

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: AR8511-010

SERFF Tr Num: GARD-126435211 State: Arkansas

TOI: H20G Group Health - Vision

SERFF Status: Closed-Approved- Closed State Tr Num: 44446

Sub-TOI: H20G.000 Health - Vision

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Diane Pappas, Migdalia Rosado

Disposition Date: 01/04/2010

Date Submitted: 12/29/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 01/04/2010

Explanation for Other Group Market Type:

State Status Changed: 01/04/2010

Deemer Date:

Created By: Migdalia Rosado

Submitted By: Diane Pappas

Corresponding Filing Tracking Number:

Filing Description:

The new forms provide benefits for vision care insurance. The certificate forms reflect the policy forms.

Company and Contact

Filing Contact Information

Migdalia Rosado, Complaint/Compliance

Migdalia_Rosado@glic.com

Coordinator

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

7 Hanover Square 212-598-8862 [Phone]
 New York, NY 10004 212-919-3339 [FAX]

Filing Company Information

The Guardian Life Insurance Company of America CoCode: 64246 State of Domicile: New York
 7 Hanover Square Group Code: 429 Company Type: Life
 New York, NY 10004 Group Name: State ID Number:
 (212) 598-8704 ext. [Phone] FEIN Number: 13-5123390

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form x 12 forms=\$240.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$240.00	12/29/2009	33154992

SERFF Tracking Number: GARD-126435211 State: Arkansas
Filing Company: The Guardian Life Insurance Company of State Tracking Number: 44446
America
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: AR8511-010
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	01/04/2010	01/04/2010

SERFF Tracking Number: GARD-126435211

State: Arkansas

Filing Company: The Guardian Life Insurance Company of
America

State Tracking Number: 44446

Company Tracking Number:

TOI: H20G Group Health - Vision

Sub-TOI: H20G.000 Health - Vision

Product Name: AR8511-010

Project Name/Number: /

Disposition

Disposition Date: 01/04/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Form List	Approved-Closed	Yes
Form	HOW THIS PLAN WORKS	Approved-Closed	Yes
Form	Standard Lenses	Approved-Closed	Yes
Form	Standard Frames	Approved-Closed	Yes
Form	Elective Contact Lenses	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Primary Eye Care Rider	Approved-Closed	Yes
Form	HOW THIS PLAN WORKS	Approved-Closed	Yes
Form	Standard Lenses	Approved-Closed	Yes
Form	Standard Frames	Approved-Closed	Yes
Form	Elective Contact Lenses	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Primary Eye Care Amendment	Approved-Closed	Yes

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

Form Schedule

Lead Form Number: GP-1-VSN-09-HPW

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/04/2010	GP-1-VSN-09-HPW	Policy/Contract	HOW THIS PLAN WORKS	Initial		0.000	GP-1-VSN-09-HPW.pdf
			Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/04/2010	GP-1-VSN-09-SL	Policy/Contract	Standard Lenses	Initial		0.000	GP-1-VSN-09-SL.pdf
			Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/04/2010	GP-1-VSN-09-SF	Policy/Contract	Standard Frames	Initial		0.000	GP-1-VSN-09-SF.pdf
			Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/04/2010	GP-1-VSN-09-ECL	Policy/Contract	Elective Contact Lenses	Initial		0.000	GP-1-VSN-09-ECL_rev12-09.pdf

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- Closed 01/04/2010	GP-1-VSN- 09-EXC	Policy/Cont Exclusions ract/Fratern al	Initial	0.000	GP-1-VSN- 09-EXC_rev 12-09.pdf
-----------------------------------	---------------------	--	---------	-------	--------------------------------------

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- Closed 01/04/2010	GP-1-VSN- 09-PEC	Policy/Cont Primary Eye Care ract/Fratern Rider al	Initial	0.000	GP-1-VSN- 09-PEC.pdf
-----------------------------------	---------------------	--	---------	-------	-------------------------

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- Closed 01/04/2010	CGP-3- VSN-09- HPW	Certificate HOW THIS PLAN Amendmen WORKS t, Insert	Initial	0.000	CGP-3-VSN- 09-HPW.pdf
-----------------------------------	--------------------------	--	---------	-------	--------------------------

Page,
 Endorseme
 nt or Rider

Approved- Closed 01/04/2010	CGP-3- VSN-09-SL	Certificate Standard Lenses Amendmen t, Insert	Initial	0.000	CGP-3-VSN- 09-SL.pdf
-----------------------------------	---------------------	--	---------	-------	-------------------------

Page,
 Endorseme
 nt or Rider

Approved-	CGP-3-	Certificate Standard Frames	Initial	0.000	CGP-3-VSN-
-----------	--------	-----------------------------	---------	-------	------------

SERFF Tracking Number: GARD-126435211 State: Arkansas

Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 44446

Company Tracking Number:

TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision

Product Name: AR8511-010

Project Name/Number: /

Closed VSN-09-SF Amendmen 09-SF.pdf
01/04/2010 t, Insert

Page,
Endorseme
nt or Rider

Approved- CGP-3- Certificate Elective Contact Initial 0.000 CGP-3-VSN-
Closed VSN-09- Amendmen Lenses 09-ECL _rev
01/04/2010 ECL t, Insert 12-09.pdf

Page,
Endorseme
nt or Rider

Approved- CGP-3- Certificate Exclusions Initial 0.000 CGP-3-VSN-
Closed VSN-09- Amendmen 09-EXC _rev
01/04/2010 EXC t, Insert 12-09.pdf

Page,
Endorseme
nt or Rider

Approved- CGP-3- Certificate Primary Eye Care Initial 0.000 CGP-3-VSN-
Closed VSN-09- Amendmen Amendment 09-PEC.pdf
01/04/2010 PEC t, Insert

Page,
Endorseme
nt or Rider

HOW THIS PLAN WORKS

We pay benefits for the covered charges a Covered Person incurs as follows. What we pay is subject to all of the terms of this Plan. Read the entire Plan to find out what we limit or exclude.

