27333

AMENDMENT TO THE GROUP MASTER POLICY BETWEEN PACIFICARE LIFE AND HEALTH INSURANCE COMPANY AND CITY OF LONG BEACH - Retirees

This **AMENDMENT TO THE GROUP MASTER POLICY** (this "Amendment"), dated as of February 1, 2007, is made and entered into by and between PacifiCare Life and Health Insurance Company ("PLHIC"), a California corporation, and City of Long Beach ("Group").

Amendment. Pursuant to Section "Provisions required By Law – Changes in the Entire Contract" on Page 12 of the Certificate of Group Insurance ("Agreement"), the benefits set forth in the Agreement are hereby amended as follows:

WHO IS ELIGIBLE TO RECEIVE BENEFITS UNDER THIS BENEFT PLAN

Death of Covered Person, (Dependent Eligibility), shall be added to read as follows:

Death of Covered Person, Survivor Benefits. In the event of the Covered Person's death while actively employed on a regular full-time basis, the surviving spouse and dependent(s) may be eligible for continued coverage as determined by Group:

(a.) Surviving spouse may be eligible for continued coverage, if spouse is currently enrolled on this Plan immediately prior to the Covered Person's death. Spouse must continue to meet eligibility requirements set forth in the Certificate of Group Insurance attached to this Agreement and for whom applicable Plan premiums are received by PLHIC. The eligible and enrolled surviving spouse shall be covered up to the last day of the current month following date:

(i) Of remarriage; or
(ii) That surviving spouse, becomes eligible to receive other health benefit coverage or is covered under another health insurance; or
(iii) Of death; or
(iv) Termination of Survivor Benefits from the employer benefit package as determined by Group.
(v) Termination by PLHIC or Group of this Agreement, including but not limited to nonpayment of health plan premiums.

Survivor coverage is an additional employee benefit which at the discretion of Group, the terms and conditions of Survivor coverage may change at any time, including but not limited to, the termination of such benefit from the Group's benefit package.

(b) Surviving Dependent(s) may be eligible for continued coverage, if Dependent is enrolled on this Plan immediately prior to the Covered Person's death and Dependent is not eligible under any other health insurance coverage. Additionally Dependent continues to meet eligibility requirements set forth in the Certificate of Group Insurance attached

to this Agreement and for whom applicable Plan premiums are received by PLHIC. The eligible Dependent shall be covered up to the last day of the current month following date:

(i) Dependent reaches the limiting age on the Cover Sheet.
(ii) Dependent becomes eligible to receive or is covered under another health insurance; or
(iii) The Surviving Spouse no longer meets eligibility as defined in (a) above.
(iv) Termination of Survivor Benefits from the employer benefit package as determined by Group.
(v) Termination by PLHIC or Group of this Agreement, including but not limited to nonpayment of health plan premiums.

Your Dependents eligible for coverage are. Shall be amended to read as follows:

2. Your Dependents eligible for coverage are: (a) Your spouse or domestic partner and (b) each of Your Children, and children of your domestic partner, to the age of nineteen (19) years who is unmarried and chiefly Dependent upon You for support. If a student verification form is submitted, eligibility can be extended for a full-time, unmarried student up to age twenty-six (26) years old.

Effect of this Amendment. The Amendment shall not be further amended, modified or revised and the Agreement shall continue in full force and effect and shall be enforced in accordance with its terms and conditions. This Amendment shall expire on January 31, 2008.

GROUP MASTER POLICY

AGREEMENT

IN CONSIDERATION of the Group Application and the payment of Premiums when due, and subject to all terms of this Policy.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
3100 Lake Center Drive
Santa Ana, Ca. 92704
(hereinafter, the "Company")

hereby accepts the attached Application and agrees to deliver to each Covered Person of:

CITY OF LONG BEACH - Retirees
333 W OCEAN BLVD 13TH FLR
LONG BEACH, CA 90802

(hereinafter, the "Policyholder")

the benefits of this Policy beginning on each Insured Employee's Effective Date.

This Group Policy Date is February 1, 2007 and the Policy will continue until January 31, 2008 when, unless terminated as provided by this Policy, it will renew for a further period of 12 consecutive months and thereafter from year to year.

This Group Policy is comprised of the Group Application and Section I through IV (Agreement, Premium, Termination and Policy Specifications) and the Certificate, which is incorporated herein.

The Company accepts the application of the Group at its Administrative Office in Costa Mesa, California, as of the Group Policy Date.

CITY OF LONG BEACH – Retirees

Group Policy Number: **PL12362-V**

Signed by: _____

Title: _____

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY

Robert P. Pfotenhauer, President

II PREMIUM

A. PREMIUM PAYMENT

The Policyholder is required to make the monthly Premium payments on behalf of each enrolled Employee. Premiums are due by the date indicated on the Group Application.

B. PREMIUM CHANGES

The Company reserves the right to change Premiums under this Policy on any Premium due date by giving the Policyholder at least thirty-one (31) days prior written notice when:

(a) the Policy has been in effect for at least twelve (12) months from its Effective Date; or

(b) the provisions of the Policy are changed as to benefits or as to the classes of Insured Employees; or

(c) following any governmental action affecting the Company's liability under the Policy.

