



**VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
CLIENT VISION CARE POLICY**

Client Name **ADP TOTAL SOURCE**
Policy Number **12338432**
State of Delivery **FLORIDA**
Effective Date **JUNE 1, 2022**
Policy Period **SIXTY (60) MONTHS**

In consideration of the statements and agreements contained in the Client Application, if applicable, and in consideration of payment by the Client of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Client Vision Care Policy ("Policy") for the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Policy.

A handwritten signature in black ink, appearing to read "Kate Renwick-Espinosa", is written over a horizontal line.

Kate Renwick-Espinosa, President

**VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY
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I.

TERM, RENEWAL AND TERMINATION

1.01. Term: This Policy shall commence on the Effective Date noted on the front page of this Policy, and shall remain in effect for the Policy Period, also noted on the front page of this Policy.

1.02. Renewal:

(a) VSP shall issue written renewal notice to Client at least sixty (60) days before the end of the Policy Period. If Client fails to accept the renewal terms and/or rates in writing prior to the end of the Policy Period, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Period.

(b) If Client wishes to renew the Policy but acceptance of the renewal cannot be formalized before the end of the Policy Period, or if the parties continue to negotiate renewal terms after the Policy Period, Client may submit a written request to have the Policy renew on a temporary month- to- month basis under the expired contract terms, not to exceed six months, until Client's acceptance of the renewal is formalized in writing and a new Policy is issued. Once renewal is accepted, VSP reserves the right to bill Client retroactively at the renewal premium for the temporary month-to-month renewal period. During the temporary month to month period, either party may terminate the Policy by providing thirty (30) days advance written notice to other party.

1.03. Termination:

(a) This Policy may be terminated by either the Client or VSP upon expiration of a Policy Period as set forth in paragraph 1.02.

(b) This Policy may also be terminated by VSP.

(i) Upon 10 (ten) days prior written notice if Client fails to pay premiums by the dates defined in paragraph 3.04.

(ii) Upon 45 (forty-five) days prior written notice if Client fails to report a material change in accordance with paragraph 3.03.

(c) If Client terminates this Policy as of any date other than the end of the Policy Period, such termination will be treated by VSP as a breach by Client.

(d) If this Policy is terminated under paragraph 1.03(b) or (c), coverage is terminated and VSP is released from all obligations of this Policy, effective as of the termination date (except for preexisting obligations specifically set forth in Section 1.03 (e), below).

(e) If this Policy is terminated for any cause as stated in this section 1.03, VSP is not required to pay for services provided after such termination date, except for any outstanding, unexpired benefit that is authorized before termination, or any other claim obligations that arose prior to termination.

II.

OBLIGATIONS OF VSP

2.01. Coverage of Covered Person: VSP will enroll for coverage, as directed by Client, each eligible Enrollee and his/her Eligible Dependents (if dependent coverage is provided), all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Client to complete, sign and forward to VSP a Client Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums.

Following the enrollment of the Covered Persons, VSP will provide Client with an Evidence of Coverage for distribution to Covered Persons by Client. Such Evidence of Coverage and Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

2.02. Administration of Plan Benefits: Through VSP Preferred Providers (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from, an Open Access Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A(s)) and when purchased by Client, the Additional Benefit Rider (Schedule C(s)) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. VSP Preferred Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials. Notwithstanding any other provision, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits, and when purchased by Client, the Additional Benefit Rider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Preferred Provider for information describing vision care services and vision care materials offered.

A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from a VSP Preferred Provider. When a Covered Person seeks Plan Benefits from a VSP Preferred Provider, the Covered Person must schedule an appointment and identify himself/herself as a VSP Covered Person so the VSP Preferred Provider can obtain a Benefit Authorization from VSP. VSP shall provide a Benefit Authorization to the VSP Preferred Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Client and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the VSP Preferred Provider that payment will be made.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days by providing notice to the claimant of the reasons for the extension.

2.03. Open Access Provider Services: When Covered Persons elect to utilize the services of an Open Access Provider, benefit payments for services from such Open Access Provider will be determined according to the Plan's Open Access Provider benefit fee schedule if Open Access Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Open Access Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of VSP's Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Open Access Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Open Access Provider reimbursement schedule shown on the attached Schedule of Benefits (Exhibit A (s)) and Additional Benefit Rider (Schedule C(s)) (if purchased by Client), less any applicable Copayments.

