

March 27, 2026



CHERYL THIBAUT
COUNTY OF SONOMA
1440 GUERNEVILLE RD

**RE: COUNTY OF SONOMA, GROUP #12437001
JUNE 1, 2026 DOCUMENTS**

Attention Cheryl Thibault:

Enclosed are the JUNE 1, 2026 documents for the above-referenced Client.

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 your client has with VSP. If you have any questions, or need additional information, please do not hesitate to contact us at 800-216-6248, and a VSP representative will assist you.

Enclosures

These documents are intended only for the client to whom they are addressed and may contain confidential information. If you are not the intended recipient (or the person responsible for delivering it to the intended recipient) and have received these documents in error, please notify the sender immediately by telephone, and destroy or delete these documents.



VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
(916) 851-5000 (800) 877-7195

GROUP VISION CARE PLAN

Group Name	COUNTY OF SONOMA
Plan Number	12437001
State of Delivery	CALIFORNIA
Effective Date	JUNE 1, 2026
Plan Term	SIXTY (60) MONTHS
Premium Due Date	FIRST DAY OF MONTH

In consideration of the statements and agreements contained in the Group Application, if applicable, and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN ("VSP") agrees to provide certain individuals under this Group Vision Care Plan ("Plan") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Plan 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 Plan.

Dave Plevyak, Chief Financial Officer

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I. DEFINITIONS

Key terms used in this Plan are defined:

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

1.02. **AFFILIATE:** As to either Party, any corporation or other entity that directly, or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common control with that Party. The term "***Control***" means the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

1.03. **BENEFIT AUTHORIZATION:** Authorization from VSP identifying the individual named a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

1.04. **COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985.

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

1.06. **CONFIDENTIAL INFORMATION:** The information as further defined in Paragraph 5.01 of this Plan.

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

1.08. **COPAYMENTS:** Any 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.

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

1.10. **ELIGIBLE DEPENDENT:** Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP in Article VI of this Plan under which such Enrollee is covered.

1.11. **EMERGENCY CONDITION:** A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

1.12. **ENROLLEE:** An employee or member of Group who meets the criteria for eligibility specified under Article VII. ELIGIBILITY FOR COVERAGE.

- 1.13. **EVIDENCE OF COVERAGE (“EOC”)**: A summary of the provisions of this Plan, prepared by VSP and provided to Group for distribution to Enrollees by Group.
- 1.14. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
- 1.15. **GROUP**: An employer or other entity which contracts with VSP for coverage under this Plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
- 1.16. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of VSP.
- 1.17. **GROUP VISION CARE PLAN (also, "THE PLAN")**: The Plan issued by VSP to a Group, under which its 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 Plan.
- 1.18. **OUT-OF-NETWORK 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.
- 1.19. **PLAN BENEFITS**: The vision care services and vision care materials which Covered Person is entitled to receive by virtue of coverage under this Plan, as defined in the Schedule of Benefits attached hereto as Exhibit A.
- 1.20. **PLAN TERM**: The length of time this PLAN is in effect, as shown on the front page of this Plan.
- 1.21. **RENEWAL DATE**: The date when the Plan shall renew, or terminate if proper notice is given.
- 1.22. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Plan, which lists the vision care services and vision care materials which Covered Person is entitled to receive under this Plan.
- 1.23. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.
- 1.24. **STATE OF DELIVERY**: The State in which this Plan is being issued, delivered or renewed.
- 1.25. **TERMINATION**: Cancellation of the Plan as stated in Article II.
- 1.26. **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 vision care services and/or vision care materials on behalf of Covered Persons of VSP.

II.
TERM, RENEWAL, AND TERMINATION

2.01. **Term**: This Plan is effective on the Effective Date noted on the front page of this plan, and shall remain in effect for the Plan Term, also noted on the front page of this Plan.

2.02. **Termination**:

(a) The Premium rate payable by Group to VSP under this Plan is based on an assumption that VSP will receive these amounts over the full Plan Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Plan Term. If Group terminates this Plan before the end of the Plan Term or before the end of any subsequent renewal terms, for any reason other than material breach by VSP, Group will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Group would have paid for the remaining term of this Plan, 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 Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay VSP within thirty-one (31) days of notification of the amount due.

(b) Plan Benefits will cease on the date of cancellation or termination of this Plan whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to a Covered Person as of the termination or cancellation date of this Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this Plan.

III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons:** VSP will enroll for coverage, as directed by Group, each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of who shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Group to complete, sign and forward to VSP a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

Following the enrollment of the Covered Persons, VSP will provide Group with Member Benefit Summaries for distribution to Covered Persons. Such Member Benefit Summaries will summarize the terms and conditions set forth in this Plan.

