolled for coverage at a later date.

Standard Lenses - Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 plastic trifocals through flat top 35.

Sub-Normal Optical Correction - means vision is not correctable to better than 20/70 in the better eye by the use of conventional lenses.

The Administrator - The entity which will provide complete claims service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Usual, Customary and Reasonable - means the lesser of: (a) the reasonable charges the provider charges for a vision service or supply; or (b) the customary charge for the vision service or supply. We will determine the customary charge from within the range of charges made for such vision service or supply by other providers of similar training and experience in that general geographic area.

Vision Benefit Manager - The entity which will provide a network of Network Providers and claims payment services as agreed to in a contract with The Administrator.

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

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

CERTIFICATE DECLARATIONS

Employer/Policyholder: City of Mission

Group Policy Number: 10774-1071 Policy Effective Date: 10/1/2011

Policy Month: The period of time which begins on the 1st day of each calendar month and ends on the day just before that date of the next month. The first Policy Month begins on the Effective Date; the last Policy Month ends on the day the Policy ends.

FILING FORMAT

Plan selected: [] Standard [] Enhanced [] Plus [] Other

BENEFITS SUMMARY

Benefits	Provided / Not Provided	In-Network	Out-of-Network
VISION EXAM	Provided	Covered in Full	\$35.00
MATERIALS			
Standard Lenses			
Single Vision	Provided	Covered in Full	\$25.00
Bifocals	Provided	Covered in Full	\$40.00
Trifocals	Provided	Covered in Full	\$50.00
Lenticular	Provided	Covered in Full	\$80.00
Progressives	Provided	\$50.00	\$40.00
Frames	Provided	\$50.00	\$45.00
Contact Lenses*			
Standard	Provided	\$130.00	\$130.00
Optical Necessity	Provided	Covered in Full	\$250.00
* In lieu of Eyeglass lenses and Frames. Allowances include the contact lens fitting fee.			
CO-PAY AMOUNT			
Vision Exam		\$10.00 copayment	N/A
All Materials Combined		\$0.00 copayment	N/A
FREQUENCY	[Policy Year /Calendar Year/Rolling Benefit Plan]		
Vision Exam		Once every 12 Months	Once every 12 Months
Lenses		Once every 12 Months	Once every 12 Months
Frames		Once every 24 Months	Once every 24 Months
Contact Lenses		Once every 12 Months	Once every 12 Months

Note: The Copay Amount for Materials is a Co-pay for frames & lenses. Insureds who elect contact lenses are responsible for any separate contact lens professional fitting fee not paid by the contact lens allowance above.

The Certificate Declarations for an Employee's Eligible Class, together with the Group Insurance Certificate and Certificate Riders (if any), forms that Member's Certificate of Insurance while insured under the Policy and replaces any previous Certificates of Insurance issued under the Policy to that Member. Any insurance set out in the Certificate Declaration applies to the Employee only if the Employee enrolls for, and becomes and remains insured for, such insurance in accord with the terms and conditions of the Policy.

Coordination of Benefits: (a) Insureds insured under both another plan and this plan: We consider ourselves primary in all circumstances. (b) Insureds insured under two group policies with Us: Primary coverage is under the plan in which the Insured Person is the Member. In case the Insured is a dependent child who is not insured as an Employee, primary coverage is under father's plan.

COVERED SERVICES AND MATERIALS

The amount of Vision Benefits payable hereunder and the manner of payment is determined by whether the Insured utilizes the services of a Network Provider or an Out-of-Network Provider.

The Insured will receive an identification card or cards for use while covered under this Certificate. The Policyholder shall submit to the Administrator on a monthly basis, a list of all Insureds. When the Insured incurs the services of a Network Provider, such Insured may be required to present the program on the identification card to the Network Provider. The Network Provider will submit the information on the identification card electronically and may: (1) verify eligibility; and (2) notify the Insured of any out-of-pocket expenses.

If the Insured incurs the services of an Out-of-Network Provider, such Insured will be required to pay the full cost of such services at the time of the purchase.