2.04. Information to Covered Persons: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and instructions for use. A copy of this Policy shall be provided to Client and will be made available at the offices of VSP for any Covered Persons. Covered Persons may obtain information on VSP's Preferred Providers through VSP's website at www.vsp.com, VSP's Customer Care toll-free number (1-800-877-7195), or by written request. If Client supplies email addresses of Covered Persons to VSP, VSP may use the email addresses to communicate information to Covered Persons about their vision benefits.

2.05. Confidentiality and Non-Disclosure Agreements VSP and Client have delivered, or will deliver, upon execution and delivery of this Policy, certain information about the properties and operations of their respective businesses. VSP and Client, therefore, agree as follows:

a) Definition of Confidential Information. For purposes of this Policy, "Confidential Information" means any data and/or information, in any form, disclosed by the disclosing Party ("Discloser") to the receiving Party ("Recipient") either before or after the Effective Date, which relates to Discloser and/or its Affiliates, and solely by way of illustration and not in limitation shall include the following information: (i) current or future product(s), services, methodologies, plans, designs, costs, prices, customer or doctor names and addresses, finances or financial information (including budgets), marketing plans or strategies (including e-commerce development plans), business plans, matters, opportunities or offerings, equipment and other purchase matters, strategic matters, research, development, know-how and/or personnel, (ii) is

identified as confidential at the time of disclosure, (iii) given the nature of the information disclosed and the circumstances surrounding its disclosure, reasonably ought to be treated as Confidential Information by a person in the same industry as Discloser, or (iv) by law must be protected as Confidential Information. Recipient acknowledges that the Confidential Information is proprietary to Discloser and has been developed and obtained through great efforts by Discloser. Confidential Information shall not, however, include information that (A) at the time of disclosure is, or subsequently becomes, available to the public or the industry through no fault or breach on the part of Recipient; (B) Recipient can demonstrate to have had rightfully in its possession prior to disclosure by Discloser; (C) is independently developed by Recipient without the use of any Confidential Information; or (D) Recipient rightfully obtains from a third party who has the right to transfer or disclose it. Confidential Information shall also be deemed to include any and all confidential information defined as Confidential Matters hereunder, the treatment of which shall be as set forth in Paragraph 2.05 of this Policy.

b) Non-Disclosure and Non-Use of Confidential Information. Recipient shall not, directly or indirectly, without the prior written approval of Discloser in each instance or unless otherwise expressly permitted herein, use for its own benefit, publish or otherwise disclose to others, or authorize the use by others for their benefit, or to the detriment of Discloser, any of Discloser's Confidential Information. Recipient shall carefully restrict access to Discloser's Confidential Information to only those of its and its Affiliates' officers, directors, employees, agents and representatives (collectively, "Representatives") who (i) clearly require such access in order to enable to perform their respective obligations under this Policy (ii) who are bound by confidentiality obligations that protect third party information which are at least as restrictive and protective as those contained in this Policy, and (iii) are not (or do not work for) direct competitors of Discloser. Recipient shall not use, copy, distribute and/or remove any of Discloser's Confidential Information from Recipient's premises except to the extent necessary or appropriate to carry out its respective obligations under the Policy, without the prior consent of Discloser. Recipient and its Representatives will employ all security measures used for their own proprietary information of similar nature but in no event using less than a reasonable degree of care. Recipient agrees to advise and require its Representatives of their obligations to keep such information confidential and shall each be liable for any acts and omissions of their Representatives related thereto.

c) Return or Destruction of Confidential Information. The Receiving Party, including its Personnel, its employees and/or agents shall upon request of Discloser (i) immediately return to Discloser's designated representative any and all documents or other information and materials in whatever form which contain Discloser's Confidential Information, or as permitted by Discloser, (ii) destroy all copies thereof, and certify to Discloser in writing that all copies of such documents or other information and materials have been destroyed; provided, however, that the Receiving Party may retain one set of

such documents and other information and materials for archival purposes only, subject to the continuing confidentiality and security obligations set forth under this Policy. Recipient may disclose Discloser's Confidential Information if and to the extent required by a judicial or governmental request, requirement or order; provided that Recipient will take reasonable steps to give