3.02. **Provision of Plan Benefits:** Through its VSP Network Providers (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Out-Of-Network Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, (Exhibit A (s)) and when purchased by Group, 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 Group, the Additional Benefit Rider. Covered Person may contact VSP Network Provider for information describing vision care services and vision care materials offered.

A Benefit Authorization must be obtained prior to a Covered Person obtaining 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 as a VSP Covered Person so the VSP Network Provider can obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the VSP Network Provider to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Group 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, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

3.03. **Payment of Claims:** 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.

3.04. **Out-Of-Network Provider Services:** When Covered Persons elect to utilize the services of a Out-Of-Network Provider, benefit payments for services from such Out-Of-Network Provider will be determined according to the Plan's Out-Of-Network Provider benefit fee schedule if Out-Of-Network Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Out-Of-Network 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 a Out-Of-Network Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Out-Of-Network Provider reimbursement schedule shown on the attached Schedule of Benefits (Exhibit A (s)) and Additional Benefit Rider (Schedule C(s)) (if purchased by Group), less any applicable Copayments.

3.05. **Provision of Information to Covered Persons:** Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Plan shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons. VSP shall provide Group with an updated list of VSP Network Providers' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the VSP Network Provider directory through contacting VSP's Customer Service Department's toll-free Customer Service telephone line (1-800-877-7195), VSP's Web site at www.vsp.com, or by written request.

3.06. **Preservation of Confidential Matters:** VSP shall hold in strict confidence all confidential information concerning the medical, personal, financial, or business affairs of Covered Persons obtained while providing Plan Benefits ("Confidential Matters") and exercise its best efforts to prevent any of its employees, VSP Network Provider, or agents from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Plan, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on VSP's Confidentiality policy may obtain a copy of the policy by contacting VSP's Customer Service Department or VSP's Web site at www.vsp.com.

3.07. **Emergency Vision Care**: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Network Provider or Out-of-Network Provider. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Supplemental Essential Medical Eye Care Plan. If Group has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department's toll-free number (1-800-877-7195) for assistance. Reimbursement and eligibility are subject to the terms of this Plan.

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

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

3.09 **Data Breach**

1. Data Security

Contractors shall preserve and shall ensure that its sub-consultants or vendors preserve, the confidentiality, integrity, and availability of County data with administrative, technical and physical measures that conform to generally recognized industry standards and best practices that the selected firm then applies to its own processing environment. Maintenance of a secure processing environment includes, but is not limited to, the timely application of patches, fixes and updates to operating systems and applications as provided by Contractor and/or its sub-consultants or vendors. Contractor agrees to and shall ensure that its sub-consultants or vendors comply with, and in the case of sub-consultants, substantially similar but no less restrictive standards than, the County's information security policies, standards, procedures, and guidelines as contained herein.

2 Encryption Requirements

Contractor shall encrypt and shall ensure that its sub-consultants or vendors encrypt confidential information whether the data is in transit, or at rest, including but not limited to Personally Identifiable Information (PII) or Protected Health Information (e.g., PHI, ePHI).

3 Security Breach

Contractors shall comply and shall ensure that its sub-consultants or vendors comply, with all applicable laws that require the notification of individuals in the event of unauthorized release of personally identifiable information (PII) or protected health information (e.g., PHI, ePHI) or other events requiring notification. In the event of a breach, or other event requiring notification under applicable law, Contractor shall:

- a. Notify County by telephone and e-mail within seventy-two (72) hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of information of which Contractor or its agents become aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations.
- b. Assume responsibility for informing all such individuals in accordance with applicable federal or state laws or regulations.
- c. Pursuant to Article 5 (Indemnification) of the Agreement, provide indemnity and other protection as specified therein.

4 Request for Audit

Contractors will accommodate and upon reasonable notice by Sonoma County, work with Sonoma County and/or its subcontractors to submit to a random information security audit. This is to ensure that the contractor's and/or vendor's information security practices or standards comply with Sonoma County's information security policies, standards, procedures and guidelines.

Cyber Risk Insurance Requirements

Contractors shall include cyber risk insurance requirements in compliance with County of Sonoma Risk Management standards.

IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Plan if he/she satisfies the enrollment criteria specified in Paragraph 7.01(a) and/or as mutually agreed to by VSP and Group. By the Effective Date of this Plan, Group shall provide VSP with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under this Plan as of that date. Thereafter, Group shall supply to VSP by the last day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from VSP's coverage rosters for the next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon VSP's request, Group shall make available for inspection records regarding the coverage of Covered Persons under this Plan.