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges incurred by a Covered Person while he or she is insured by this Plan. Charges in excess of any payment limits shown in this Plan are not covered charges.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive pre-authorization from VSP prior to providing the Covered Person with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this Plan for specific requirements.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within [¹ 90 days] of the date services are completed or supplies are received.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include the necessary tests to ensure visual wellness and detect potential eye-related medical problems, such as glaucoma.

We cover no more than one vision examination for each covered person in any [² 12-month period].

From a Preferred Provider: [⁴ The Covered Person must pay a Copayment of [³ \$10.00] each time he or she receives a vision exam from a Preferred Provider.] We pay benefits in full for the covered charges a Covered Person incurs [⁴ in excess of the Copayment.]

From a Non-Preferred Provider: [⁴ The Covered Person must pay a Deductible of [³ \$10.00] each time he or she receives a vision examination from a Non-Preferred Provider.] We pay benefits for the covered charges a Covered Person incurs [⁴ in excess of the Deductible] up to a maximum of [⁵ \$46.00] for each examination.

Vision Materials

Glasses (Lenses and Frames) or Contact Lenses: We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We pay benefits for frames. We pay benefits for prescription contact lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contact lenses.

In any [² 12-month period] we pay benefits for either glasses or contact lenses, but not both.

Materials Payment Limit: We limit what we pay for covered materials in any [² 12-month period] to an allowance of [⁶ \$75.00]. The discounts shown below are applied before the charges are applied to the allowance.

Materials purchased from either a Preferred Provider or a Non-Preferred Provider are covered by this Plan, and can be used toward the [⁶ \$75.00] allowance.

If the materials are purchased from a Preferred Provider either more than [² 12 months] after a covered eye exam, or from a doctor other than the Preferred Provider who performed the exam, the cost of the purchase will not be covered by this plan and cannot be used toward the allowance.

¹⁰Charges for only an initial purchase can be used toward the [⁶ \$75.00] allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. For example, if a covered person purchases a pair of glasses for [⁷ \$60.00], the remaining [⁷ \$15.00] of the allowance will be unused. The covered person will have a new [⁶ \$75.00] allowance [² starting 12 months from the date of the purchase].

Also, if a covered person purchases only frames or lenses (not a complete pair of glasses) the initial purchase will be used toward the allowance and the unused balance will not be banked for future use, even if the covered person purchases the other item later. The covered person will have a new [⁶ \$75.00] allowance starting [² starting 12 months from the date of the purchase].

Discounts on Materials Purchased From a Preferred Provider: For glasses, a covered person will receive a [⁸ 20%] discount off the Preferred Provider's usual and customary fee, if:

- A complete (lenses and frames) pair of glasses is purchased; and
- The purchase is made within [² 12 months] of a covered eye exam, and only from the Preferred Provider who performed the exam.

If a covered person purchases either lenses or frames only (not a complete pair of glasses), the discount will not be given. If the glasses are purchased either more than [² 12 months] after a covered eye exam, or from a Preferred Provider other than the one who performed the exam, the discount will not be given.

For non-covered cosmetic lens options such as coated or blended lenses, the Covered Person will receive a [⁸ 20%] discount off the Preferred Provider's usual and customary fee for the additional cost of the cosmetic feature.

For contact lenses, a Covered Person will receive a [⁹ 15%] discount off the Preferred Provider's usual and customary contact lens professional services fees for the contact lens exam, if the purchase is made within [² 12 months] of a covered eye exam, and only from the Preferred Provider who performed the exam. Discounts do not apply to the contact lenses.

Standard Lenses: We cover charges for single vision, bifocal, trifocal or lenticular lenses. [³ We cover glass, plastic [³ or [¹ for dependent children to age [² 20,]] polycarbonate lenses.] [³ We cover glass and plastic lenses.]

If a covered person uses a non-preferred provider, we limit what we pay to

- [⁴ \$48] for each pair of single vision lenses
- [⁵ \$67] for each pair of bifocal lenses
- [⁶ \$86] for each pair of trifocal lenses and
- [⁷ \$126] for each pair of lenticular lenses.

[³ For tinted lenses, these limits are increased by [⁸ \$5].]

[³ We cover charges for one set of standard lenses in any [⁹ 24-month period].]

[³ However, we will cover one pair of standard lenses in a 12-month period if the *covered person's* vision examination in that period results in a prescription change that meets one of the following criteria:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]

[³ We cover charges for two pairs of standard lenses. Coverage of each pair is subject to its own [⁹ 12-month benefit period].]

[³ With respect to bifocal and trifocal prescriptions, we cover charges for progressive multi-focal lenses.]

