

October 2, 2017



Vision Care for Life

KELLY BONANNO
GALLAGHER BENEFIT SERVICES
100 MERIDIAN CTR BLVD STE 100
ROCHESTER, NY 14618-3925

RE: NOTIFICATION OF DOCUMENT CHANGES FOR UNIVERSITY OF ROCHESTER

Enclosed are your new VSP Plan document and Evidence of Coverage booklet, both effective JANUARY 1, 2018

Please retain a copy of the documents for your records and forward the additional copy directly to the group.

This new document supersedes any existing document you have with VSP. If you or your client have any questions concerning the new document, please call 916-851-6045, and a VSP representative will assist you.

Enclosures



**EASTERN VISION SERVICE PLAN, INC.
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
(800) 852-7600**

CLIENT VISION CARE POLICY

Client Name **UNIVERSITY OF ROCHESTER**
Policy Number **30077876**
State of Delivery **NEW YORK**
Effective Date **JANUARY 1, 2018**
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, EASTERN VISION SERVICE PLAN, 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 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 dark ink, appearing to read "Kate Renwick-Espinosa", is written over a horizontal line.

Kate Renwick-Espinosa, President

EASTERN VISION SERVICE PLAN, INC.
GROUP VISION CARE POLICY
TABLE OF CONTENTS

I.	TERM, RENEWAL, NONRENEWAL AND TERMINATION.....	1
II.	OBLIGATIONS OF VSP.....	3
III.	OBLIGATIONS OF CLIENT.....	10
IV.	OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY.....	12
V.	CONTINUATION OF COVERAGE.....	15
VI.	DISPUTE RESOLUTION.....	17
VII.	NOTICES.....	18
VIII.	STANDARD PROVISIONS.....	19
IX.	DEFINITIONS.....	21
ATTACHMENTS		
	EXHIBIT A	
	SCHEDULE OF BENEFITS.....	24
	EXHIBIT B	
	SCHEDULE OF PREMIUMS.....	30
	EXHIBIT C	
	ADDITIONAL BENEFIT - DIABETIC EYECARE.....	31

I.

TERM, RENEWAL, NONRENEWAL 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. Nonrenewal: VSP shall issue written nonrenewal notice to Client at least thirty (30) days before the end of the Policy Period.

1.04. 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 immediately upon written notice, if Client fails to:

(i) Pay premiums by the dates defined in paragraph 3.04.

(ii) 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 1.04(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). Client will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Client would have paid for the remaining term of this Policy, not to exceed one year. A deficit incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Client. Net premiums shall mean premiums paid by Client minus any applicable retention amounts and/or broker commissions. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

(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.

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 to VSP Preferred 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. If the cost of service is less than the copayment for the service, the patient is responsible for the lesser amount.

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, 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 Preferred 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: 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: This coordination of benefits (COB) provision applies when a Covered Person has vision care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

(a) Definitions

1. A "plan" has the meaning defined in Paragraph 9.17, below, but for the purposes of this section also includes the provisions herein described. A plan is any of the following that provides vision care services or materials.

- a. "Plan" includes: group insurance and Medicare or other governmental benefits, as permitted by law.
- b. "Plan" does not include: individual or family insurance; coverage through health maintenance organizations (HMOs) or closed panel plans; blanket insurance policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
- c. "This plan" refers to the part or parts of this Policy providing vision care benefits to which the COB provision applies and which may be reduced on account of the benefits of the other plans. Each contract for coverage under a. or b. 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.

2. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
3. "Allowable expense" means a vision care service or expense that is covered at least in part by any of the plans covering the Covered Person except where a statute requires a different definition. An expense or service that is not covered by any of the plans is not an allowable expense.
- a. If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
 - b. If a Covered Person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fees is not an allowable expense.
 - c. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the plan whose payment arrangement is based on a negotiated fee shall be the allowable expense for all plans.
 - d. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions.
 - e. Amounts for Plan Benefits under the Computer VisionCare, Repair or Safety Plans are not allowable expenses under this plan.
4. "Claim determination period" may be either a calendar year or a benefit year, but shall be no less than twelve (12) consecutive months. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed panel plan" is a plan that provides vision care benefits to Covered Persons through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(b) Order Of Benefit Determination Rules:

1. When two or more plans pay benefits the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The plan that does not contain a coordination of benefits provision, or that contains a coordination of benefits provision that differs from those permitted by section 2.07 is always primary. If all plans which cover the Covered Person use the order of benefits determination rules required by this section and under those rules a plan determines its benefits first, that plan is primary.

2. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

3. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

a. The benefits of a plan which covers the Covered Person as an Enrollee is primary.

b. . The order of benefits when a child is covered by more than one plan is:

(1) The primary plan is the plan of the parent whose birthday (based only on the month and day within a calendar year) falls earlier in the year whether the parents are married, are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

(2) If the specific terms of a court decree state that one of the parents is responsible for the 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 or plan years commencing after the plan is given notice of the court decree.

(3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is: the plan of the custodial parent; the plan of the spouse of the custodial parent; the plan of the noncustodial parent; and then the plan of the spouse of the noncustodial parent.

c. The plan that covers a person as an Enrollee who is neither laid off nor retired, is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

d. If none of the above rules determines the order of benefits, the plan that covered the person as an Enrollee longer is primary.

