NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(called "We", "Our", and "Us")

2 East Gilman Street, Madison, Wisconsin 53701

GROUP VISION INSURANCE MASTER POLICY

Underwritten by:	National Guardian Life Insurance Company Two East Gilman Street P.O. Box 1191 Madison, WI 53701-1191
Administrator:	National Vision Administrators, LLC 1200 Rt 46 West, 2nd Floor, Clifton, NJ 07013

In return for the application, which is attached, and payment of premium as it becomes due, National Guardian Life Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown on the Policy Schedule.

This Policy may be continued in force by payment of premium at the rates We establish until the insurance ends as provided.

This Policy is governed by the laws of the jurisdiction shown below.

POLICYHOLDER:	**First United Corporation**
GROUP POLICY NUMBER:	**NVAI8227**
POLICY EFFECTIVE DATE:	**January 1, 2013**
ANNIVERSARY DATE:	**January 1, 2014**
JURISDICTION:	**Maryland**
PREMIUM DUE DATE:	**1st of every Month**
COVERAGE PROVIDED:	**See Certificate's Schedule of Benefits**
INITIAL TERM:	**24 Months**

Mathew J. Dew, Secretary

Mark Solverud, President

NON-PARTICIPATING

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PART I: PREMIUMS

A. PREMIUM SCHEDULE

Refer to the attached Group Application for premium rate information.

B. PAYMENT OF PREMIUMS: The premiums due under this Policy are payable in advance directly to Us at the Administrator's Office. The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the GRACE PERIOD provision.

C. PREMIUM ADJUSTMENTS: When additional or increased insurance begins or insurance ends and such change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly). Upon agreement between the Policyholder and Us, the mode of premium payment may be changed as of any Premium Due Date.

D. PREMIUM CALCULATION: The total premium for insurance coverage under this Policy is the sum of the premiums for each Insured.

E. CHANGES IN PREMIUM RATES: We have the right to change the premium rates on any premium due date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any 12-month period. We will notify the Policyholder in writing at least 45 days before any increase in premium rates.

F. GRACE PERIOD: A Grace Period of 30 days is granted for the payment of any premium due after the first, unless We do not intend to renew this Policy beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the group policyholder at least 45 days before the premium is due. During the grace period the policy shall continue in force.

Unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended before the end of the Grace Period We will have the right to collect premium for the 30-day Grace Period.

If We receive a notice of intention to terminate the policy during the Grace Period, We may collect premium for the period beginning on the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later. The Policyholder will owe Us the pro-rata premium for the time insurance was in effect during the Grace Period.

If premium for the 30-day grace period is paid after the Grace Period ends, We may charge interest for the premium, but:

(1) Interest may not begin to accrue during the 30-day Grace Period, and

(2) The interest rate charged may not exceed an effective rate of 6 percent per year.

PART II: PROVISIONS SPECIFIC TO EMPLOYER GROUPS

A. DEFINITIONS: The following Definitions apply in addition to those contained in the attached Certificate:

1. **Active Employee** – Means an Actively At Work Employee of the Employer named as the Policyholder.

2. **Active Work and Actively at Work** – Means that the Active Employee is performing all of the usual and customary duties of his or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the Active Employee to travel.

3. **Retiree** – Means retirees ages 55-65 who have met the service requirements of the Policyholder.

B. CONTINUING INSURANCE ON ACTIVE EMPLOYEES ABSENT FROM WORK

Coverage may be continued on Active Employees absent from work subject to the following provisions. If an Active Employee is absent from work because of injury, sickness, approved leave of absence or temporary lay-off, or is placed on part-time employment, the Employer, acting on a basis which does not discriminate for or against any person, may consider the Active Employee as still employed until the Employer notifies Us differently or stops paying premiums for the Active Employee. However, in any event, insurance cannot be continued in this way for longer than the Maximum Continuation Period stated below.

FOR ABSENCE DUE TO:	MAXIMUM CONTINUATION PERIOD:
Temporary Lay-Off	One Year
Approved Leave of Absence	One Year
Part-Time Employment	One Year
Injury or Sickness	One-year periods, each of which begins on the Anniversary Date of this Policy, subject to the following conditions: 1. the first period begins on the date the Active Employee stops Active Work due to injury or sickness and ends on the next following Anniversary Date of this Policy (up to six months); 2. request to continue insurance must be made by the Employer to Us within 31 days before each Anniversary Date.

