



**VSP VISION CARE, INC.
One Union Square Building
600 University Street, Suite 2004
Seattle, Washington 98101-1129**

**ADMINISTRATIVE OFFICES:
3333 Quality Drive
Rancho Cordova, California 95670
CLIENT VISION CARE POLICY**

Client Name **HEALTH ALLIANCE FOR TECHNOLOGY HEALTH TRUST**
Policy Number **30086118**
State of Delivery **WASHINGTON**
Effective Date **JANUARY 1, 2021**
Policy Period **FORTY-EIGHT (48) 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, VSP VISION CARE, INC. ("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 Washington and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or Washington-specific Addenda, which are a part of this Policy.

A handwritten signature in cursive script, appearing to read 'Kate Renwick-Espinosa'.

Kate Renwick-Espinosa, President

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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) At the end of the Plan Term, the Plan shall renew on a month to month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Plan Term, that such party is unwilling to renew the Plan. If such notice is given, the Plan shall terminate at 11:59 p.m. in the state of delivery on the last day of the Plan Term unless the parties agree to renewal of the Plan. If the Plan continues on a month to month basis after the Plan Term, either party may terminate the Plan upon thirty (30) days advance written notice to the other party.

(b) If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Plan Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Plan Term, this Plan shall terminate at 11:59 p.m. in the state of delivery on the last day of the Plan Term.

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 Network 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 Network 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 Network 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 Network Provider. When a Covered Person seeks Plan Benefits from a VSP Network Provider, the Covered Person must schedule an appointment and identify himself/herself as a VSP Covered Person so the VSP Network Provider can obtain a Benefit Authorization from VSP. VSP shall provide a Benefit Authorization to the VSP Network 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 Network Provider that payment will be made to VSP Network Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

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 Network 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. Preservation of Confidentiality: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, VSP Network Providers, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is permitted or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law.

2.06. Urgent Vision Care: VSP shall cover Urgent Conditions necessary to screen or stabilize a Covered Person. When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Network Provider or Open Access Provider. VSP shall not require pre-certification of such services prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an urgent medical condition existed. 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.

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 Network Providers: A Benefit Authorization must be obtained prior to receiving Plan Benefits from a VSP Network Provider. When a Covered Person seeks Plan Benefits, the Covered Person must select a VSP Network Provider, schedule an appointment, and identify himself as a Covered Person so the VSP Network Provider can obtain a Benefit Authorization from VSP. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Network 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 or Open Access Providers may submit requests for reimbursement to VSP. VSP will pay available Plan Benefits to Covered Persons, or directly to Open Access Providers when claims include a valid Assignment of Benefits. 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 this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of three hundred and sixty-five (365) days after the date of service.

4.05. Complaints and Grievances: Covered Persons shall report any complaints and/or grievances to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. A Covered Person may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred

twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

4.06. Appeals of Adverse Determinations: A Covered Person must submit an appeal of an Adverse Determination in writing. VSP will reconsider its decision within fourteen (14) days of receipt of the appeal unless VSP notifies the Covered Person that an extension is necessary to complete the appeal. The extension will not delay the decision beyond thirty (30) days of the request for an appeal without the Covered Person's written consent. In the event a delay would jeopardize the health of a Covered Person, VSP will expedite and process either a written or oral appeal and issue a decision within seventy-two (72) hours after receipt of the appeal. Adverse Determination Appeals follow the same reviewer qualifications standards set forth in Section 4.07 below.

Written notice of Adverse Determinations will include the reason(s) for the determination, the instructions for appealing the decision, a statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the decision.

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. Claim Appeals for Services of an Experimental Nature: In the event a claim is denied because of an experimental or investigational exclusion or limitation, an appeal determination will be made within twenty (20) working days of receipt of the fully documented appeal. This review period may be extended beyond twenty (20) working days upon written consent to the Covered Person. A person qualified by reasons of training, experience and medical expertise to evaluate it will review the appeal. The person reviewing the appeal will not be the same person who made the initial decision to deny benefits. The Covered Person will be notified of the result of the appeal in writing, which will include the basis for the decision, the name of the reviewer and that person's professional qualifications. In the event that a delay would jeopardize the health of a Covered Person, VSP will issue a decision within seventy-two (72) hours after receipt of the appeal.