III. TERMINATION OF THE POLICY

If the Policy terminates, the Policyholder will be liable for all unpaid Premiums for the period the Policy was in force.

TERMINATION BY THE POLICYHOLDER

The Policyholder may terminate the Policy by giving written notice to the Administrator who in turn will notify the Company. This notice must be received by the Administrator at least 30 days in advance of the desired termination date.

TERMINATION BY THE COMPANY

The Company reserves the right to terminate the Policy if any one of the following occurs:

1. The Policyholder fails to pay promptly furnish any information which the Company may reasonably require or fails to perform it's duties pertaining to the Policy in good faith. The Company will provide thirty (30) days written notice of termination.

2. The Policy has been in effect for at least twelve (12) months and the Company provides thirty (30 days notice of termination.

3. If the Policyholder fails to pay the required Premiums to the Company, the Policy will terminate on the last day of the month in which Premiums were paid. **(Note, this may result in a retroactive termination date, due the Grace Period. The Policyholder is responsible for all Premiums due during the period this Policy was in effect.**

IV. POLICY SPECIFICATIONS

EMPLOYEE CONTRIBUTIONS:

Employee	[] Non-Contributory	[x] Contributory
Dependent	[] Non-Contributory	[x] Contributory

EFFECTIVE DATE of coverage shall be:

[] First of the month following date of hire
[x] First of the month following introductory period
[] Other, _____

INITIAL PREMIUM RATES:

Single	$ 13.65
Employee & Child (ren)	$ 13.65
Employee & Spouse	$ 13.65
Family	$ 13.65

PREMIUM DUE DATE: First of the Month

PREMIUM IS PAYABLE [X] Monthly [] Quarterly [] Semi-Annually [] Annually

OPTIONAL BENEFITS ELECTED - Rider must be attached to this Policy in order for Optional Benefits to be in force.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY

3120 LAKE CENTER DRIVE.
SANTA ANA, CA 92704

VISION POLICY

EXHIBIT NO. [1]

Issued to: CITY OF LONG BEACH
Group Number: Retirees 102237 & 102238
Effective Date: February 1, 2007

THIS EXHIBIT [I] is made to the PacifiCare Life and Health Insurance Company, Group Vision Insurance Policy (the "Policy") by and between the employer identified on the Group Vision Insurance Policy (the "Group Policyholder") and PacifiCare Life and Health Insurance Company ("Company"). Unless otherwise indicated herein, all terms initially capitalized herein shall have the same meaning attributed to such terms in the Policy.

This Exhibit is issued as part of the Policy and Certificate to which it is attached effective February 1, 2007. It is subject to the terms and provisions of the Policy and Certificate, except as stated below:

The **Covered Vision Care Services and Supplies List** is amended to read as follows:

A. COVERED VISION CARE SERVICES AND SUPPLIES LIST

Covered Vision Care Services and Supplies are:

1. One comprehensive eye examination during any 12-month period;
2. One pair of any type of lenses during any 12-month period;
3. One frame during any 12-month period;

This Exhibit is effective on the effective date of the *Policy*, *Schedule of Benefits* and *Certificate* to which it is attached. This Exhibit terminates at the same time as the *Policy*, *Schedule of Benefits* and *Certificate* to which it is attached and is subject to all provisions, definitions, limitations and conditions of the *Policy*, *Schedule of Benefits* and *Certificate*. This Exhibit does not change, waive or extend any part of the *Policy*, *Schedule of Benefits* and *Certificate* other than as stated herein.

Signed for by PacifiCare Life and Health Insurance Company at our Home Office in Santa Ana, California.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY

Robert P. Pfotenhauer, President

POLICYHOLDER - City of Long Beach - Retirees

Signed by: _____

Title: City Manager

APPROVED AS TO FORM

July 6 20 07

ROBERT E. SHANNON, City Attorney

BY _____

Deputy City Attorney

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, INC.
3100 Lake Center Drive
Santa Ana, Ca. 92704

CERTIFICATE OF GROUP INSURANCE

Group Policy Number: **PL12362-V**

When a validation sticker (showing Your name, Your benefits and the effective date of those benefits) is attached to the inside front cover of this booklet, it becomes Your Certificate of Group Insurance. The Policy is issued by PacifiCare Life and Health Insurance Company, Inc., (the Company) to:

CITY OF LONG BEACH RETIREES

The benefits that apply to You and Your Dependents are described in this booklet and are subject to the terms of the Policy. If that Policy is changed in any way which affects Your insurance, riders describing those changes will be issued to You for You to attach to this booklet, or a new booklet will be issued to You to replace this one.

PacifiCare Life and Health Insurance Company, Inc.

Robert P. Pfotenhauer, President

PLEASE KEEP THIS BOOKLET IN A SAFE PLACE.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(PacifiCare Vision Plus Option)

VISION CARE COVERAGE – For you and your Covered Dependents

The Validation Sticker shows the Vision Care Maximums and any deductible amount that apply to You and to any Dependents You may have covered under the Policy. The Validation Sticker will either confirm the amount shown below or show the different amount that applies to Your coverage.