PART III: WHEN INSURANCE UNDER THIS POLICY ENDS

By giving the Policyholder written notice at least 60 days in advance, We have the right to end coverage under this policy as follows:

1. We have the right to terminate all insurance under this Policy at the end of the Initial Term or on any Premium Due Date after participation drops below the following requirements:
   a. When Members are not required to contribute to the cost of their own insurance, there must be 100% participation.
   b. For groups of 10 or more Members where benefits are funded by the Members, 25% participation is required in all circumstances for both Members and Eligible Dependents. A minimum of 10 or more must enroll.
   c. Participation must not drop 25% or more from the participation on the original effective date.

2.. We will also have the right to terminate all insurance under this Policy when the Policyholder:
   a. fails to pay the renewal premiums when due, subject to the 30-day Grace Period; or

b. sends Us notice of cancellation. Such termination will be effective as of the next renewal date following Our receipt of the Policyholder's notice, unless another date later than the next renewal date is specified in the notice. The Policyholder will remain responsible for all premium payments coming due between our receipt of its notice of cancellation and the termination date.

All insurance or any part may be ended on any date by mutual agreement between the Policyholder and Us.

After the Initial Term, the Policy shall continue on a month-to-month basis. It will automatically renew on the first day of each renewal period unless We give at least 60 days advance written notice of cancellation.

Insurance will end as provided above without the consent of, or notice to, any Insured Dependent or Beneficiary.

PART IV: GENERAL PROVISIONS

A. ENTIRE CONTRACT: The entire contract consists of:

1. this Policy;
2. the application of the Policyholder;
3. the provisions shown in the Certificate;
4. the Insured enrollment forms; and
5. riders and endorsements, if any, adding or changing the provisions of the Policy or Certificate.

No change in this Policy will be valid:

1. until approved by one of Our executive officers; and,
2. unless the approval is endorsed on or attached to this policy.

B. CONTESTABILITY OF COVERAGE: After this Policy has been in force for 2 years from its Policy Date (shown in the Policy Schedule) it may not be contested, except for the nonpayment of premiums. Absent fraud, each statement made by an Eligible Employee making application for coverage, the Policyholder or an Insured Person will be considered to be a representation and not a warranty.

A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under this Policy unless: (a) the statement is contained in a written instrument signed by the Policyholder or the Insured Person, and (b) a copy of the statement is given to the Policyholder and the Insured Person or his/her beneficiary.

No statement made by an Insured Person relating to insurability may be used in contesting the validity of his/her coverage under this Policy after such coverage has been in force for a period of 2 years during such Person's lifetime.

C. CHANGES IN POLICY: The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our President or Our Secretary. Any changes will be made without the consent of, or notice to, any Insured or Beneficiary, if any. No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

D. CONFORMITY WITH LAW: If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

E. POLICY NON-PARTICIPATING: This Policy is not entitled to share in the surplus earnings of Our company.

F. INFORMATION TO BE FURNISHED BY POLICYHOLDER: The Policyholder will furnish Us with all information which pertains to this Policy. Failure to furnish Us with such information without good and sufficient cause will permit Us to terminate this Policy. We may inspect at all reasonable times (while this Policy is in effect and thereafter until all rights and payments have been made) any records of the Policyholder which have a bearing on the insurance or premiums.

G. CLERICAL ERROR: Clerical error (whether by the Policyholder or Us) in keeping records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

H. POLICYHOLDER NOT AGENT: The Policyholder will in no event be considered Our agent for any purpose under this Policy.

I. ASSIGNMENT: No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us at Our Home Office.

J. INDIVIDUAL CERTIFICATES: We will issue to the Policyholder, to make available to each person insured under this Policy, a Certificate of insurance that describes the essential features of this Policy. The Certificate may be made available electronically. The word Certificate includes Certificate riders and Certificate supplements, if any.

K. ADDITIONAL INSUREDS: The following will be added to the group originally insured:

1. All new persons becoming eligible to and applying for insurance in such group or class, including new members of a family; and
2. Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

L. LEGAL ACTIONS: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or "NGL") are committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."

Why We Collect and How We Use Information:

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL's website, www.nglic.com.