(c) Effect On Plan Benefits

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 100 percent of total allowable expenses, or of the total billed amount, whichever is less.

(d) Right To Receive And Release Needed Information: VSP has the right to decide which facts it needs to implement COB provisions. VSP may get needed facts from or give them to any other organization or person. VSP need not disclose to nor obtain permission from the Covered Person in order to obtain these facts, except as required by applicable state or federal law.

(e) Facility Of Payment: A payment made under another plan may include an amount that should have been paid under this plan. If it does, VSP may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. VSP will not have to pay that amount again.

(f) Right Of Recovery: If the amount of the payments made by VSP is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

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. Open Enrollment: This plan will insure all persons without evidence of insurability provided, that coverage is elected during an initial period of eligibility of at least thirty (30) days. Specified periods of open enrollment must be provided every twelve (12) months, for a period of no less than thirty (30) days.

3.03. 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.

3.04. 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.

3.05. 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.

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

3.07. 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.

3.08. 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.

3.09. Notice of Right to Convert to Conversion Contract Client agrees to notify Covered Persons of the right to convert to a conversion contract upon the termination of a Covered Person's employment or membership in the group. Such notice must be given within fifteen (15) days of the date of the event causing the termination of the Covered Person's group coverage by mailing the notice first class mail to the Covered Person's last known address. If such notice is given more than 15 days but less than 90 days after the date of termination of coverage under the group contract, the time allowed for the exercise of such conversion privilege shall be extended for 45 days after the giving of such notice. If such notice is not given within 90 days after the date of termination of coverage under the group contract, the time allowed for the exercise of the conversion privilege shall expire at the end of such 90 days.

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.

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.

4.05. 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 forty-five (45) days from receipt of all necessary information. 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. If a Covered Person is not satisfied with the resolution of any complaint and/or grievance, the Covered Person may file an appeal in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. A Covered Person has up to sixty (60) business days from receipt of the complaint and/or grievance determination to file an appeal. VSP will make a determination of an appeal within thirty (30) business days of receipt of all necessary information. If Covered Person remains dissatisfied with VSP's appeal determination or at any other time, Covered Person may call the New York State Department of Financial Services at 1-800-342-3736 or write them at New York State Department of Financial Services, Consumer Assistance Unit, One Commerce Plaza, Albany, NY 12257.

4.06. 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.

4.07. 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 three years after the time any such claim has been filed with VSP

4.08. 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.

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.

5.03 Conversion Privilege: A Covered Person is eligible to convert to the conversion contract effective as of the date of termination of the covered person's group coverage, upon submitting an application and payment of the applicable first monthly premium within the required time. The coverage will be issued without evidence of insurability, if the application is mailed or delivered to VSP within 60 days of the date that the member first becomes eligible to exercise the conversion privilege. The conversion privilege is available upon:

- a) The termination of the subscriber's employment or membership with the group.
- b) The termination of the dependent's eligibility, regardless of the time period the member was covered, by reason of: reaching the maximum age set out in the contract and/or any riders attached to it where the member can no longer be considered an eligible dependent; death of the subscriber; or divorce or annulment of the marriage to the subscriber.
- c) The termination of the group contract, for any reason. This shall not apply if the group contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured.

A Covered Person shall not be eligible to convert to the conversion contract as long as the member is actually covered under another group or individual plan or the member is eligible for comparable group coverage through an employer.

5.04 Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty: If

You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

- i) Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
- ii) You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Policy will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the policyholder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty Your coverage under this Policy may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

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.

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, as defined in the Schedule of Benefits (Exhibit A) and, if applicable, the Additional Benefit Rider (Exhibit C), attached hereto.

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

EASTERN VISION SERVICE PLAN, INC. SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of EASTERN VISION SERVICE PLAN, 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 Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of \$20.00 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 \$20.00 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 age 26.

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.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$200.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum \$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 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 not correctable 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 may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame 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 allowed 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.
- 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 \$20.00 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 \$20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

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

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

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

Lenticular Up to \$100.00* once every 12 months**

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

CONTACT LENSES

Elective

Elective Contact Lenses are covered up to \$185.00 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 day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-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.

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.



Kate Renwick-Espinosa, President

Exhibit B

**EASTERN VISION SERVICE PLAN, INC. (VSP)
SCHEDULE OF PREMIUMS
VSP Choice Plan**

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.

- \$ 7.92 per month for each eligible Enrollee without dependents.
- \$ 15.82 per month for each eligible Enrollee with an eligible spouse or Domestic Partner.
- \$ 16.94 per month for each eligible Enrollee with eligible child(ren).
- \$ 27.06 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.



Kate Renwick-Espinosa, President

Exhibit C

EASTERN VISION SERVICE PLAN, INC. ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of EASTERN VISION SERVICE PLAN, INC. ("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. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes 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 or Domestic Partner of Enrollee
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

PROGRAM DESCRIPTION

The Diabetic Eyecare Program ("DEP") 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 an Covered Person seeking services under 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 DEP Plus may include, but are not limited to:

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

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 Doctor 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 Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured 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 Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDER

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.
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.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.



Kate Renwick-Espinosa, President