[³ We cover charges for the following :

- tinted lenses and photochromic lenses
- ultra violet coating
- scratch resistant coating
- blended lenses
- high index lenses
- mirror/ski coating
- oversized lenses
- polarized/laminated lenses
- edge treatment
- progressive lenses
- anti-reflective coating
- polycarbonate lenses for adults.]

Standard Frames: We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of [⁴ \$130], plus 20% of any amount over the allowance

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to [² \$48].

[¹ We cover charges for two sets of standard frames. Coverage of each set is subject to its own [³ 12-month benefit period].]

[¹ If the covered person chooses elective contact lenses, we do not cover standard frames [³ for 12 months from] the date the elective contacts are purchased.]

[¹ We cover charges for one set of standard frames in any [³ 24-month period].]

[¹ However, we will cover one set of frames in a 12-month period if: (1) the *covered person's* vision examination in that period results in a prescription change that meets one of the criteria set forth below; and (2) new frames are needed to replace lost or broken frames or because the new prescription requires a frame of a different shape or size.

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]

Elective Contact Lenses: We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses [² for 12 months] and standard frames [² for at least 24 months].

[¹ If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to [³ \$130].]

[¹ If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to [⁴ \$120].]

[¹ We cover charges for two sets of elective contact lenses. Coverage of each set is subject to its own [² 12-month benefit period].]

[¹ We cover charges for one set of elective contact lenses in any [² 24-month period].]

[¹ However, we will cover one set of elective contact lenses in a 12-month period if the *covered person's* vision examination in that period results in a prescription change that meets one of the following criteria:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]]

[¹ VSP Contact Lens Program - If a *covered person* who now wears soft contact lenses receives a vision examination from a *preferred provider*, and the same type of contact lenses is prescribed, we cover charges in full for the contact lens evaluation and fitting; and for an initial supply of soft contact lenses from the list below that are received from the same provider.

Manufacturer	Brand	Brand
[⁵ Vistakon	<ul style="list-style-type: none"> • Acuvue 	<ul style="list-style-type: none"> • Acuvue2
CIBA Vision	<ul style="list-style-type: none"> • Cibasoft Standard Visitint • Cibasoft Visitint • Durasoft 2 Lite Tint • Focus 1-2 Week Visitint (New Vues) • Focus Monthly Visitint 	<ul style="list-style-type: none"> • FreshLook Handling Tint • Precision U V • Softmate B • Softmate II • 2 Optix • Focus Dailies
Cooper Vision	<ul style="list-style-type: none"> • Cooper Clear (DW or FW) • Frequency 38 • Frequency 55 • Proclear • Proclear Compatibles • Silver 07 • Vertex Sphere (Encore Sphere CV Encore Premium) 	<ul style="list-style-type: none"> • ProActive 55 • Hydrogenics 60UV • Hydron Zero 4 Sofblue (FW) • Hydron Zero 6 Sofblue (DW) • Biomedics 38 • Biomedics 55 Premier • Biomedics 55U V
Hydrogel	<ul style="list-style-type: none"> • Extreme H20 G60 S-Thin 	<ul style="list-style-type: none"> • Extreme H20 G60 S-Xtra
Bausch & Lomb	<ul style="list-style-type: none"> • Optima 38/SP DW (1+1 spare) 	<ul style="list-style-type: none"> • Soflens 38 (OptimaFW , SeeQuencell)]]

¹ Signature Contact Lens Care Program - If a *covered person* receives a vision examination from a *preferred provider*, and soft contact lenses are prescribed, we cover charges in full for:

- the contact lens evaluation and fitting;
- for an initial supply of soft contact lenses from the list below that are received from the same provider; and
- up to two follow-up visits to the same provider.

⁵ Brand	Manufacturer	Boxes Covered	Replacement Wearers*	Refit Wearers*
Tier 1			Price	
ACUVUE	Vistakon	4	\$130	\$170
ACUVUE 2	Vistakon	4	\$130	\$170
AIR OPTIX AQUA	CIBA Vision	2	\$130	\$170
Biofinity	Coopervision	2	\$130	\$170
Biomedics 55 Premier	Coopervision	4	\$130	\$170
Biomedics 55 UV	Coopervision	4	\$130	\$170
Biomedics XC	Coopervision	4	\$130	\$170
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2	\$130	\$170
Frequency 38	Coopervision	2	\$130	\$170
Frequency 55 Sphere	Coopervision	2	\$130	\$170
Frequency 55 Aspheric	Coopervision	2	\$130	\$170
FreshLook Handling Tint	CIBA Vision	4	\$130	\$170
O2OPTIX	CIBA Vision	2	\$130	\$170
ProClear Sphere (Compatibles)	Coopervision	2	\$130	\$170
PureVision	Bausch & Lomb	2	\$130	\$170
SofLens 38 (Optima FW, Seequence II)	Bausch & Lomb	4	\$130	\$170
Vertex Sphere (Encore Sphere)	Coopervision	4	\$130	\$170
Tier 2			Price	
ACUVUE ADVANCE	Vistakon	4	\$160	\$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4	\$160	\$190
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2	\$160	\$190
Avaira	Coopervision	4	\$160	\$190
Biomedics 38	Coopervision	4	\$160	\$190
Extreme H2O 59% - Thin	Hydrogel	4	\$160	\$190
Extreme H2O 59% - Xtra	Hydrogel	4	\$160	\$190
Extreme H2O 54%	Hydrogel	4	\$160	\$190
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4	\$160	\$190
PRECISION UV	CIBA Vision	4	\$160	\$190
Tier 3			Price	
ACUVUE ADVANCE for ASTIGMATISM	Vistakon	4	\$180	\$210
ACUVUE OASYS for ASTIGMATISM	Vistakon	4	\$180	\$210
AIR OPTIX for ASTIGMATISM	CIBA Vision	2	\$180	\$210
Biofinity Toric	Coopervision	2	\$180	\$210
Focus Monthly Toric Visitint (Focus Toric)	CIBA Vision	2	\$180	\$210
Frequency 55 Multifocal	Coopervision	2	\$180	\$210
Frequency 55 Toric	Coopervision	2	\$180	\$210
ProClear EP Multifocal	Coopervision	4	\$180	\$210
PureVision Multifocal	Bausch & Lomb	2	\$180	\$210
PureVision Toric	Bausch & Lomb	2	\$180	\$210
SofLens Toric	Bausch & Lomb	4	\$180	\$210