Discloser sufficient prior notice (to the extent that sufficient time is available) of such request, requirement or order for Discloser to contest, limit and/or protect such disclosure.

d) Injunctive Relief. The Parties understand and acknowledge that any disclosure or misappropriation of any Confidential Information in violation of this Policy may cause irreparable harm, for which monetary damages alone may not be an adequate remedy and, therefore, agrees that Discloser shall have the right to apply to a court of competent jurisdiction for an order immediately restraining any such further disclosure or misappropriation and for other equitable relief, without objection and without the requirement of posting a bond or other form of security. Such right of each Party is in addition to the remedies otherwise available under this Policy or otherwise at law or equity.

e) Survival: The obligations laid down in this Section 2.05 shall continue and survive beyond the termination of this Policy.

2.06. Urgent Vision Care: When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider, if Open Access benefits are available. Services for conditions of a medical nature are covered by VSP only under supplemental eyecare plans. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider (Schedule C). If Client has not purchased one of these plans, Covered Persons are not covered by VSP for such services and should contact a physician under Covered Persons' medical insurance plan for care.

For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person should call VSP's Customer Care toll-free number (1-800-877-7195) for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

2.07. Coordination of Benefits: Unless otherwise agreed to by Client and VSP, the following rules governing coordination of benefits shall apply. When VSP is the primary insurer, it will pay benefits according to the terms of this Policy, subject to any applicable state or federal codes, statutes or regulations. When VSP is the secondary insurer, it will coordinate those vision care services and materials that were considered by the primary insurer as allowable expenses. VSP will pay the lesser of:

- a) The normal Plan Benefit, in the absence of other coverage, or
- b) The remaining balance up to Covered Person's Plan Benefits, not to exceed the billed amount.

2.08. Time of Payment of Claims: Benefits for any loss covered by this Policy will be paid as soon as VSP receives proper written proof.

III.

OBLIGATIONS OF CLIENT

3.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified by the Client, and in accordance with applicable state and federal law. Client shall provide VSP with required eligibility information, in a mutually agreed upon timeframe, format and medium, to identify all Enrollees who are eligible for coverage under this Policy.

3.02. Retroactive Eligibility Terminations: Retroactive eligibility changes are limited to the month in which notification is received by VSP, plus two prior months. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

3.03. Change of Client Composition: Client's percentage of Enrollees covered under the Policy as well as Client's contribution and eligibility requirements are factors used to determine rates and are considered material to VSP's obligations under this Policy. During the term of this Policy and in accordance with section 1.03, Client must provide VSP with written notification of any changes that will significantly impact utilization of the benefits and such changes must be agreed upon by VSP. Nothing in this section shall limit Client's ability to add Enrollees or Eligible Dependents under the terms of this Policy. For purposes of this paragraph, Client may not reduce membership by more than fifty percent (50%) over a twenty-four (24) month period without VSP's written consent.

3.04. Payment of Premiums: Upon receipt of VSP's billing statement, Client shall remit to VSP the premiums as set forth in Exhibit B. The premiums set forth in Exhibit B shall remain in effect for the term of this Policy unless the Client requests a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Client), or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by VSP. Client premium payments are due upon receipt of VSP's billing statement and shall become delinquent after thirty-one (31) days. If the premium payment remains unpaid the coverage may be cancelled and the Client will be responsible for payment for all Plan Benefits provided to Covered Persons. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

3.05. Distribution of Required Materials: Client shall provide to Enrollees any materials required by any regulatory authority, within the timeframe required under applicable law.

3.06. Communication Materials: Communication materials created by Client which relate to this Vision Care Policy may be submitted to VSP for review and approval. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Client's materials meet any applicable legal or regulatory requirements including, but not limited to, ERISA requirements. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

3.07. Converting to an Administrative Services Program In the event Client wishes to convert its method of funding from a fully insured Risk Program to a self insured Administrative Services Program, Client shall establish an appropriate level of reserves as determined by VSP, prior to conversion. Upon conversion to an Administrative Services Program, all claims for vision care begun on and after the effective date of conversion will be paid through the Administrative Services Program.