VISION CARE MAXIMUMS	Participating Provider	Non-Participating Provider
Examinations	100% of Covered Vision Care Charges	$ 55.00
Frames	$ 90.00	$ 50.00
Lenses (Basic – See Vision Definitions):		
Single Vision	100% of Covered Vision Care Charges	$ 35.00
Bifocal	100% of Covered Vision Care Charges	$ 50.00
Trifocal	100% of Covered Vision Care Charges	$ 75.00
Lenticular	100% of Covered Vision Care Charges	$130.00
Contact Lenses:		
When Medically Necessary	100% of Covered Vision Care Charges	$200.00
For Cosmetic Purposes	$100.00	$90.00
Lens Options	20% Retail Discount	Not Covered

If a covered Person incurs a Covered Vision Care Charge for one lens only, the Vision Care Coverage will not pay more than 50% of the maximum shown above for a pair of the lenses.

VISION CARE MATERIAL DEDUCTIBLE $0.00
The Vision Care Material Deductible applies to all Vision Care Covered Charges, except charges for examinations and refractive surgery.

VISION CARE COVERAGE

We will pay Vision Care Benefits for Covered Vision Charges as provided by the provision, limits and exclusions of this Vision Care Coverage. Terms with special meanings are capitalized in the text and defined in this Vision Care Coverage section and in the Definitions section of the Certificate.

VISION CARE BENEFIT

A vision Care Benefit is the amount of Covered Vision Care Charges incurred in excess of the Vision Care Material Deductible shown in the Schedule of Benefits.

Benefits payable under the Vision care Coverage may be reduced by the amount of benefits paid to, or on behalf of, a Covered Person because of coverage under another group benefit plan. See the section of the Certificate titled "If you Have Another Group Benefit Plan."

VISION CARE MATERIAL DEDUCTIBLE

The Vision Care Maximums and the services and supplies to that they apply are shown in the Vision Care Coverage section of the Schedule of Benefits.

VISION CARE MAXIMUMS

The Vision Care Maximums and the services and supplies to that they apply are shown in the Vision Care Coverage section of the Schedule of Benefits.

COVERED VISION CARE CHARGES

A Covered Vision Care Charged is a charge which meets all of the following tests:

1. The charge is incurred by a Covered Person while insured under the Vision Care Coverage;
2. The treatment, service or supply for which the charge is made is prescribed by a Provider acting within the lawful scope of his or her license;
3. The charge is made for an item shown in the Covered Vision Care Services and supplies List;
4. The charges is for a treatment, service or supply that is not excluded by the exclusions of the Vision Care Coverage or otherwise by the Policy;
5. The charge is determined to be (a) the negotiated fee if it is made by a Participating Provider, or (b) is the usual and customer amount if it is made by a Non-Participating Provider; and
6. The charge is not more than any limit that applies to the charge;

COVERED VISION CARE SERVICES AND SUPPLIES LIST

Covered Vision Care Services and Supplies are:

1. One comprehensive eye examination during any 12-month period;
2. One pair of lenses during any 24-month period, except that if a Change in Prescription is indicated by the examination that gives rise to the prescription order, one pair of lenses is covered during any 12-month period;
3. One frame during any 24-month period;
4. One pair of contact lenses during any 12-month period that are Medically Necessary;
   a. Following cataract surgery;
   b. For anisometropia;
   c. For keratoconus;
   d. When visual acuity cannot be corrected to 20/70 in the better eye with conventional lenses;
5. One Pair of contact lenses during any 12-month period that are for cosmetic purposes or for convenience when provided in place of other eye wear during the periods such other eye wear would be covered.

VISION CARE COVERAGE (cont'd.)

VISION CARE EXCLUSIONS

No benefits under the Policy are payable for, and Covered Vision Care Charges do not include:

1. A lens when no Change in Prescription is indicated by the examination giving rise to the prescription order;
2. Services and materials in connection with special procedures such as orthotics, vision training or subnormal vision aids;
3. Non-prescription (plano) lens;
4. Replacement or repair or lost, stolen or broken lenses or frames, except at the intervals specified above for any other lenses or frames;
5. Services or supplies obtained through, or required by, any government agency or program, whether Federal or State, or a subdivision thereof;
6. Services or supplies for which the enrolled person may be entitled to benefits under any workers' compensation law;
7. Charges for which the Insured is not required to pay;
8. Any lens or lens style or feature not specifically listed in the Vision Care Coverage description or the Schedule of Benefits;
9. Drugs or any other medication;
10. Duplicate eyeglasses, lenses or frames;
11. Contact lenses provided in addition to eyeglasses; or
12. Services begun, or supplies provided, prior to the Insured's effective date of coverage or after the Vision Care Coverage has terminated;.
13. Medical or surgical treatment of the eyes; or
14. Any service or material provided by another group benefit plan.