4.09. 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.

4.10. Insurance Fraud: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Such an act is grounds for immediate termination of the Plan for the Group or individual that committed the fraud.

V.
ELIGIBILITY FOR COVERAGE

5.01. Eligibility Criteria: Individuals will be accepted for coverage hereunder only upon meeting all requirements set forth below.

a) Enrollees: To be eligible, a person must:

1. currently be an employee or member of Group, and
2. meet the coverage criteria mutually agreed upon by Group and VSP.

(b) Eligible Dependents: If dependent coverage is provided, the persons eligible for dependent coverage are specified on the attached Schedule of Benefits and Additional Benefit Riders (if purchased by Group). If a dependent child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force provided that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated and at such other times as VSP may request proof, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

5.02. Documentation of Eligibility: Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

a) for an Enrollee, the individual's name and Member ID Number have been reported by Group to VSP in the manner provided hereunder; and

b) for changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein.

5.03. Change of Participation Requirements, Contribution of Fees, and Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Plan, and Group's contribution and eligibility requirements, are all material to VSP's obligations under this Plan. During the term of this Plan, Group must provide VSP with written notice of changes to its composition, percentage of Enrollees covered, contribution and eligibility requirements. Any change which materially affects VSP's obligations under this Plan must be agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Plan for purposes of paragraph 3.04. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Plan.

5.04. Change in Family or Employment Status: In the event Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent , etc.], or employment status, Group shall provide notice of such change to VSP via the next eligibility listing required under paragraph 3.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the sixty (60) day period after birth, and an adopted child will be covered for the sixty (60) day period after the date the Enrollee or the Enrollee's spouse acquires the right to control that child's health care. To continue coverage for a newborn or adopted child beyond the initial sixty (60) day period, the Group must be properly notified of the Enrollee's change in family status, and applicable premiums must be paid to VSP if payment of an additional premium is required under Exhibit B.

VI.

CONTINUATION OF COVERAGE

6.01. 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.

6.02. 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.

6.03. Labor Disputes: If an Enrollee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, the Enrollee may pay any premiums due directly to the Group for a period not exceeding six (6) months and at the rate and coverages that the Plan contract provides

VII.

DISPUTE RESOLUTION

7.01. 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.

7.02. 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.

7.03. Procedure: Mediation shall be conducted pursuant to mediation rules agreed to by the parties.

VIII.

NOTICES

8.01. 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.

IX.

STANDARD PROVISIONS

9.01. 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.

9.02. 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.

9.03. Liability: VSP arranges for the provision of vision care services and materials through agreements with VSP Network Providers. VSP Network Providers are independent contractors and 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 for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Policy, except as provided by RCW 48.43.545, whereby VSP may not deny any liability for any and all harm caused by its failure to follow a standard of care when the failure resulted in a denial, delay, or modification of the health care service recommended for, or furnished to, a Covered Person.

9.04. 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.

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

9.06. 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.

9.07. 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.

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

9.09. Force Majeure: Neither Party will be liable for a delay in performing its obligations under this Agreement to the extent that delay is caused by insurrection, war, terrorism, riot, explosion, nuclear incident, fire, flood, earthquake, or other catastrophic event or Act of God beyond the reasonable control of the affected Party; provided the affected Party immediately notifies the other Party and takes reasonable and expedient action to resume operations. Nothing in this Section will relieve a Party from liability for failure to have back-up systems that are standard in its industry. During the period of delay, the Party that is not affected by the catastrophic event may suspend its own performance pending resumption of performance by the affected Party.

X.