IV.

OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

4.01. General: This Policy provides coverage for Client's Enrollees. If Client offers dependent coverage, this Policy will also cover Enrollees' Eligible Dependents. This Policy may be amended or terminated by agreement between VSP and Client without the consent or concurrence of Covered Persons. This Policy with any and all Exhibits and/or attachments constitutes the entire obligation of VSP to Covered Persons.

4.02. Copayments for Services Received: Any Copayments required under this Policy shall be the personal responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed Plan allowances, annual maximum benefits or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

4.03. Obtaining Services from VSP Preferred Providers: To utilize Plan Benefits, Covered Persons must select a VSP Preferred Provider, schedule an appointment and inform the doctor's office that they are Covered Persons of VSP. The VSP Preferred Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from a VSP Preferred Provider without a Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Open Access Provider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Preferred Provider for information describing vision care services and vision care materials offered.

4.04. Open Access Provider Benefits: If required by state law, or if purchased by Client, this Policy provides Plan Benefits for services and materials received from Open Access Providers. Covered Persons may submit requests for reimbursement or Proof of Loss to VSP and VSP will pay available Plan Benefits to Covered Persons. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided.

4.05. Proof of Loss: Written proof of loss shall be furnished to VSP within 365 days after the date of the loss. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided. Failure to submit a claim within the time required does not invalidate or reduce the claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time the claim is otherwise required.

4.06. Complaints and Grievances: Complaints and grievances may be submitted by Covered Persons to VSP in writing, by telephone, online or through Covered Persons' VSP Preferred Providers, as explained in the Evidence of Coverage for this Policy. VSP will resolve all complaints and grievances within thirty (30) calendar days following receipt

unless special circumstances require an extension of time. Where such extension is required, VSP will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the final resolution of all complaints and grievances.

4.07. Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal .

b) Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. VSP's communication to the Covered Person shall include the specific reasons for the determination.

c) Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

4.08. Time of Action: No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

4.09. Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

4.10. Assignment of Incidents of Ownership: No provision of this Policy shall prohibit an insured from making an assignment of all or any part of his or her incidents of ownership under this Policy, including but not limited to, the right to designate a beneficiary and the right, if any, to have an individual policy issued in accordance with the terms thereof.

V.

CONTINUATION OF COVERAGE

5.01. **COBRA**: If, and only to the extent, COBRA applies to the parties to this Policy, VSP shall make the required COBRA continuation coverage available to Covered Persons in accordance with the provisions of COBRA.

5.02. **Replacement Coverage**: VSP reserves the right to offer replacement VSP coverage to individuals whose previous VSP coverage has terminated or is subject to termination. Any such offer of replacement coverage shall be separate and distinct from, and not in lieu of, any COBRA-required offer of continuation coverage.

VI.

DISPUTE RESOLUTION

6.01. Dispute Resolution: VSP and Client agree that all disputes arising out of or relating to this Policy shall be resolved, wherever possible, through mediation. When such negotiation is not successful, both parties agree to try in good faith to settle disputes by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures. All efforts shall be made by both parties to avoid arbitration, litigation, or other dispute resolution procedures.

6.02. Choice of Law: If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of this Policy shall be the applicable law.

VII.

NOTICES

7.01. Notices: Any notices required under this Policy to either Client or VSP shall be in written format. Notices sent to the Client will be sent to the address or email address shown on the Client's Application unless otherwise directed by Client. Notices to VSP shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

VIII.
STANDARD PROVISIONS

8.01. Entire Agreement: This Policy, the Client Application, the Evidence of Coverage, and all Exhibits and attachments hereto, constitute the entire agreement of the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to this Policy must be mutually agreed upon by both VSP and Client. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Client for distribution to Enrollees do not constitute a part of this Policy.

8.02. Indemnity: VSP agrees to indemnify, defend and hold harmless Client, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Client agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Client, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

8.03. Liability: VSP arranges for the provision of vision care services and materials through agreements with VSP Preferred Providers. VSP Preferred Providers are independent contractors and are responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. Under no circumstances shall VSP or Client be liable to each other for the negligence, wrongful acts or omissions of any doctor, non-VSP owned laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

8.04. Assignment: Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto, except as expressly authorized herein.

8.05. Severability: Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

8.06. Governing Law: This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in conformance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulation, now or hereafter existing.