Vision Examination Benefit. If an Insured incurs expenses for a Vision Examination, We will pay such expenses up to the applicable Vision Examination Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Vision Examination Benefit Frequency shown in the Benefits Summary.

Standard Lenses Benefit. If an Insured incurs expenses for Standard Lenses, We will pay such expenses up to the Standard Lenses Maximum Benefit shown in the Benefits Summary subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Standard Lenses Benefit Frequency shown in the Benefits Summary.

Eyeglass Frame Benefit. If an Insured incurs expenses for eyeglass frames, We will pay such expenses up to the applicable Eyeglass Frame Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; and 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary. Benefits will be payable at the Eyeglass Frame Benefit Frequency shown in the Benefits Summary.

Contact Lenses Benefit. If an Insured incurs expenses for contact lenses, We will pay such expenses up to the applicable Contact Lenses Maximum Benefit shown in the Benefits Summary, subject to the Exclusions, provided: 1) such expenses were incurred while the Insured was covered under this Certificate; 2) the Insured has paid any applicable Copay Amount, as shown in the Benefits Summary; and 3) the Contact Lenses are due to an optical necessity.

In addition to the above, benefits will not be payable for expenses incurred for Sub Normal Optical Correction, unless: 1) the Network or Out-of-Network Provider of such services, makes a request, in writing, to the Vision Benefit Manager that a special contact lens or lenses is necessary to achieve the best possible correction for the Insured; and 2) the Vision Benefit Manager, upon review of such request, approves the request. Benefits will be payable at the Contact Lenses Benefit Frequency and amount shown in the Benefits Summary.

PROCEDURE FOR USING BENEFITS

1. The Insured's Identification Card should be readily available when scheduling and visiting a Network Provider. For information on Network Providers, the Insured can call the toll-free number listed on the Identification Card.
2. The Insured should present their Identification Card at the time services and materials are received from a Network Provider. The Copay Amount and any other charges that are not covered must be paid at the time of service. No paperwork is required.
3. If an Insured is using an Out-of-Network Provider, they do not receive Network Pricing. Full payment must be provided to the Out-of-Network provider at the time of service and the original invoice, including an itemized statement of charges and prescription(s), should be submitted to:

Avesis Third Party Administrators, Inc.
Phoenix, Arizona 85012

Time of Payment of Claim: Upon receipt of an itemized invoice, prescription and a photocopy of the membership card, claims will be paid immediately.

ELIGIBILITY DETERMINATION

Child (or Children) means a Member's unmarried natural child, stepchild, adopted child (including a child for which the insured is a party in a suit in which the adoption of the child by the insured is sought), and a grandchild under age 25 (all children must be eligible dependents for federal income tax purposes at the time of application). It also means a child for whom the insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

RENEWAL PROVISIONS

After the Initial Term of the Policy, the Policy shall continue on a "month-to-month" basis automatically renewing the first day of each month unless proper notice has been given in accordance with the termination conditions.

When the Company initiates a premium increase, the date said premium increase is to take effect shall become the Policy anniversary date.

BASIS FOR TERMINATION OF POLICY

1. Failure of the Policyholder to make payment to Us as outlined under the "Premiums" section of the Policy, or
2. The Policyholder falls below minimum size requirement. However, in the event the Policyholder falls below the minimum size, the Group may continue receiving benefits under this Certificate by making premium payment to the Company at the minimum Group size.

Terminating Members are dropped as reported by their Employer with 30 days notice to Us.

CANCELLATION

In the event of cancellation of the Policy by Us or the Policyholder, We shall within thirty (30) days return to Policyholder the pro rata portion of the money paid to Us which corresponds to any unexpired period for which payment has been received, if any, less any amounts due to Us.

TERMINATION OF POLICY - SERVICES BEING RENDERED

If service for an Insured hereunder is being rendered as of the termination date of the Policy, coverage shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

WITHDRAWAL FROM ELECTIVE PLANS

Once an Employee and/or dependent elects to participate in the Plan, they must remain in the Plan for at least twenty four (24) months or the remainder of the Policy term (including renewals) if shorter, unless the Policy is canceled in accordance with the cancellation conditions shown on page seven of the Policy.