COORDINATION OF THIS POLICY'S BENEFITS WITH OTHER BENEFITS

10.01. Coordination of Benefits: ("COB" herein) applies when a Covered Person has coverage under more than one Plan. Plan, for the purpose of this Section X, is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits according to its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

10.02. DEFINITIONS OF KEY TERMS USED IN THIS SECTION X :

(a) A Plan is any of the following that provides benefits or services for medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) Plan includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

(3) Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

(b) This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract

providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

(c) The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the Total Allowable expense for that claim. This means that when this Plan is Secondary, it must pay the amount which, when combined with what the Primary plan paid, totals 100% of the highest Allowable expense. In addition, if this Plan is Secondary, it must calculate its savings and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable expense under this Plan. If this Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

(d) Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense.

(e) Closed panel plan is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(f) Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

10.03. ORDER OF BENEFIT DETERMINATION RULES: When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(a) The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(b) (1) Except as provided in subsection (2), a Plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder.

(c) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(d) Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent, then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the spouse of the non-custodial parent, last

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would

hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

10.04. EFFECT ON THE BENEFITS OF THIS PLAN: When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total Allowable expense for that claim Total Allowable expense is the highest Allowable expense of the Primary plan or the Secondary plan. In addition, the Secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

10.05. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. VSP may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. VSP need not tell, or

get the consent of, any person to do this. Each person claiming benefits under This plan must give VSP any facts it needs to apply those rules and determine benefits payable.

10.06. FACILITY OF PAYMENT: If payments that should have been made under This plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This plan. To the extent of such payments, the issuer is fully discharged from liability under This plan.

10.07. RIGHT OF RECOVERY: The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

XI

DEFINITIONS

The key terms in this Policy are defined:

11.01. 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.

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

11.03 ADVERSE DETERMINATION: A decision made by VSP regarding a Covered Person resulting in the denial, modification, reduction or termination of coverage or authorization of Plan Benefits.

11.04 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.

11.05. 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.

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

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

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

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

11.10. 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.

11.11. 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.

11.12. 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.

11.13. COUNTY: All counties located in the State of Washington.

11.14. 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.

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

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

11.17. 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.

11.18. 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.

11.19. 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.

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

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

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

11.23. 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.

11.24. 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.

11.25. 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.

11.26. SERVICE AREA: The entire state of Washington.

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

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

11.29. 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.

11.30. 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.

11.31. VSP NETWORK 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

SCHEDULE OF BENEFITS VSP Signature Plan® Plan B

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC. ("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 Network Doctors are those doctors who have agreed to participate in VSP's Signature Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- 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, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. 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.

Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners.

PLAN BENEFITS VSP NETWORK 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 \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

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

FRAMES - Covered up to the Plan allowance* once every 24 months**

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

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$160.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a \$60.00 Copayment.

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 Network Provider.

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe vision 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 Network 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 Network 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 Member Doctor 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 under the SunCare enhancement, if purchased by Client.
- 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.
- 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 \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to \$ 50.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Up to \$ 50.00 - 125.00 once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements, if purchased by Client.

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to \$105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

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 date of service.

LOW VISION

Professional services for severe vision 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.

*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 Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Network 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 Network 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 C

ADDITIONAL BENEFIT RIDER SUPPLEMENTAL DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any applicable Copayment and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes, glaucoma or age-related macular degeneration (AMD) and specific ophthalmological conditions. This Rider forms a part of the Policy or 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.

Dependent children are covered up to the end of the month in which they attain 26 years of age.

A dependent child over the age of 26 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.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will 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.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under the DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- "floating" spots
- visual distortion

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

- diabetic retinopathy
- diabetic macular edema
- glaucoma
- rubeosis
- age related macular degeneration

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program 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 DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Network Provider and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Person's VSP Network Provider cannot provide Covered Services, 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 DEP Plus, the VSP Network 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 Network Provider in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP NETWORK PROVIDERS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of \$20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

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

DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, "straight ahead" central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Special Ophthalmological Services	Medical eye care procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma or AMD.