8.07. Gender: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or

plural, as the identity(ies) of the person(s) may require.

8.08. Equal Opportunity: VSP is an Equal Opportunity and Affirmative Action employer.

8.09. Legal Actions: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

IX.

DEFINITIONS

The key terms in this Policy are defined:

9.01. ADDITIONAL BENEFIT RIDER: The document, attached as Exhibit C to this Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under Exhibit A.

9.02. ADMINISTRATIVE SERVICES PROGRAM: A self-insured vision care plan whereby Client pays VSP for the Plan Benefits in addition to a monthly administrative fee.

9.03 ASSIGNMENT OF BENEFITS: A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

9.04. BENEFIT AUTHORIZATION: A process used to confirm eligibility of an individual named as a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

9.05. CLIENT: An employer or other entity which contracts with VSP to provide coverage under this Policy for its Enrollees and their Eligible Dependents.

9.06. CLIENT APPLICATION: The form signed by an authorized representative of the Client to apply for Enrollee coverage under this Policy.

9.07. COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985.

9.08. COMPLAINTS AND GRIEVANCES: Disagreements regarding access to care, quality of care, treatment or service.

9.09. CONFIDENTIAL MATTER: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons acquired by VSP in the course of providing Plan Benefits hereunder.

9.10. COORDINATION OF BENEFITS: A procedure which allows more than one insurance plan to consider a Covered Person's vision care claims for payment or reimbursement.

9.11. COPAYMENTS: Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

9.12. **COVERED PERSON**: An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under this Policy.

9.13. **ELIGIBLE DEPENDENT**: Any dependent of an Enrollee who meets the criteria for eligibility established by Client.

9.14. **ENROLLEE**: An employee or member of Client who meets the criteria for eligibility established by Client.

9.15. **EVIDENCE OF COVERAGE ("EOC")**: A summary of the provisions of this Policy, prepared by VSP and provided to Client for distribution to Enrollees by Client.

9.16. **OPEN ACCESS PROVIDER**: Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

9.17. **PLAN or PLAN BENEFITS**: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.

9.18. **POLICY PERIOD**: The length of time this Policy is in effect, as shown on the front page of this Policy.

9.19. **RENEWAL DATE**: The date when this Policy shall renew or terminate if proper notice is given.

9.20. **RETENTION**: VSP's administrative fee deducted from net premiums paid by Client.

9.21. **RISK PROGRAM**: A fully insured vision care plan whereby VSP will calculate a rate per Enrollee to cover the cost of claims incurred and administrative costs. Under the arrangement, VSP assumes the risk of utilization exceeding the rate per Enrollee over the full Policy Term.

9.22. **SCHEDULE OF BENEFITS**: The document, attached as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

9.23. **SCHEDULE OF PREMIUMS**: The document, attached as Exhibit B to this Policy, which defines the payments a Client is obligated to pay to VSP on behalf of a Covered Person to entitle him/her to Plan Benefits.

9.24. **STATE OF DELIVERY**: The State in which this Policy is being issued, delivered or renewed.

9.25. **TERMINATION**: Cancellation of the Policy as stated in Article I.

9.26. **URGENT CONDITION**: A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

9.27. **VISION CARE POLICY or POLICY**: The Policy issued by VSP to a Client, under which the Client's

Enrollees or members, and their Eligible Dependents, are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.

9.28. VSP PREFERRED PROVIDER: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons of VSP.

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on June 1st and ending on May 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible. This includes an adopted child from the date of birth when a written agreement to adopt such child has been entered into prior to the birth of the child.

A dependent child is covered up to the end of the month in which they turn age 26, or until the end of the month in which the child reaches the age of 26 if the child is living in the household, or the child is a full time or part-time student.