VISION CARE DEFINITIONS

The following words and phrases when capitalized in the text of this Certificate have the meanings shown below. Other words and phrases that have special meanings are defined in the General Definitions section of the Certificate and as they are used in the description of the Vision Care Coverage.

"Change in Prescription" means any of the following: (a) a change in prescription of 0.50 diopter or more in one or both eyes; (b) a shift in axis of astigmatism of 15°; or (c) a difference in vertical prism greater than 1 prism diopter.

"Medically Necessary" means those services and supplies that are: (a) required to treat an injury or sickness in a manner consistent with the diagnosis and treatment of the Covered Person's condition; (b) in accordance with the standards of good medical proactive; (c) not for the convenience of the Covered Person or the Provider; (d) performed or provided as the most appropriate level of care as determined by the Covered Person's medical condition.

" Non-Participating Provider" means a Provider who has contracted with the Company or the Company's designated provider organization to provide services, treatment and supplies to a Covered Person at a negotiated fee.

"Participating Provider" means a Provider who has contracted with the Company or the Company's designated provider organization to provide services, treatment and supplies to a Covered Person at a negotiated fee.

"Provider" means a licensed physician, ophthalmologist, optometrist or optician practicing within the lawful scope of his or her license.

"Usual and Customary Charge" means the lesser of:

a. Provider's usual charge for furnishing treatment, service or a supply; or
b. The charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area for a condition of comparable nature and severity.

IF YOU HAVE ANOTHER GROUP BENEFIT PLAN

1. COORDINATION OF BENEFITS (COB). All the Benefits provided under this Plan are subject to these COB provisions.

   If the Company has paid benefits under this Plan and if benefits with respect to the same expenses are also payable under another Plan, the Company may recover from the Covered Person or from such other Plan an amount equal to the benefits it has so paid.

2. DEFINITIONS. In addition to the Definitions of this Plan, the following definitions apply to this section:

   a. A "Plan" means any group insurance coverage, prepayment plan, coverage under union welfare plan, other plan growing out of Employer/employee relationship, and other statutory plan.

   b. "Allowable Expense" means any usual and customary item of expense at least a portion of which is covered by one or more Plans (s) covering the Covered Person. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and benefit paid.

3. NON-DUPLICATION.

   a. Workers' Compensation. The benefits under this Plan are not designed to duplicate any Benefit to which the Covered Person is entitled under Worker's Compensation insurance laws. Charges for services arising out of job related injuries are not covered under this Plan. In the event services are provided, all sums payable to, and retained by the Company. Each Covered Person shall complete and submit to the Company such consents, releases, assignments and other documents reasonably requested by the Company in order to obtain or assure such reimbursement.

   b. Other Plans. If any benefits to which a Covered Person is entitled under this Plan are also covered by any other Plan, the benefits payable shall be coordinated with the benefits that are available to the Covered Person under such other Plan, whether or not a claim is made for the same.

4. ORDERS OF BENEFIT DETERMINATION. The order of Benefit determination between this Plan and any other Plan covering the Covered Person on whose behalf a claim is made is established as follows.

   a. Whenever a Plan does not contain a Coordination of Benefits clauses, the Plan which pays first is the primary Plan must pay its benefits before the secondary Plan pays.

   b. When two or more Plans contain Coordination of Benefits clauses, the Plan which pays first is the primary Plan. The Plan that pays additional benefits for Allowable Expenses not covered by the primary Plan, but not to exceed 100% of total Allowable Expenses, is the secondary Plan. The sequence of Payments is as follows:

      1) The Plan covering the Covered Person as an employee pays before the Plan covering the Covered Person as a Dependent.

      2) The benefits of a Plan which covers a Covered Person as a Dependent of a person whose date of birth, excluding year of birth occurs earlier in a Calendar year, shall be determined before the benefits of any other Plan which covers such Covered Person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year.

         If either Plan does not coordinate benefits in the same manner as in this Subparagraph 2 regarding Dependents, and as a result each Plan determines its benefits before the other or each Plan determines it's benefits after the other, the rule set forth in the Plan which does not have this provision of this Subparagraph 2 shall determine the order of benefits.

3) If the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of a parent without custody.

4) If the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the step-parent, and the benefits of a Plan which covers that child as the Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as the Dependent of the parent without custody.

5) Notwithstanding Subparagraphs (3) and (4) above, if there is a court decree which would otherwise establish financial responsibility for the expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child. It is Your obligation to notify the Company and, upon the Company's request, to provide a copy of such court decree.

6) When the foregoing rules do not establish an order of Benefit determination, the benefits of a Plan which has covered the Covered Person for the longer period of time shall be determined before the benefits of a Plan which has covered the Covered Person the shorter period of time except that:

a) The benefits of a Plan covering the Covered Person as a laid-off or retired employee, or Dependent of such Covered Person, shall be determined after the benefits of any other Plan covering such person as an active employee, other than a laid-off or retired employee, or Dependent of such person; and

b) If either Plan does not have a provision regarding laid-off or retired employees, and, as a result, each Plan determines its benefits after the other, then the provisions of this Subparagraph (6) do not apply.