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O. Box 671 – Suite 216C
Owings Mills, Maryland 21117
1-410-998-3907

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116 Ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(called "We", "Our", and "Us")
2 East Gilman Street, Madison, Wisconsin 53701

GROUP VISION CARE INSURANCE CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: National Vision Administrators, LLC
1200 Rt 46 West, 2nd Floor, Clifton, NJ 07013

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Mathew J. Dew

Mathew J. Dew, Secretary

Mark Z Solverud

Mark Solverud, President

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

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PART I. CERTIFICATE SCHEDULE

Policyholder:	**First United Corporation**
Group Policy Number:	**NVAI8227**
Effective Date:	**January 1, 2013**
Initial Term:	**24 Months**
Eligible Classes:	**Class I: All Part Time and Full Time Employees Working At Least 20 Hours Per Week After Completing the required length of Service**
Waiting Period:	**1st of the month following 30 days of Active Work**
Mode of Premium Payment:	**MONTHLY**
Method of Premium Payment:	**Remitted by Policyholder**
Premium Due Date:	**1st of every month**

PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Calendar Year Rolling Benefit] Plan Basis	
Vision Exam:	**Once every 12 Months**
Eyeglass Lenses:	**Once every 12 Months**
Frames:	**Once every 12 Months**
Contact Lenses:	**Once every 12 Months**
Contact Lens Fit:	**Once every 12 Months**

CO-PAY (PER INSURED)			
		In-Network Providers:	Out-of-Network Provider*:
Vision Exam:		$0.00	$0.00
Contact Lens Fit:		$0.00	$0.00
Eyeglass Lenses:		$0.00	$0.00
Frames:		$0.00	$0.00
Contact Lenses:		$0.00	$0.00

BENEFITS AND ALLOWANCES [1]			
		Other In-Network Providers:	Out-of-Network Provider*:
Vision Exam:			
By Ophthalmologist		Covered in Full	$40 Allowance
By Optometrist		Covered in Full	$40 Allowance
Contact Lens Fit:		Covered in Full	Daily Wear: $20 Extended Wear: $30
Materials- Eyeglass Lenses[3]:			
Single Vision		Covered in Full	$35 Allowance
Bifocals		Covered in Full	$60 Allowance
Trifocals		Covered in Full	$80 Allowance
Lenticular		Covered in Full	$80 Allowance
Materials – Frames[3]:		$100 Allowance	$50 Allowance
Materials – Contact Lenses[2]:			
Non-Elective		Covered in Full	$200 Allowance
Elective		$100 Allowance	$80 Allowance

* Benefits paid to Out-of-Network Providers will never be less than 80% of the aggregate payments made in a full calendar year to Preferred Providers for similar services, in the same geographic area.

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

[2] The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames

[3] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

PART III. DEFINITIONS

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A request for payment of benefits under this Certificate.

Co-Pay – An Insured's share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. If an Out-of-Network Provider is used, the Co-Pay will be deducted from the Out-of-Network Allowance at the time We pay benefits. Co-Pay amounts are listed in the Schedule of Benefits.

Contact Lenses, Elective – Elective contact lenses refer to contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective – Non-elective Contact Lenses refer to contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

1. Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective Contact Lenses for this condition.
2. When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
4. Keratoconus.

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of an In-Network Provider.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Services or Materials – Means the Vision Exam services and Materials that qualify for benefits under the Group Policy. Covered Services or Materials are shown in the Schedule of Benefits.

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Waiting Period, if any.

Eligible Dependent - Means a person listed below:

1. Your spouse;
2. Your child under age 26, who is your natural or legally adopted child, step-child, grandchild who is in Your court-ordered custody, or an individual for whom guardianship is granted by a court or testamentary appointment (other than temporary guardianship of less than 12 months duration).
3. Your unmarried child who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental or physical incapacity.

   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Eyeglass Lenses – A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

He, Him and His – Refers to the male or female gender.

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

Initial Term - The period following the group's initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period.

In-Network Provider - An Ophthalmologist, Optometrist or Optician who has entered into a agreement with the Administrator to provide Covered Services or Materials at an agreed to cost. When an In-Network Provider is used, the Insured will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory - A list of In-Network Providers and the services they are contracted for in Your area. The list will be updated periodically.