A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS

VSP NETWORK DOCTORS

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Enhancements, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

LENS OPTIONS

Scratch coating covered in full once every 12 months.**

UV (ultraviolet) protected covered in full once every 12 months.**

FRAMES - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Frame Allowance may be applied towards non-prescription ready-made sunglasses for individuals who have had laser correction surgery, in lieu of prescription glasses. Lab fabricated plano lenses are not covered

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$150.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials. A 15% discount applies to VSP Network Doctor's usual and customary professional fees for contact lens fitting and evaluation.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Preferred Provider or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed for individuals who have had laser correction surgery.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

**REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS**

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 45.00* once every 12 months**

Bifocal Up to \$ 65.00* once every 12 months**

Trifocal Up to \$ 85.00* once every 12 months**

Lenticular Up to \$125.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 12 months**

Frame Allowance may be applied towards non-prescription ready-made sunglasses for individuals who have had laser correction surgery, in lieu of prescription glasses. Lab fabricated plano lenses are not covered

CONTACT LENSES

Elective

Elective Contact Lenses are covered up to \$150.00 once every 12 months**

Necessary

Necessary Contact Lenses are covered up to \$210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

*Less any applicable Copayment.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT B

**VISION SERVICE PLAN INSURANCE COMPANY (VSP)
SCHEDULE OF PREMIUMS
VSP Choice Plan**

VISION SERVICE PLAN INSURANCE COMPANY ("VSP") shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

- \$ 6.46 per month for each eligible Enrollee without dependents.
- \$ 12.93 per month for each eligible Enrollee with an eligible spouse.
- \$ 13.84 per month for each eligible Enrollee with eligible child(ren).
- \$ 22.12 per month for each eligible Enrollee with eligible spouse and child(ren).

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

EXHIBIT C

VISION SERVICE PLAN INSURANCE COMPANY ADDITIONAL BENEFIT RIDER Laser VisionCare® Preferred Plan

GENERAL

This Rider lists the vision care services to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated, and forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible. This includes an adopted child from the date of birth when a written agreement to adopt such child has been entered into prior to the birth of the child.

A dependent child is covered up to the end of the month in which they turn age 26, or until the end of the month in which the child reaches the age of 26 if the child is living in the household, or the child is a full time or part-time student.

A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Current guidelines published by the Federal Drug Administration (FDA) may affect Covered Person's eligibility. Also, some Laser VisionCare facilities have established their own eligibility policies regarding laser surgery candidates. Covered Persons should confirm with their VSP LaserVision Care Doctor whether these additional eligibility criteria will apply.

Laser VisionCare Preferred ("LVC") Plan Benefits are in lieu of all other lens and frame, and Contact Lens benefits available herein.

This means that utilization of Laser VisionCare benefits exhausts all of the Covered Person's lens and frame, and contact lens benefits for the current Benefit Period, and future eligibility for lenses and frames, and contact lenses will be determined as if spectacle lenses and frames or contact lenses were obtained in the current Benefit Period.

PROCEDURE FOR OBTAINING LVC PLAN BENEFITS

Complimentary Screening

A Covered Person considering laser vision correction should first consult a VSP Laser VisionCare Doctor to determine whether Covered Person is a viable candidate for such surgery. Minimum services required include determination of refractive error with a brief discussion about the surgery.

Pre-Operative Exam†

If the VSP Laser VisionCare Doctor determines that Covered Person is a viable candidate and would like to pursue laser vision correction surgery, he/she will perform a comprehensive pre-operative exam including dilation and corneal topography and forward the results to the VSP-contracted laser vision center with which VSP Laser VisionCare Doctor is affiliated.

Consultation†

The VSP-contracted laser vision center will conduct an additional consultation to further evaluate refractive errors, and will confirm Covered Person's benefit eligibility.

Surgery

A participating surgeon affiliated with the VSP-contracted laser vision center will perform the surgical procedure best suited for Covered Person's needs, subject to the conditions stated under Plan Benefits.

Post-Operative Care†

After completion of the surgery, Covered Person will return to the VSP Laser VisionCare Doctor for post-operative care and continued eye health management.

†Depending upon the availability of providers in certain geographical areas, pre- and post-operative care may be provided by professional staff of the center performing the surgery. Covered Person may contact VSP's Customer Care Division for additional information and assistance in locating a participating VSP-contracted laser vision center.

PLAN BENEFITS

VSP LASER VISIONCARE DOCTORS

COPAYMENT

There is no Copayment for LVC services.