7) The primary Plan Calculates its benefits as though duplicate coverage did not exist. The other Plans will then reimburse for all Allowable Expenses not covered by the other Plan, provided this amount does not exceed the benefits payable under the Plan in the absence of duplicate coverage.

5. NO INCREASE IN BENEFITS. Benefits under this Plan will not be increased by virtue of these provisions.

6. INFORMATION TO BE FURNISHED. Any covered Person claiming benefits under this provision must furnish to the Company all information necessary by the Company to implement this provision.

7. RIGHT TO RECEIVE AND RELEASE INFORMATION. For the purposes of determining the applicability and implementing the terms of the provision of this Plan or any provision of similar purpose of any other Plan, the Company may, without the consent of or notice to any other person, release to or obtain from any other insurance company or other organization or person any information if permitted by law, with respect to any person, which the Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish the Company such information as may be necessary to determine the benefits payable or coverage to be provided under this Plan.

8. PAYMENT TO CERTAIN ORGANIZATIONS. Whenever payment which would otherwise have been made under this Plan in accordance with this provision have been made under any other Plans, the company shall have the right, exercisable alone and in its sole discretion, to determine whether or not to pay to any organization making such request, and to determine the amount of such payment, to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent such payment, the Company shall be fully discharged from liability under this Plan.

IF YOU HAVE ANOTHER GROUP BENEFIT PLAN (cont'd.)

9. RIGHT OF RECOVERY. Whenever payments have been made by the Company in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Company shall determine: any persons to, or for,, or with respect to whom such payments were made by any insurance company, person, firm, Health Maintenance Organization or other involved organization.

10. GOVERNMENT PROGRAMS. The benefits under this Plan are not designed to duplicate any benefits to which Covered Persons are, or would be, entitled under government programs for which they are eligible, including Medicare. All sums payable under such programs for services covered by this Plan shall be payable to, and retained by the Company. Each Covered Person shall submit to the Company such consents, releases, assignments, and other documents as may be requested by the Company in order to obtain or assure reimbursement under government programs for which Covered Persons are eligible.

11. THIRD PARTY REFUND. When a Covered Person is injured or becomes ill through the act or omission of another person (the "Third Party") and benefits are paid under the Policy as a result of injury or illness, the Company is entitled to a refund by the Insured Employee of all Policy benefits paid as a result of the injury or illness. The refund must be made to the extent that the Insured Employee received payment for the injured from the Third Party, or that party's insurance carrier. The Company may file a lien against the Third Party payment. To enforce this lien, the Insured Employee must complete and send any required forms to the Company upon request.

HOW TO FILE A CLAIM

A Covered Person may choose to go any ophthalmologist, optometrist or optician. Participating Provider benefits, however, are available **only** from a Provider listed in the Vision PPO Provider Directory.

WHEN YOU VISIT A PARTICIPATING PROVIDER LISTED IN THE VISION PPO PROVIDER DIRECTORY

1. Complete the personal information in the first section of the claim form before Your visit to the Participating Provider. A claim form was included with your I.D. card. If You do not have a claim form, contact PacifiCare Vision Member Services department at 1-800622-6388 and one will be sent to You.

2. Give the Participating Provider the claim form.

3. The Participating Provider will complete the remainder of the claim form and forward it to the Administrator for processing.

4. The amount of Covered Vision Care Charges will be determined in accordance with the Schedule of Benefits and the other terms of the certificate.

5. The Insured will be responsible for satisfying and Vision Care Material Deductible, any copayments and any amounts that are not determined to be Covered Vision Care Charges.

WHEN YOU VISIT A NON-PARTICIPATING PROVIDER

1. Complete the personal information in the first section of the claim form before Your visit to the Non-Participating Provider of Your choice. A claim form was included with Your ID card. If you do not have a claim form, contact PacifiCare Vision Member Services department at 1-800-622-6388 and one will be sent to you.

2. Give the Provider the claim form.

HOW TO FILE A CLAIM (cont'd.)

3. Once the services have been completed and materials delivered, the Covered Person or his or her Provider should return the claim form, with the appropriate signatures, indicating the date(s) services and materials were rendered. The claim form should be mailed to:

MEDICAL EYE SERVICES
POST OFFICE BOX 93033
LONG BEACH, CALIFORNIA 92781

4. A check will be sent to the Insured Employee or, if the benefits have been assigned, to the Provider for the appropriate amount. Covered Vision Care Benefits will be determined as follows:

   a. The amount of the Covered Vision Care Charges will be determined in accordance with the Schedule of Benefits section and the other terms of the certificate.

   b. Any applicable deductible and copayment amounts that have not been satisfied will be subtracted from the Covered Vision Care Charges.

   c. The scheduled maximums will be applied to the submitted claim.

   d. The resulting amount, to the extent that it does not exceed the scheduled maximums, will be the Covered Vision Care Benefits for the services performed. Any amounts that are determined not to be Covered Vision Care Charges are payable by the Covered Person to the Provider.