INDIVIDUAL CONTINUATION OF COVERAGE

The Group Vision Care Policy is available to voluntary groups of a minimum of [ten (10)] Employees and employer-funded groups of [five (5)] and is, therefore, not available on an individual basis. When a Policyholder terminates coverage, individual coverage is not available for Members who may desire to retain same.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that under certain circumstances health plan benefits available to an eligible participant and his or her dependents be made available for purchase by said persons upon the termination of employment of said participant, or the termination of the relationship between said participant and his or her dependents. If, and only to the extent, COBRA applies to the parties covered under this Certificate, the Company shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

LIMITATIONS AND EXCLUSIONS

The Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and Eyeglass Frame Benefit. An Insured shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

The Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit is payable in lieu of the Contact Lenses Benefit. An Insured shall be eligible to receive benefits under the Contact Lenses Benefit only after the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit Frequency has ended.

In no event will coverage exceed the lesser of:

1. the actual cost of insured Services or Materials; or
2. the limits of coverage shown in the Certificate of Coverage Benefits Summary.

Materials paid for under the Policy that are lost or broken will only be replaced at normal intervals when other Services are available.

Vision – Late Entry Benefit: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-Enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents if enrolled.

We will not cover:

1. Professional Services and/or Materials in connection with:
 - a) blended bifocals, no line, or progressive addition lenses.
 - b) compensated or special multi-focal lenses.
 - c) plain (non-prescription) lenses.
 - d) anti-reflective, scratch, UV400, or any coating or lamination applied to lenses.
 - e) Subnormal Visual Aids.
 - f) tints other than solid.
 - g) Orthoptics, vision training and developmental vision procedures.
 - h) polycarbonate lenses.
2. Medical or surgical treatment of the eyes.
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses. Although no-line bifocals and blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
6. Sub-normal vision aids.
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a) the Member resides in the U.S. or Canada; and
 - b) the charges are incurred while on a business or pleasure trip.

8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials.
9. Experimental or non-conventional treatment or device.
10. Safety eyewear.
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary.
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
13. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within 31 days from the date of such order.
15. Services rendered or Materials ordered before the date coverage began under this Certificate.
16. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Benefits Summary.

PREMIUMS

Premium Payments: Premiums will be payable by the Policyholder to Us for the coverage provided under the Policy. Premium payments are due on the first day of each consecutive calendar month.

Grace Period: If the Policyholder has not given written notice to Us that the coverage under the Policy is to be terminated at least 60 days prior to the premium due date, a grace period of 31 days will be allowed for any premium due after the first premium. If the Policyholder fails to pay such premium prior to the end of the grace period all coverage will lapse as of the first of the month for which the premium is in default. The policyholder will be liable to Us for payment of the pro-rata premium for the time the policy was in force during such grace period.

Change in Premiums: We have the right to change the premium rates after the Initial Term shown on the face page of the Policy, and not more than once in any six-month period following the Initial Term. We will notify the Policyholder in writing at least thirty days before any increase in policy rates.

Misstatement of Age: If the age of any Insured has been misstated and the amount of insurance would be affected by such misstated age, the amount of insurance will be adjusted to the amount to which the Insured would have been entitled at his correct age and the premiums will be based on the adjusted amount.

CLAIMS AND GENERAL PROVISIONS

Notice of Claim: Written notice of claim must be given to Us within twenty (30) days of the date such loss begins. Notice must be given to Us with enough information to identify the Insured. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to file notice within such time. However, the notice must be given as soon as reasonably possible.

Claim Forms: We will provide claim forms upon request of Insured or when We receive notice of claim We will also give claim forms. If the forms are not given within fifteen (15) days, the Insured can submit written proof covering the occurrence, character and extent of loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us not later than ninety (90) days after the date of such loss. Failure to give such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible, but in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the date of time such proof is otherwise required.

Physical Exam: We, at Our own expense, will have the right and opportunity to examine the person whose loss is the basis of claim under the Policy when and so often as may be reasonably required while the claim is pending.