COVERED SERVICES

The LVC Plan pays for the following services as part of a combined benefit of up to \$150.00 payable once per Covered Person every 12 months*. Benefits for these services are not payable separately except as indicated.**

- Consultation
- Preoperative ophthalmic exam**
- LASIK, Custom LASIK, Custom PRK, PRK Surgery or All Laser LASIK
- Postoperative care, including an ophthalmic exam and Enhancement Surgery (if required)

* Beginning with the first day of the Benefit Period.

**If a Covered Person obtains a pre-operative exam, the cost of the comprehensive pre-operative exam is included in the global surgery fee; however, if the patient does not proceed with the surgery for any reason, the doctor may charge the patient 75% of the usual and customary fees for the exam, not to exceed \$100.00. If the Covered Person is part of the Preferred Program, the exam may be covered in full on their base plan if the patient is eligible. Other claims for exam only services are filed by the facility on behalf of the doctor and if the patient decides to have the surgery performed at a later date, the benefit available will be reduced by the amount paid for the preoperative exam.

DEFINITIONS

Custom LASIK is performed after the flap is made. With Custom LASIK, a customized map is created for each individual eye. This data allows for treatment on tiny imperfections in the eye that can have a significant impact on one's quality of vision. Digital technology identifies and measures imperfections 25 times more precisely than Conventional LASIK.

Enhancement Surgery: One or more surgical procedures performed after covered Laser Vision Correction Surgery for the purpose of making minor adjustments to a patient's visual acuity.

Laser Vision Correction Surgery: Surgical procedures, such as Laser In Situ Keratomileusis or Photorefractive Keratectomy, used to correct vision problems such as nearsightedness, farsightedness or astigmatism, and which are covered under the LVC Plan.

Conventional LASIK (LASIK): After the flap is made; Conventional LASIK uses a cool beam of light from the excimer laser to gently reshape the front surface (cornea) of the eye.

Photorefractive Keratectomy (PRK) Laser Refractive Surgery: Like LASIK, PRK utilizes the excimer laser to reshape the curvature of the eye and treats nearsightedness, farsightedness and astigmatism. PRK differs from LASIK as it is performed on the surface of the eye and no flap is created during the procedure. Most patients will benefit from Custom PRK, which provides your surgeon an additional level of data about your vision requirements using customized wavefront technology.

All-laser LASIK: An advanced form of LASIK eye surgery that uses two separate lasers — a femtosecond laser for the first step of the procedure (creating the corneal flap) and an excimer laser to reshape the underlying corneal tissue and improve vision.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

1. Services not specifically included in this Rider as covered Plan Benefits.
2. Prescription drugs or other medications
3. Laser vision correction procedures other than PRK, Custom PRK, PRK, Custom LASIK, Conventional LASIK or All Laser LASIK.,
4. Surgical or pathological treatment of the eye, except as specified under Plan Benefits.
5. Inpatient hospital and anesthesia costs for Covered Services not able to be provided on an outpatient basis.
6. Frames, spectacle lenses, contact lenses or other materials of any kind.
7. Plano Lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power).
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

Covered Person should pay the provider's fee in full and request a copy of the itemized bill and operative (surgery) report. Send a copy of the bill and operative report along with the name, address and identification number of the Covered Person, and the name of the Enrollee's employer. Please be sure to write "PRK", "LASIK", or "Custom LASIK" on all receipts, depending upon the procedure performed.

COPAYMENT

There is no Copayment for LVC Plan services.

COVERED SERVICES

The LVC Plan pays for the following services as part of a combined benefit of up to \$150.00, payable once per Covered Person every 12 months*. Benefits for these services are not payable separately except as indicated.**

- Consultation
- Preoperative ophthalmic exam**
- LASIK, Custom LASIK or PRK Surgery
- Postoperative care, including an ophthalmic exam and Enhancement Surgery (if required)

* Beginning with the first day of the Benefit Period.

**If a Covered Person obtains a preoperative exam but does not have surgery performed within six (6) months of the date of the exam, the LVC Plan will cover the cost of the preoperative exam separately, in full, not to exceed the combined \$150.00 LVC Plan benefit. If the Covered Person decides to have the surgery performed at a later date, the benefit available for such surgery will be reduced by the amount paid for the preoperative exam.