* A Replacement wearer is an existing soft contact lens wearer who is ordering the same contact lens type.
A Refit wearer is an existing contact lens wearer who is ordering a different contact lens type.

If a *covered person* selects contact lenses from a tier in which the listed price is higher than the elective contact lens allowance for *preferred providers*, the *covered person* must pay the difference between the price and the elective contact lens allowance.

If a *covered person* selects contact lenses from a tier in which the listed price is lower than the elective contact lens allowance for *preferred providers*, the *covered person* may apply the difference between the price and the elective contact lens allowance to the purchase of additional contact lenses.]

[¹ Choice Contact Lens Care Program - If a *covered person* who now wears soft contact lenses receives a vision examination from a *preferred provider*, and the same type of contact lenses is prescribed, we cover charges in full for the contact lens evaluation and fitting; and for an initial supply of soft contact lenses from the list below that are received from the same provider.

[⁵ Brand	Manufacturer	Boxes Covered	Replacement Wearers
Tier 1			Price
ACUVUE	Vistakon	4	\$130
ACUVUE 2	Vistakon	4	\$130
AIR OPTIX AQUA	CIBA Vision	2	\$130
Biofinity	Coopervision	2	\$130
Biomedics 55 Premier	Coopervision	4	\$130
Biomedics 55 UV	Coopervision	4	\$130
Biomedics XC	Coopervision	4	\$130
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2	\$130
Frequency 38	Coopervision	2	\$130
Frequency 55 Sphere	Coopervision	2	\$130
Frequency 55 Aspheric	Coopervision	2	\$130
FreshLook Handling Tint	CIBA Vision	4	\$130
O2OPTIX	CIBA Vision	2	\$130
ProClear Sphere (Compatibles)	Coopervision	2	\$130
PureVision	Bausch & Lomb	2	\$130
SofLens 38 (Optima FW, Seequence II)	Bausch & Lomb	4	\$130
Vertex Sphere (Encore Sphere)	Coopervision	4	\$130
Tier 2			Price
ACUVUE ADVANCE	Vistakon	4	\$160
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4	\$160
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2	\$160
Avaira	Coopervision	4	\$160
Biomedics 38	Coopervision	4	\$160
Extreme H2O 59% - Thin	Hydrogel	4	\$160
Extreme H2O 59% - Xtra	Hydrogel	4	\$160
Extreme H2O 54%	Hydrogel	4	\$160
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4	\$160
PRECISION UV	CIBA Vision	4	\$160
Tier 3			Price
ACUVUE ADVANCE for <i>ASTIGMATISM</i>	Vistakon	4	\$180
ACUVUE OASYS for <i>ASTIGMATISM</i>	Vistakon	4	\$180
AIR OPTIX for <i>ASTIGMATISM</i>	CIBA Vision	2	\$180
Biofinity Toric	Coopervision	2	\$180
Focus Monthly Toric Visitint (Focus Toric)	CIBA Vision	2	\$180
Frequency 55 Multifocal	Coopervision	2	\$180
Frequency 55 Toric	Coopervision	2	\$180
ProClear EP Multifocal	Coopervision	4	\$180
PureVision Multifocal	Bausch & Lomb	2	\$180
PureVision Toric	Bausch & Lomb	2	\$180
SofLens Toric	Bausch & Lomb	4	\$180]

This program is only available to a *covered person* who is an existing soft contact lens wearer ordering the same contact lens type. A new contact lens wearer or an existing contact lens wearer ordering a different contact lens type is not eligible for this program.

If a *covered person* selects contact lenses from a tier in which the listed price is higher than the elective contact lens allowance for *preferred providers*, the *covered person* must pay the difference between the price and the elective contact lens allowance.

If a *covered person* selects contact lenses from a tier in which the listed price is lower than the elective contact lens allowance for *preferred providers*, the *covered person* may apply the difference between the price and the elective contact lens allowance to the purchase of additional contact lenses.]

We will not pay for plano lenses (lenses with less than a +/- .38 diopter power).

We will not pay for two sets of glasses in lieu of bifocals.

We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.

We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

We will not pay for a frame that costs more than the plan allowance.