5. For claims information, please call 1-800-877-6372.

Claim Forms: You must give Us written notice of Your claim within 20 days after the services were performed or as soon as it is reasonably possible. We will furnish You with forms for submitting proof of services performed ("proof of loss") within 15 days after we receive notice of Your claim. If such forms are not furnished, You will still meet the "proof of loss" requirement by submitting written proof covering the extent of the loss, its character and when it happened.

Proof of Loss: You must give Us written proof of vision services performed ("proof of loss") within 90 days after the services were performed, or after the end of each benefit period for which insurance benefits are, i reasonable possible, but not later than one year after the end of the 90-day period, except in the absence of legal capacity.

Right to receive and Release Necessary Information: For the purposes of making claims payments, the Company may, with the consent of the affected person, as may be necessary, release to or obtain from any insurance company, organization or person any information, with respect to any person, which this Company considers necessary for such purposes. Any person claiming benefits under the Policy shall furnish to this Company the information as may be necessary to implement this provision.

Payment of Claims: When we receive Your completed claim form, Your claim will be paid within 30 days, unless periodic payments are specified. They will be paid as they accrue and at least once a month.

Assignment: No assignment of the Policy, nor any rights or benefits under the Policy, shall be valid unless We have consented to tit in writing, except for assignment of benefits payable under this insurance coverage for covered charges.

Benefits Exempt from Attachment: To the full extent permitted by law, all rights and benefits under the Policy are exempt from execution, attachment, garnishment or other legal or equitable process, for the debts or liabilities of any Insured Employee.

HOW TO FILE A CLAIM (cont'd.)

Examination: The Company, at its own expense, will have the right and opportunity to have a covered person examined as often as reasonable necessary while a claim is pending. This right may be used as often as it is reasonably required.

WHEN YOUR BENEFITS BEGIN

Your Benefits will begin on the 1st day of the month after both of the following conditions are met:

1. You have enrolled for coverage; and

2. We have received the required monthly payment for your coverage.

WHO IS ELIGIBLE TO RECEIVE BENEFITS UNDER THIS BENEFIT PLAN?

1. You are eligible for coverage if You are Actively Employed by a Covered Employer and satisfy the eligibility requirements established by that employer, including the completion of any probationary or waiting period.

2. Your Dependents eligible for coverage are: (a) Your spouse and (b) each of Your children under the age of 19 years who is unmarried and chiefly Dependent upon You for support. If a student verification form is submitted, eligibility can be extended for a full-time, unmarried student to the day preceding his or her 25th birthday.

3. Your eligible Dependents will also include newborn infants. Coverage for such an infant will begin at the moment of birth. Adopted and foster children will be covered from the date any such child is placed in Your physical custody.

   Coverage of a Dependent child will not end at age 19 if:

   a. The child cannot hold a job because of a mental or physical handicap, as defined by the applicable state law; and

   b. The child is chiefly Dependent upon You for support and maintenance.

   You must give us proof of this within 31 days of the time the child reaches the age of 19 and every two years after that. We must, of course, receive the correct monthly payment to continue providing Benefits.

4. No person may be covered as a Dependent if he or she is eligible for coverage as an Employee. No person may be covered as the Dependent of more than one Employee.

5. Eligible Dependents may be added at the time of enrollment or during the Employer's annual open enrollment period. Dependents may not be deleted until the annual open enrollment period unless they become ineligible under the terms of the Policy. Eligible Dependents may be added when a qualifying event (such as marriage or birth) takes place. You must give us proof of this qualifying event within 31 days.

6. It Is YOUR responsibility to keep us advised of changes that affect each Dependent's status.

WHEN YOUR BENEFITS END

1. If You leave the Covered Employer or a class of persons eligible for coverage or You quit or lose Your job, Your benefits will continue through the last day of the month in which that happens.

2. Benefits will end of the last day of the month for which the last monthly payment was received by us except as otherwise provided in this Certificate.

3. We can terminate the coverage under the Policy of a Covered Employer's Insured Employees and their covered Dependents upon 31 days' written notice, if the required monthly payment for such coverage has not been paid.

4. A Covered Employer is responsible for making the monthly payments for coverage up to the date benefits end for employees and Dependents who are Covered Persons under the Policy. If We receive all of the money the owed us, We will reinstate coverage for those Covered Persons, as long as the Monthly Payment is no more than 60 days past due. However, We will not reinstate coverage for such Covered Persons:

   a. If We do not receive payment within those 60 days. In that case, a Covered Employer must apply anew for coverage under the Policy. Or

   b. If We receive payment more than 31 days after the termination notice and refund that money to the Covered Employer within 20 business days after giving that notice; OR

   c. If We receive payment more than 31 days after the termination notice and, in return for that payment, We issue new coverage to the Employer, clearly showing any differences between the new and the canceled coverage.

5. We reserve the right to cancel Our Policy with the Policyholder if it has been in effect as least 12 months from its effective date and We give at least 20 days' advance written notice.