Insured – Means You (the Insured Member) and each Covered Dependent.

Insured Member– Means a person:

1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Waiting Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the section titled "Limitations."

Materials – Means corrective Eyeglass Lenses, Frames and Contact Lenses.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

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. The Ophthalmologist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optician – A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Out-of-Network Provider – An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges. They are not listed in the In-Network Provider Directory.

Plano Lens - A lens that has no refractive power.

Policyholder - The entity stated on the front page of the Policy.

Vision Exam – An examination of principal vision functions. A Vision Exam 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 must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

You or Your – The Insured Member.

Waiting Period - The period of time a Member must wait before He is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder,each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other spouse's coverage.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder's discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within 31 days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse, domestic partner or child;
5. Other changes as permitted by the Policyholder.

Addition of Dependent Children: Members may enroll an Eligible Dependent child at any time and without evidence of insurability if:

1. the dependent child was previously covered under the Insured Member's spouse's coverage; and
2. the Insured Member's spouse has died.

This provision:

1. applies regardless of whether or not such dependent children are eligible for any continuation or conversion privileges under the spouse's coverage; and
2. must be exercised within 6 months after the death of the spouse.

Spouse's Loss of Coverage under another Group Health Plan: If an Insured Member's spouse has lost his or her coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause, such spouse may enroll for coverage under the Policy at any time and without evidence of insurability. Such enrollment privilege will exist for a 6-month period beginning with the date such spouse loses his or her coverage under the other group health insurance contract or policy.

Court-Ordered Coverage for a Child: If an Insured Member or such Member's spouse is required under a court order to provide health insurance coverage for a child, such child will be eligible for enrollment at any time regardless of enrollment period restrictions.

If the Insured Member does not include the child in the enrollment, any non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene will be allowed to apply for enrollment on behalf of the child at any time regardless of any enrollment period restrictions.

The coverage for such child may not be terminated unless written evidence is provided to Us that:

1. the court order is no longer in effect;
2. the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
3. the employer has eliminated family members' coverage for all of its employees; or
4. the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the child consistent with the employer's plan for post-employment health insurance coverage for dependents.

If a is child enrolled by an Insured Member, We will:

1. provide to the non-insuring parent (if any) membership cards, claims forms, and any other information necessary for the child to obtain benefits provided hereunder; and
2. process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or Department of Health and Mental Hygiene if the non-insuring parent incurs expenses for covered dental care provided to the child.

If an eligible Member's plan requires that the eligible Member be enrolled in order for the child to be enrolled and the employee is not currently enrolled, We will enroll both the employee and the child, without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice from an employer.

PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective the date specified by the Policyholder. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

PART VI. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date, subject to the Grace Period provision.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date He is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A Grace Period of 30 days is granted for the payment of any premium due after the first, unless We do not intend to renew the Policy beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the group policyholder at least 45 days before the premium is due. During the grace period the Policy shall continue in force.

Unless the Policyholder has given written notice to Us that the insurance under the Policy is to be ended before the end of the Grace Period We will have the right to collect premium for the 30-day Grace Period.

If We receive a notice of intention to terminate the policy during the Grace Period, We may collect premium for the period beginning on the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later. The Policyholder will owe Us the pro-rata premium for the time insurance was in effect during the Grace Period.

If premium for the 30-day grace period is paid after the Grace Period ends, We may charge interest for the premium, but:

(1) Interest may not begin to accrue during the 30-day Grace Period, and

(2) The interest rate charged may not exceed an effective rate of 6 percent per year.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 12-month period. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

We pay a benefit if an Insured receives Covered Services or Materials at the allowable Frequency while his coverage under this Certificate is in force. An Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

A. In-Network Benefits

When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A provider's status may occasionally change. We recommend that You call the Administrator to verify the provider's participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Both the Co-Pay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

B. Out-of-Network Benefits
If an Insured chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us. (See the "Notice of Claim" provision.)

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits.

C. Covered Services or Materials
Covered Services or Materials are shown in the Schedule of Benefits. In order to be a Covered Service or Material, the services or materials must be furnished to an Insured:

1. To check or improve their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Schedule of Benefits.

PART IX. LIMITATIONS AND EXCLUSIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. An Insured is eligible to receive benefits under the Contact Lenses benefit only after the Eyeglass Lenses benefit Frequency has ended.