[¹ We will not pay for blended lenses.]

[¹ We will not pay for oversized lenses.]

[¹ We will not pay for progressive lenses.]

[¹ We will not pay for polycarbonate lenses.]

[¹ We will not pay for high index lenses.]

[¹ We will not pay for the laminating of the lens or lenses.]

[¹ We will not pay for UV (ultraviolet) protected lenses.]

[¹ We will not pay for progressive multifocal lenses.]

[¹ We will not pay for the anti-reflective coating of the lens or lenses.]

[¹ We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.]

[¹ We will not pay for the mirror/ski coating of the lens or lenses.]

[¹ We will not pay for the scratch resistant coating of the lens or lenses.]

[¹ We will not pay for edge treatment.]

[¹ We will not pay for refitting of contact lenses after the initial 90 day fitting period.]

[¹ We will not pay for routine maintenance of contact lenses such as polishing or cleaning.]

[¹ We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).]

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

¹ [**ABC Company**]

(herein called the Policyholder)

Effective ¹ [99/99/99], this rider amends this plan as follows:

We cover charges for Primary Eye Care (PEC) treatment from a preferred provider in excess of a ² [\$5] copay for each office visit.

PEC is designed for the detection, treatment and management of ocular conditions and systemic conditions which produce ocular or visual symptoms that, if left untreated, may result in vision loss.

We cover services performed by a preferred provider only if such service is within the scope of his or her optometric license.

Covered persons may call for an appointment or be seen immediately if the preferred provider determines urgent care is necessary.

Under this provision, we do not cover charges for:

- PEC treatment or services from a non-preferred provider;
- Pre- and post- operative services;
- Laser surgery;
- A and B scans;
- Lab tests, including surgical pathology and microbiology services, which should be coordinated with a covered person's medical primary care physician; or
- Services provided for refractive diagnoses that are part of the covered person's routine vision care coverage.

This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

¹ [Dated at _____ This _____ Day of _____, _____

¹ [**ABC Company**]

Full or Corporate Name of Policyholder

BY: _____

Witness

Signature And Title]

The Guardian Life Insurance Company of America

³ [



SPECIMEN

Second Vice President & Actuary, Group Insurance]

HOW THIS PLAN WORKS

We pay benefits for the covered charges a Covered Person incurs as follows. What we pay is subject to all of the terms of this Plan. Read the entire Plan to find out what we limit or exclude.

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges incurred by a Covered Person while he or she is insured by this Plan. Charges in excess of any payment limits shown in this Plan are not covered charges.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive pre-authorization from VSP prior to providing the Covered Person with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this Plan for specific requirements.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within [¹ 90 days] of the date services are completed or supplies are received.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include the necessary tests to ensure visual wellness and detect potential eye-related medical problems, such as glaucoma.

We cover no more than one vision examination for each covered person in any [² 12-month period].

From a Preferred Provider: [⁴ The Covered Person must pay a Copayment of [³ \$10.00] each time he or she receives a vision exam from a Preferred Provider.] We pay benefits in full for the covered charges a Covered Person incurs [⁴ in excess of the Copayment.]

From a Non-Preferred Provider: [⁴ The Covered Person must pay a Deductible of [³ \$10.00] each time he or she receives a vision examination from a Non-Preferred Provider.] We pay benefits for the covered charges a Covered Person incurs [⁴ in excess of the Deductible] up to a maximum of [⁵ \$46.00] for each examination.

Vision Materials

Glasses (Lenses and Frames) or Contact Lenses: We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We pay benefits for frames. We pay benefits for prescription contact lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contact lenses.

In any [² 12-month period] we pay benefits for either glasses or contact lenses, but not both.

Materials Payment Limit: We limit what we pay for covered materials in any [² 12-month period] to an allowance of [⁶ \$75.00]. The discounts shown below are applied before the charges are applied to the allowance.

- Materials purchased from either a Preferred Provider or a Non-Preferred Provider are covered by this Plan, and can be used toward the [⁶ \$75.00] allowance.

- If the materials are purchased from a Preferred Provider more than [² 12 months] after a covered eye exam, or from a doctor other than the Preferred Provider who performed the exam, the cost of the purchase will not be covered by this plan and cannot be used toward the allowance.

10

- Charges for only an initial purchase can be used toward the [⁶ \$75.00] allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. For example, if a covered person purchases a pair of glasses for [⁷ \$60.00], the remaining [⁷ \$15.00] of the allowance will be unused. The covered person will have a new [⁶ \$75.00] allowance [² starting 12 months from the date of the purchase].

- Also, if a covered person purchases only frames or lenses (not a complete pair of glasses) the initial purchase will be used toward the allowance and the unused balance will not be banked for future use, even if the covered person purchases the other item later. The covered person will have a new [⁶ \$75.00] allowance [² starting 12 months from the date of the purchase].

**Discounts on
Materials
Purchased From a
Preferred Provider:**

For glasses, a covered person will receive a [⁸ 20%] discount off the Preferred Provider's usual and customary fee, if:

- A complete (lenses and frames) pair of glasses is purchased; and
- The purchase is made within [² 12 months] of a covered eye exam, and only from the Preferred Provider who performed the exam.

If a covered person purchases either lenses or frames only (not a complete pair of glasses), the discount will not be given. If the glasses are purchased either more than [² 12 months] after a covered eye exam, or from a Preferred Provider other than the one who performed the exam, the discount will not be given.