Legal Proceedings: No action at law or in equity can be brought to recover on the Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time proofs of loss are required to be filed.

Entire Contract: The Policy, all applications of the Insured (if any) and the application of the Policyholder, a copy of which is attached hereto, make up the entire contract between the parties. All statements made by the Policyholder or by the Insureds are deemed representations and not warranties. No such statement will be used in any contest under the Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person or his beneficiary, if any.

Our Right to Contest: The validity of the Policy cannot be contested, except for non-payment of premiums, after it has been in force for two years from its effective date. No statement, except for a fraudulent misstatement, made by any Insured relating to his insurability will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such Insured's lifetime nor unless it is contained in written instrument, signed by him, and a copy of such instrument is or has been furnished to him or his beneficiary.

Grievance Procedure

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

National Guardian Life Insurance Company
c/o Avesis Third Party Administrators, Inc.
Phoenix, Arizona 85012

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

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

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

In situations requiring urgent care, grievances will be resolved within 4 business days of receiving the grievance.

LASIK SURGERY BENEFIT RIDER

This Rider amends the Policy/Certificate to which it is attached. The following benefit is added:

DEFINITIONS

Insured means a person who is insured under the Policy/Certificate to which this Rider is attached.

LASIK means Laser Assisted In Situ Keratomileusis.

Medically Necessary means that LASIK surgery is necessary and appropriate for the diagnosis or treatment of a condition based on generally accepted current medical practice. The procedure will not be considered Medically Necessary if: (1) provided only as a convenience to the Insured or provider; (2) not appropriate treatment for the Insured's diagnosis or symptoms; (3) it exceeds (in scope, duration or intensity) that level of care needed to provide safe, adequate and appropriate diagnosis or treatment; or (4) it is part of a plan of treatment that is experimental, unproven or related to a research protocol. Because any particular Physician may prescribe, order, recommend, or approve such a procedure does not, of itself, make the service or supply Medically Necessary.

Ophthalmologist means an oculist who specializes in diseases and refractive errors of the eye.

BENEFIT


If an Insured has LASIK surgery that has been determined by an Ophthalmologist to be Medically Necessary, We will pay a total of \$150 for either one or both eyes. We pay the benefit one time only for each Insured.

This benefit is an in-network benefit only.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY


Secretary


President

IMPORTANT NOTICE

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You may call National Guardian Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-923-6766

You may also write to National Guardian Life Insurance Company at:

National Guardian Life Insurance Company
c/o Avesis Third Party Administrators, Inc.
Phoenix, Arizona 85012

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: 512-475-1771
Web: <http://www.tdi.state.tx.us>
E-Mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact your agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become part or condition of the attached document.

NOTICE-AVS-TX

AVISO IMPORTANTE

Usted puede llamar al numero de teléfono gratis de National Guardian Life Insurance Company para información o para someter una queja al:

1-800-923-6766

Usted tambien puede escribir a la oficina National Guardian Life Insurance Company:

National Guardian Life Insurance Company
c/o Avesis Third Party Administrators, Inc.
Phoenix, Arizona 85012

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: 512-475-1771
Web: <http://www.tdi.state.tx.us>
E-Mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con su agente o la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de información y no se convierte en parte o condición del documento adjunto.

**Important Information About Coverage Under the
Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association
(For insurers declared insolvent or impaired on or after September 1, 2005)**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Services Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitation, and conditions of the Association Law. (The law is found in the Texas Insurance Code, Article 21 .28-D.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time (**irrespective of the policyholder's residency at policy issue**)
- Residents of other states, **ONLY** if the following conditions are met
 - 1) The policyholder has a policy with a company domiciled in Texas;
 - 2) The policyholder's state of residence has a similar guaranty association; and
 - 3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

Life Insurance

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on any one life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities

- Present value of benefits up to a total of \$100,000 under one or more contracts on any one life.

Group Annuities

- Present value of allocated benefits up to a total of \$100,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for any one contract holder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439
www.tdi.state.tx.us