IF YOU LOSE YOUR ELIGIBILITY FOR THIS BENEFIT PLAN

1. If a Covered Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if You cease to be eligible for the group coverage provided under the Policy, You may elect to continue such coverage as provided by COBRA. If Your employer provides a plan of group medical care coverage in addition to the group coverage provided under the Policy and You are covered under that plan, You must elect to continue that group medical care coverage in order to continue this group coverage. You should ask Your employer for more information on this subject.

2. If Your group coverage under this Policy is subject to COBRA, as described above, anyone of Your Dependents who ceases to be eligible for such coverage because of Your death, divorce, legal separation, or reaching the limiting age provided in the Policy may also be entitled to continue this group coverage in accordance with COBRA. You or that Dependent should ask Your employer for more information on this subject.

EXTENDED BENEFITS

If a person's insurance under the Policy ends, other than for payment of the maximum benefit, before completing a course of treatment that was begun while that person was insured, the insurance for the incomplete treatment only will be extended until the first to occur of the dates that follow:

1. The date insurance begins under another group plan that pays benefits for the treatment in progress.

2. The expiration date of the three-months period that begins on the date the insurance would otherwise end.

This Extended Benefits provision will not apply if the insurance ends because of non-payment of the required premiums.

PROVISIONS REQUIRED BY LAW

Worker's Compensation: The Policy is not in lieu of, and does not affect any requirement for coverage by workers' compensation insurance.

Misstatement of Facts: If relevant information about any Insured Employee is not accurate, the facts will decide whether and in what amount, insurance is valid under the Policy, and if any adjustment of premium will be made.

Changes in the Entire Contract: The Policy (with the group application and any individual applications) make up the entire contract. In the absence of fraud, all statements made by the Covered Employer or by any Insured Employee shall be deemed representations and not warranties. No statement made for the purpose of effective insurance shall avoid insurance or reduce benefits unless contained in a written instrument signed by the Covered Employer or Insured Employee and a copy of the document has been furnished to the Company and/or the Insured Employee.

No agent nor other individual, except the President or Secretary of the Company, can approve a change to the Policy or extend the time for payment of premium. No change will be valid unless it is made by an endorsement to the Policy, or by an amendment signed by the Policyholder and the President or Secretary of the Company. Any change made will be binding on each person insured and on any other individual(s) referred to in the Policy.

Conformity with State Statute: Any provision of the Policy which, on its effective date, is in conflict with the state laws in which the Policy was issued or delivered, is hereby amended to meet the minimum requirements of the law.

Grace Period: After payment of the first premium, We will allow the Policyholder a Grace Period of thirty-one (31) days, following a premium due date, to pay subsequent premiums. During this Grace Period, the Policy will remain in force. The Policyholder will be liable for payment of premium for the period the Policy continues in force.

Age: When an insured's age has been misstated, the Company will provide the amount of insurance for the correct age. A premium adjustment may be made so that the Company will receive the correct premium for the true age.

New Entrants: A Covered Employer may add from time to time, eligible new employees and Dependents as the case may be, in accordance with the enrollment and eligibility sections of the Policy.

Time Limit on Certain Defenses: A claim shall not be denied nor shall the validity of insurance be contested because of any statement with respect to insurability made by the Insured Employee while eligible for coverage under the Policy, if:

1. the insurance has been in force for at least two years before any such contest; and

2. the Insured Employee, with respect to whom any such statement was made, was alive during such two years.

PROVISIONS REQUIRED BY LAW (cont'd.)

Discharge of Liability: Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

Legal Action: No legal action will be brought to recover benefits under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished. No such action will be brought after the expiration of three (3) years following the time written proof of loss is required to be furnished.

Recovery of Payments: The Company reserves the right to deduct from any benefits properly payable under this Policy the amount of any payment which has been made:

1. in error;

2. pursuant to a misstatement contained in a proof of loss;

3. pursuant to a misstatement made to obtain coverage under this Policy within two (2) years after the date such coverage commences;

4. with respect to an ineligible person;

5. Pursuant to a claim for which benefits are recoverable under any policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Company to pay benefits under this policy in any such instance.

Such deduction may be made against any claim for benefits under this Policy by an Insured Employee or by any of this or her covered Dependents is such payment is made with respect to such insured person or any person covered or asserting coverage as a Dependent of such Insured Employee.

DEFINITIONS

The following words and phrases have the meanings shown below when those words and phrases appear capitalized in the text of the Certificate. Other words and phrases that have special meanings are defined in the description of the benefit coverage.

"Actively Employed" means that, in accordance with Your Employer's eligibility rules, You are working on a scheduled workday in performance of the regular duties of the Employer's business. On a day this is not a scheduled workday, You will be considered Actively Employed on the last preceding scheduled workday.

"Administrator" means the organization named at the beginning of booklet that, among other duties, is responsible for paying the claims for benefits.

DEFINITIONS (cont'd.)

"Calendar Year" means a period beginning January 1st and ending on December 31st each year.

"Company" means PacifiCare Life and Health Insurance Company, Inc.