For non-covered cosmetic lens options such as coated or blended lenses, the Covered Person will receive a [⁸ 20%] discount off the Preferred Provider's usual and customary fee for the additional cost of the cosmetic feature.

For contact lenses, a Covered Person will receive a [⁹ 15%] discount off the Preferred Provider's usual and customary contact lens professional services fees for the contact lens exam, if the purchase is made within [² 12 months] of a covered eye exam, and only from the Preferred Provider who performed the exam. Discounts do not apply to the contact lenses.

Standard Lenses We cover charges for single vision, bifocal, trifocal or lenticular lenses. We cover glass, plastic [³ or [¹ for dependent children to age [² 20,]] polycarbonate lenses.

If a covered person uses a non-preferred provider, we limit what we pay to

- [⁴ \$48] for each pair of single vision lenses
- [⁵ \$67] for each pair of bifocal lenses
- [⁶ \$86] for each pair of trifocal lenses and
- [⁷ \$126] for each pair of lenticular lenses.

[³ For tinted lenses, these limits are increased by [⁸ \$5].]

[³ We cover charges for one set of standard lenses in any [⁹ 24-month period].]

[³ However, we will cover one pair of standard lenses in a 12-month period if the *covered person's* vision examination in that period results in a prescription change that meets one of the following criteria:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]

[³ We cover charges for two pairs of standard lenses. Coverage of each pair is subject to its own [⁹ 12-month benefit period].]

[³ With respect to bifocal and trifocal prescriptions, we cover charges for progressive multi-focal lenses.]

[³ We cover charges for the following :

- tinted lenses and photochromic lenses
- ultra violet coating
- scratch resistant coating
- blended lenses
- high index lenses
- mirror/ski coating
- oversized lenses
- polarized/laminated lenses
- edge treatment
- progressive lenses
- anti-reflective coating
- polycarbonate lenses for adults.]

Standard Frames: We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of [⁴ \$130], plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to [² \$48.] .

[¹ We cover charges for two sets of standard frames. Coverage of each set is subject to its own [³ 12-month period].]

[¹ If the covered person chooses elective contact lenses, we do not cover standard frames [³ for 12 months from] the date the elective contacts are purchased.]

[¹ We cover charges for one set of standard frames in any [³ 24-month period].]

[¹ However, we will cover one set of frames in a 12-month period if: (1) the *covered person's* vision examination in that period results in a prescription change that meets one of the criteria set forth below; and (2) new frames are needed to replace lost or broken frames or because the new prescription requires a frame of a different shape or size.

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]

Elective Contact Lenses We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses [² for 12 months] and standard frames [² for at least 24 months].

[¹ If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to [³ \$130] .]

[¹ If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to [⁴ \$120] .]

[¹ We cover charges for two sets of elective contact lenses. Coverage of each set is subject to its own [² 12-month benefit period].]

[¹ We cover charges for one set of elective contact lenses in any [² 24-month period].]

[¹ However, we will cover one set of elective contact lenses in a 12-month period if the *covered person's* vision examination in that period results in a prescription change that meets one of the following criteria:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a change in the axis of 15 degrees or more.
- There is a .50 prism diopter change in at least one eye.
- The new prescription improves visual acuity by at least one line on the standard eye chart.]]

[¹ VSP Contact Lens Program - If a *covered person* who now wears soft contact lenses receives a vision examination from a *preferred provider*, and the same type of contact lenses is prescribed, we cover charges in full for the contact lens evaluation and fitting; and for an initial supply of soft contact lenses from the list below that are received from the same provider.

Manufacturer	Brand	Brand
[⁵ Vi960stakon	• Acuvue	• Acuvue2
CIBA Vision	• Cibasoft Standard Visitint • Cibasoft Visitint • Durasoft 2 Lite Tint • Focus 1-2 Week Visitint (New Vues) • Focus Monthly Visitint	• FreshLook Handling Tint • Precision U V • Softmate B • Softmate II • 2 Optix • Focus Dailies
Cooper Vision	• Cooper Clear (DW or FW) • Frequency 38 • Frequency 55 • Proclear • Proclear Compatibles • Silver 07 • Vertex Sphere (Encore Sphere CV Encore Premium)	• ProActive 55 • Hydrogenics 60UV • Hydron Zero 4 Sofblue (FW) • Hydron Zero 6 Sofblue (DW) • Biomedics 38 • Biomedics 55 Premier • Biomedics 55U V
Hydrogel	• Extreme H20 G60 S-Thin	• Extreme H20 G60 S-Xtra
Bausch & Lomb	• Optima 38/SP DW (1+1 spare)	• Soflens 38 (OptimaFW , SeeQuencell)]]

[¹ Signature Contact Lens Care Program - If a *covered person* receives a vision examination from a *preferred provider*, and soft contact lenses are prescribed, we cover charges in full for:

- the contact lens evaluation and fitting;
- for an initial supply of soft contact lenses from the list below that are received from the same provider; and
- up to two follow-up visits to the same provider.