Dilation is covered in full under the Vision Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease .

No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
9. Services and materials provided by another vision plan;

10. Services for which benefits are paid by Worker's Compensation;
11. Benefits provided under the employee's medical insurance;
12. Blended bifocal lenses;
13. Groove, Drill or Notch, and Roll and Polish;
14. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
15. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
16. Cosmetic items (Determination of what is or is not considered a "cosmetic item" will be made solely by the treating provider;
17. Faceted lenses;
18. High-Index Lenses;
19. Laminated Lenses;
20. Oversize Lenses – any lens with an eye size of 61mm or greater;
21. Photochromic (Transition) lenses;
22. Polarized;
23. Polished bevel lenses;
24. Polycarbonate lenses;
25. Prism lenses;
26. Slab-off lenses;
27. Tints (except Pink tint #1 and #2;
28. Ultra-violet tint or coating;
29. Additional cost for contact lenses over the allowance;
30. Additional cost for a frame over the allowance;
31. Progressive Power Lenses*

*Progressive Power Lens Benefit. If this type of lens is not a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

PART X. CLAIM PROVISIONS

A. In-Network Claims

When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator.

B. Out-of-Network Claims

In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

C. Notice of Claim

Written notice of claim must be given within 20 days after a covered loss starts. Such notice can be given Us at 1200 Rt 46, 2nd Floor, Clifton, NJ 07013, or to one of Our local agents. This notice should include Your name and policy number (if available). Failure to provide written notice within the 20-day period will not invalidate or reduce a claim if it can be shown that: (a) it was not reasonably possible to give notice within 20 days, and (b) notice was given as soon as was reasonably possible.

D. Claim Forms

When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not sent to You within 15 days after the giving of such notice, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

E. Proof Of Loss
Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

F. Payment Of Claims
Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate.

If any beneficiary is a minor or mentally incapacitated, We will pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the individual who is considered by the carrier to be equitably entitled to the benefit.

G. Time of Payment of Claims
Benefits payable for any covered loss will be paid not more than 30 days after receipt of written proof of loss.

H. No Reduction for Medical Assistance Program: We will not deny or reduce benefits because services are rendered to You when you are eligible for or receiving state medical assistance.

I. Prohibited Referrals: We will have the right to seek repayment from a health care practitioner of any moneys paid for a claim, bill or other demand or request for payment for health care services that the appropriate regulatory board of Your state determines were provided as a result of a prohibited referral. For purposes of this provision:

"Health care practitioner" means a person who is licensed, certified, or otherwise authorized under this article to provide health care services in the ordinary course of business or practice of a profession.

"Health care entity" means a business entity that provides health care services for the: (1) testing, diagnosis, or treatment of human disease or dysfunction; or (2) dispensing of drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

"Health care service" means medical procedures, tests and services provided to a patient by or through a health care entity.

"Immediate family" includes a health care practitioner's: (1) spouse; (2) child or adopted child; (3) child's spouse; (4) parent; (5) spouse's parent; (6) sibling; or (7) sibling's spouse.

"Prohibited referral" means the referral of a patient by a health care practitioner, either directly or through an employee or other person under contract with the health care practitioner, to a health care entity: (1) In which the health care practitioner or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; (2) In which the practitioner's immediate family owns a beneficial interest of 3 percent or greater; or (3) With which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement.

J. Extension of Benefits
Termination of Your coverage under the Policy will be without prejudice to any claim for continuous loss that commenced while coverage under the Policy was in force. However, the payment of benefits after the termination date will be predicated upon continuing loss for which benefits were payable prior

to such termination date and limited to a course of treatment for at least 90 days after the date coverage terminates or the payment of the maximum benefits payable for such loss, whichever comes first.

If You have ordered glasses or contact lenses while coverage under the Policy was in force We will continue to provide covered benefits in accordance with the policy at the time Your coverage terminates for any glasses or contact lenses You receive within 30 days after the date of the order.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or "NGL") are committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."

Why We Collect and How We Use Information:

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL's website, www.nglic.com.

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O. Box 671 – Suite 216C
Owings Mills, Maryland 21117
1-410-998-3907

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116 Ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.