"Covered Employer" means the Policyholder. When the Policy issued to trustees of a trust fund established to provide benefits to employees of employers that have agreed to subscribe to the trust and have been reported in writing to the Administrator as participating employers, ":Covered Employer" shall include such participating employers. "Covered Employer" also includes a Covered Employer's affiliates and subsidiaries that have been reported in writing to the Administrator as having employees covered under the Policy.

"Covered Person" means the Policyholder. When the Policy is issued to trustees of a trust fund established to provide benefits to employee's Dependents who are covered under the Policy.

"Dependent" means the legal spouse and Dependent children of an Employee who satisfy the eligibility requirements as described in the section entitled "who is Eligible to Receive Benefits".

"Employee" means a person who meets the eligibility rules set by the Employer.

"Exclusion" means any service or supply for which no benefits are provided under the Policy, including, but not limited to, those items listed in any exclusions or limitations sections of the Policy.

"Insured or Insured Employee" means an eligible Employee who is actually enrolled as an insured person.

"Policy" means the agreement between the Company, and the Policyholder, including any addenda and Riders, as well as the Application by the Policyholder and Applications by any individual Insured Employee.

"Policyholder" means the organization or entity that has executed an application for the Policy and to whom the Policy has been issued.}

"Our", "We" or "Us" means PacifiCare Life and Health Insurance Company, Inc., or the Administrator acting on behalf of the Company.

"You" or "Your" means an Insured Employee.

PacifiCare
SignatureOptions℠
A choice of providers and price

BENEFIT SUMMARY

Your vision is an important part of your overall good health. Here's a plan to help you give your eyes the care they deserve. The PacifiCare SignatureOptions (PPO) Vision 490 Plan.

Vision 490

CALIFORNIA

Vision care made easy.

When we receive your enrollment form, we'll send you a vision ID card and a claim form. A list of participating providers is available online at **www.pacificare-vision.com.** Or call member service at 1-800-228-3384 to find a participating provider near you. Additional claim forms are available online.

Just choose your vision provider and make an appointment. The provider will verify your eligibility. Be sure to take your claim form with you.

If you visit a participating provider, leave your claim form with the provider and it will be filed for you. If you visit a non-participating provider, make sure the provider completes the claim form; then you send it to the address printed on the form.

Vision care made affordable.

The Schedule of Benefits listed below describes your different options. As you can see, if you choose a participating provider, you can get your eye exam and lenses at no charge after deductible. Frame choice is up to you, and any additional charges for designer frames and lens options are noted.

Visit any provider in your state.

Choose a participating provider for the greatest savings, or choose a provider outside our network. Our large network of providers means there's one conveniently located near you. Or if you prefer a participating provider for your eye exam and a non-participating provider for eyewear selection (or vice versa), you're still covered.

The Schedule of Benefits below is a part of the Certificate of Coverage. Please keep this sheet with the Certificate of Coverage booklet. Please see Certificate of Coverage booklet for plan details.

Schedule of Benefits	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Limiting Age for Dependent Children	until 19; or 25 if full-time student (your plan may vary; see Group Administrator for details)	until 19; or 25 if full-time student (your plan may vary; see Group Administrator for details)
COMPREHENSIVE EYE EXAMINATION	**One exam during any 12-month period.**	**One exam during any 12-month period.**
Exam	No Charge to Covered Person	$55 Covered Person Allowance
SPECTACLE LENSES	**One pair of any type lenses during any 12-month period.**	**One pair of any type lenses during any 12-month period.**
Single Vision	No Charge to Covered Person	$35 Covered Person Allowance
Bifocal	No Charge to Covered Person	$50 Covered Person Allowance
Trifocal	No Charge to Covered Person	$75 Covered Person Allowance
Lenticular (Aspheric SV and BF)	No Charge to Covered Person	$130 Covered Person Allowance
FRAMES	**One set of frames during any 12-month period.**	**One set of frames during any 12-month period.**
Retail Frames	$90 Covered Person Allowance	$50 Covered Person Allowance
CONTACT LENSES (Materials & Fitting)*	**One pair of contact lenses during any 12-month period when provided in lieu of other eyewear.**	**One pair of contact lenses during any 12-month. period when provided in lieu of other eyewear.**
Medically Necessary*	No Charge to Covered Person	$200 Covered Person Allowance
For Cosmetic Purposes	$100 Covered Person Allowance	$90 Covered Person Allowance
LENS OPTIONS		
Glass Tints, Solid Color: Pink or Rose #1 or #2	No Charge to Covered Person	Member pays all costs above the plan lens allowance.
All Other Lens Options	20% retail discount	Member pays all costs above the plan lens allowance.
MATERIAL DEDUCTIBLE (Per Covered Person)	**$0**	**$0**

**All Charges for contact lens fitting, prescription and materials are applied toward the Covered Person's contact lens allowance. Contact lenses are considered Medically Necessary following cataract surgery; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus or Anisometropia; or for certain conditions of Myopia, Hyperopia or Astigmatism. A report from the provider and approval from Medical Eye Services is required.*

Underwritten by PacifiCare Life and Health Insurance Company.

PDV-904-70288
PDVCA1226-001