[⁵ Brand	Manufacturer	Boxes Covered	Replacement Wearers*	Refit Wearers*
Tier 1			Price	
ACUVUE	Vistakon	4	\$130	\$170
ACUVUE 2	Vistakon	4	\$130	\$170
AIR OPTIX AQUA	CIBA Vision	2	\$130	\$170
Biofinity	Coopervision	2	\$130	\$170
Biomedics 55 Premier	Coopervision	4	\$130	\$170
Biomedics 55 UV	Coopervision	4	\$130	\$170
Biomedics XC	Coopervision	4	\$130	\$170
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2	\$130	\$170
Frequency 38	Coopervision	2	\$130	\$170
Frequency 55 Sphere	Coopervision	2	\$130	\$170
Frequency 55 Aspheric	Coopervision	2	\$130	\$170
FreshLook Handling Tint	CIBA Vision	4	\$130	\$170
O2OPTIX	CIBA Vision	2	\$130	\$170
ProClear Sphere (Compatibles)	Coopervision	2	\$130	\$170
PureVision	Bausch & Lomb	2	\$130	\$170
SofLens 38 (Optima FW, Seequence II)	Bausch & Lomb	4	\$130	\$170
Vertex Sphere (Encore Sphere)	Coopervision	4	\$130	\$170
Tier 2			Price	
ACUVUE ADVANCE	Vistakon	4	\$160	\$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4	\$160	\$190
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2	\$160	\$190
Avaira	Coopervision	4	\$160	\$190
Biomedics 38	Coopervision	4	\$160	\$190
Extreme H2O 59% - Thin	Hydrogel	4	\$160	\$190
Extreme H2O 59% - Xtra	Hydrogel	4	\$160	\$190
Extreme H2O 54%	Hydrogel	4	\$160	\$190
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4	\$160	\$190
PRECISION UV	CIBA Vision	4	\$160	\$190
Tier 3			Price	
ACUVUE ADVANCE for <i>ASTIGMATISM</i>	Vistakon	4	\$180	\$210
ACUVUE OASYS for <i>ASTIGMATISM</i>	Vistakon	4	\$180	\$210
AIR OPTIX for <i>ASTIGMATISM</i>	CIBA Vision	2	\$180	\$210
Biofinity Toric	Coopervision	2	\$180	\$210
Focus Monthly Toric Visitint (Focus Toric)	CIBA Vision	2	\$180	\$210
Frequency 55 Multifocal	Coopervision	2	\$180	\$210
Frequency 55 Toric	Coopervision	2	\$180	\$210
ProClear EP Multifocal	Coopervision	4	\$180	\$210
PureVision Multifocal	Bausch & Lomb	2	\$180	\$210
PureVision Toric	Bausch & Lomb	2	\$180	\$210
SofLens Toric	Bausch & Lomb	4	\$180	\$210]

* A Replacement wearer is an existing soft contact lens wearer who is ordering the same contact lens type.

A Refit wearer is an existing contact lens wearer who is ordering a different contact lens type.

If a covered person selects contact lenses from a tier in which the listed price is higher than the elective contact lens allowance for preferred providers, the covered person must pay the difference between the price and the elective contact lens allowance.

If a covered person selects contact lenses from a tier in which the listed price is lower than the elective contact lens allowance for preferred providers, the covered person may apply the difference between the price and the elective contact lens allowance to the purchase of additional contact lenses.]

[¹ Choice Contact Lens Care Program - If a *covered person* who now wears soft contact lenses receives a vision examination from a *preferred provider*, and the same type of contact lenses is prescribed, we cover charges in full for the contact lens evaluation and fitting; and for an initial supply of soft contact lenses from the list below that are received from the same provider.

[⁵ Brand	Manufacturer	Boxes Covered	Replacement Wearers
Tier 1			Price
ACUVUE	Vistakon	4	\$130
ACUVUE 2	Vistakon	4	\$130
AIR OPTIX AQUA	CIBA Vision	2	\$130
Biofinity	Coopervision	2	\$130
Biomedics 55 Premier	Coopervision	4	\$130
Biomedics 55 UV	Coopervision	4	\$130
Biomedics XC	Coopervision	4	\$130
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2	\$130
Frequency 38	Coopervision	2	\$130
Frequency 55 Sphere	Coopervision	2	\$130
Frequency 55 Aspheric	Coopervision	2	\$130
FreshLook Handling Tint	CIBA Vision	4	\$130
O2OPTIX	CIBA Vision	2	\$130
ProClear Sphere (Compatibles)	Coopervision	2	\$130
PureVision	Bausch & Lomb	2	\$130
SofLens 38 (Optima FW, Seequence II)	Bausch & Lomb	4	\$130
Vertex Sphere (Encore Sphere)	Coopervision	4	\$130
Tier 2			Price
ACUVUE ADVANCE	Vistakon	4	\$160
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4	\$160
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2	\$160
Avaira	Coopervision	4	\$160
Biomedics 38	Coopervision	4	\$160
Extreme H2O 59% - Thin	Hydrogel	4	\$160
Extreme H2O 59% - Xtra	Hydrogel	4	\$160
Extreme H2O 54%	Hydrogel	4	\$160
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4	\$160
PRECISION UV	CIBA Vision	4	\$160

Tier 3			Price
ACUVUE ADVANCE for <i>ASTIGMATISM</i>	Vistakon	4	\$180
ACUVUE OASYS for <i>ASTIGMATISM</i>	Vistakon	4	\$180
AIR OPTIX for <i>ASTIGMATISM</i>	CIBA Vision	2	\$180
Biofinity Toric	Coopervision	2	\$180
Focus Monthly Toric Visitint (Focus Toric)	CIBA Vision	2	\$180
Frequency 55 Multifocal	Coopervision	2	\$180
Frequency 55 Toric	Coopervision	2	\$180
ProClear EP Multifocal	Coopervision	4	\$180
PureVision Multifocal	Bausch & Lomb	2	\$180
PureVision Toric	Bausch & Lomb	2	\$180
SofLens Toric	Bausch & Lomb	4	\$180]

This program is only available to a *covered person* who is an existing soft contact lens wearer ordering the same contact lens type. A new contact lens wearer or an existing contact lens wearer ordering a different contact lens type is not eligible for this program.