EXCLUSIONS AND LIMITATIONS OF BENEFITS OPEN ACCESS PROVIDERS

1. Exclusions and limitations of benefits described above for VSP Laser VisionCare Doctors shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Laser VisionCare Doctors.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

VISION SERVICE PLAN INSURANCE COMPANY ADDITIONAL BENEFIT RIDER SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible. This includes an adopted child from the date of birth when a written agreement to adopt such child has been entered into prior to the birth of the child.

A dependent child is covered up to end of the month in which they turn age 26, or until the end of the month in which the child reaches the age of 26 if the child is living in the household, or the child is a full time or part-time student.

A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the PEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB.". Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Preferred Provider and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Network Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.**

PLAN BENEFITS

VSP Preferred PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of \$20.00.

Special Ophthalmological Services: Covered in Full

Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY ADDENDUM TO GROUP VISION CARE POLICY

The **Dependent Eligibility** section on Exhibit A is hereby amended to include the following:

Domestic Partners: Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits. The domestic partner's unmarried dependent children are also covered provided they depend upon the Enrollee for support and maintenance.

**VISION SERVICE PLAN INSURANCE COMPANY
PERFORMANCE STANDARDS**

VSP guarantees the performance standards outlined herein by offering to pay a financial penalty as a percentage of quarterly administrative revenue per unmet standard, up to a total annual maximum of \$100,000 per performance standard (specific penalty percentages vary; see below for the penalty associated to each standard). VSP's company-wide quarterly performance results shall be used in determining whether any or all of the performance standards have been met. Any penalties owed shall be accrued quarterly and paid on an annual basis (minimum annual payment threshold is \$250 per performance standard). Payment of penalties shall be conditioned on VSP's receipt of all premiums due to VSP within established due dates.

VSP's performance hereunder is subject to interruption and delay due to causes beyond VSP's reasonable control such as acts of God, act of any government, war or other hostility, the elements, fire, explosion, power failure, equipment failure, industrial or labor dispute. In the event of any such interruption or delay, any period of performance shall be extended for a period of time equal to the interruption or delay.

CLAIMS PROCESSING

Claims financial accuracy

Performance Standard = 99% processed without financial error

Performance Penalty = 2.0%

Claims financial accuracy is calculated much like that of claims processing accuracy. The same random sampling of claims audited for processing accuracy is also audited for financial accuracy. Any error found that results in a financial impact is recorded as a financial error. At the end of the month, financial errors are totaled and taken as a percentage of the total dollar paid for all claims audited during the given month.

Claims timeliness

Performance Standard:

- All preferred provider claims = 95% processed within 5 business days

Performance Penalty = 2.0%

- All member claims = 95% processed within 5 business days

Performance Penalty = 1.0%

- All claims = 99% processed within 15 business days

Performance Penalty = 2.0%

Claims timeliness, or turnaround time, is measured on a monthly basis. Each claim is audited for timeliness. Timeliness is measured by calculating the number of working days for each clean claim elapsing between the received date and the pricing date. A clean claim is defined as a claim which has no defect, impropriety, or lack of any required substantiating documentation, including incomplete documentation or incomplete data fields. When additional information is needed to process a claim, the timeliness date is calculated from the date the information needed to process the claim was received to the pricing date.

CLIENT-SPECIFIC STANDARDS

VSP Level Data

Report Frequency: Quarterly

Penalty Calculation Frequency: Annually

Claims Processing Accuracy

Performance Standard = 97% number of claims without any errors divided by number of audited claims

Performance Penalty = 2.0%

Coding Accuracy

Performance Standard = 98% number of claims without any errors divided by number of audited claims

Performance Penalty = 2.0%

Abandoned Call Rate

Performance Standard = Less than or equal to 2%

Performance Penalty = 2.0%

The Call Center telephone abandon rate is calculated monthly by taking the total number of abandoned calls, divided by the number of calls accepted by the Call Center, which include calls answered via the Interactive Voice Response and Automated Call Distribution systems.

Average Speed of Answer

Performance Standard = Less than or equal to 60 seconds

Performance Penalty = 2.0%

The average speed of answer (the amount of time a caller is waiting while on hold) is calculated by dividing the total time all calls are on hold (in seconds) by the total number of calls received.