If a *covered person* selects contact lenses from a tier in which the listed price is higher than the elective contact lens allowance for *preferred providers*, the *covered person* must pay the difference between the price and the elective contact lens allowance.

If a *covered person* selects contact lenses from a tier in which the listed price is lower than the elective contact lens allowance for *preferred providers*, the *covered person* may apply the difference between the price and the elective contact lens allowance to the purchase of additional contact lenses.]

We will not pay for plano lenses (lenses with less than a +/- .38 diopter power).

We will not pay for two sets of glasses in lieu of bifocals.

We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.

We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

We will not pay for a frame that costs more than the plan allowance.

[¹ We will not pay for blended lenses.]

[¹ We will not pay for oversized lenses.]

[¹ We will not pay for progressive lenses.]

[¹ We will not pay for polycarbonate lenses.]

[¹ We will not pay for high index lenses.]

[¹ We will not pay for the laminating of the lens or lenses.]

[¹ We will not pay for UV (ultraviolet) protected lenses.]

[¹ We will not pay for progressive multifocal lenses.]

[¹ We will not pay for the anti-reflective coating of the lens or lenses.]

[¹ We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.]

[¹ We will not pay for the mirror/ski coating of the lens or lenses.]

[¹ We will not pay for the scratch resistant coating of the lens or lenses.]

[¹ We will not pay for edge treatment.]

[¹ We will not pay for refitting of contact lenses after the initial 90 day fitting period.]

[¹ We will not pay for routine maintenance of contact lenses such as polishing or cleaning.]

[¹ We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).]

CERTIFICATE AMENDMENT

We cover charges for Primary Eye Care (PEC) treatment from a preferred provider in excess of a ² [\$5] copay for each office visit.

PEC is designed for the detection, treatment and management of ocular conditions and systemic conditions, which produce ocular or visual symptoms which, if left untreated, may result in vision loss.

We cover services performed by a preferred provider only if such service is within the scope of his or her optometric license.

Covered persons may call for an appointment or be seen immediately if the preferred provider determines urgent care is necessary.

Under this provision, we do not cover charges for:

- PEC treatment or services from a non-preferred provider;
- Pre- and post- operative services;
- Laser surgery;
- A and B scans;
- Lab tests, including surgical pathology and microbiology services, which should be coordinated with a covered person's medical primary care physician; or
- Services provided for refractive diagnoses that are part of the covered person's routine vision care coverage.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

³ [



Second Vice President & Actuary, Group Insurance]

SERFF Tracking Number: GARD-126435211 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of State Tracking Number: 44446
 America
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: AR8511-010
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/04/2010
Comments:			
Attachment:			
ReadCert (40).pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/04/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Form List	Approved-Closed	01/04/2010
Comments:			
Attachment:			
Forms List_generic.pdf			

CERTIFICATION OF READABILITY

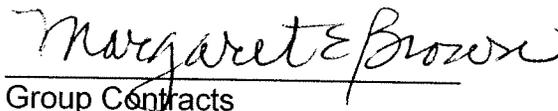
Form number(s): GP-1-VSN-09-HPW, et al

The undersigned individuals have carefully reviewed, and know the contents of, the filing submitted herewith, and except as qualified, do hereby certify the following:

1. The said form(s) meet the minimum reading ease requirements of your jurisdiction.
2. The captioned form(s) have a Flesch reading ease test score of at least 40 with no exemptions.
3. The said form(s) are printed in 10-point or larger type.



(Signature of Officer)



Group Contracts

December 18, 2009
Date

Form List

FORM NUMBER	FORM TYPE	FORM TITLE/DESCRIPTION
GP-1-VSN-09-HPW	Policy Insert	How This Plan Works
CGP-3-VSN-09-HPW	Certificate Insert	How This Plan Works
GP-1-VSN-09-SL	Policy Insert	Standard Lenses
CGP-3-VSN-09-SL	Certificate Insert	Standard Lenses
GP-1-VSN-09-SF	Policy Insert	Standard Frames
CGP-3-VSN-09-SF	Certificate Insert	Standard Frames
GP-1-VSN-09-ECL	Policy Insert	Elective Contact Lenses
CGP-3-VSN-09-ECL	Certificate Insert	Elective Contact Lenses
GP-1-VSN-09-EXC	Policy Insert	Exclusions
CGP-3-VSN-09-EXC	Certificate Insert	Exclusions
GP-1-VSN-09-PEC	Policy Rider	Primary Eye Care Rider
CGP-3-VSN-09-PEC	Certificate Amendment	Primary Eye Care Amendment