4.02. **Prepayment Fees/Payment of Premiums**: By the last day of each month, Group shall remit to VSP the premiums payable for the next month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Plan. The Schedule of Premiums is incorporated in this Plan as Exhibit B provides the premium amount for each Covered Person. Only Covered Persons for whom premiums are actually received by VSP shall be entitled to Plan Benefits under this Plan and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received on time, VSP may terminate all rights of such Covered Person. Such rights may be reinstated only in accordance with the requirements of this Plan.

VSP may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving Group at least sixty (60) days advance written notice. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or there is a material change in Plan terms or conditions, provided any such change is mutually agreed upon in writing by VSP and Group.

Notwithstanding the above, VSP may increase premiums during a Plan Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums VSP received from Group.

4.03. **Grace Period**: Group shall be allowed a grace period of thirty-one (31) days following the premium payment due date to pay premiums due under this Plan. During said grace period, this Plan shall remain in full force and effect for all Covered Persons of Group. VSP will consider late payments at the time of Plan renewal. Such payment may impact Group's premium rates in future Plan Terms.

If Group fails to make any premiums payment due by the end of any grace period, VSP may notify Group that the premiums payment has not been made, that coverage is canceled and that Group is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the grace period through the effective date of termination. Group shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Plan.

4.04. **Distribution of Required Documents**: Group shall distribute to Enrollees any disclosure forms, plan summaries or other material required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by Group no later than thirty (30) days after the receipt thereof, or as required under state law.

V.

CONFIDENTIALITY AND MUTUAL NON-DISCLOSURE COVENANTS

VSP and Group have delivered, or will deliver, upon execution and delivery of this Plan, certain information about the properties and operations of their respective businesses. VSP and Group, therefore, agree as follows:

5.01. Definition of Confidential Information. For purposes of this Plan, “Confidential Information” means any data and/or information, in any form, disclosed by the disclosing party (“Discloser”) to the receiving party (“Recipient”) either before or after the Effective Date, which relates to Discloser and/or its Affiliates, and solely by way of illustration and not in limitation shall include the following information: (i) current or future product(s), services, methodologies, plans, designs, costs, prices, customer or doctor names and addresses, finances or financial information (including budgets), marketing plans or strategies (including e-commerce development plans), business plans, matters, opportunities or offerings, equipment and other purchase matters, strategic matters, research, development, know-how and/or personnel, (ii) is identified as confidential at the time of disclosure, (iii) given the nature of the information disclosed and the circumstances surrounding its disclosure, reasonably ought to be treated as Confidential Information by a person in the same industry as Discloser, or (iv) by law must be protected as Confidential Information. Recipient acknowledges that the Confidential Information is proprietary to Discloser and has been developed and obtained through great efforts by Discloser. Confidential Information shall not, however, include information that (A) at the time of disclosure is, or subsequently becomes, available to the public or the industry through no fault or breach on the part of Recipient; (B) Recipient can demonstrate to have had rightfully in its possession prior to disclosure by Discloser; (C) is independently developed by Recipient without the use of any Confidential Information; or (D) Recipient rightfully obtains from a third party who has the right to transfer or disclose it. Confidential Information shall also be deemed to include any and all confidential information defined as Confidential Matters hereunder, the treatment of which shall be as set forth in Paragraph 3.04 of this Plan.

5.02. Non-Disclosure and Non-Use of Confidential Information. Recipient shall not, directly or indirectly, without the prior written approval of Discloser in each instance or unless otherwise expressly permitted herein, use for its own benefit, publish or otherwise disclose to others, or authorize the use by others for their benefit, or to the detriment of Discloser’s Confidential Information. Recipient shall carefully restrict access to Discloser’s Confidential Information to only those of its and its Affiliates’ officers, directors, employees, agents and representatives (collectively, “Representatives”) who (i) clearly require such access in order to enable to perform their respective obligations under this Plan (ii) who are bound by confidentiality obligations that protect third party information which are at least as restrictive and protective as those contained in this Plan, and (iii) are not (or do not work for) direct competitors of Discloser. Recipient shall not use, copy, distribute and/or remove any of Discloser’s Confidential Information from Recipient’s premises except to the extent necessary or appropriate to carry out its respective obligations under the Plan, without the prior consent of Discloser.

Recipient and its Representatives will employ all security measures used for their own proprietary information of similar nature. Recipient agrees to advise and require its Representatives of their obligations to keep such information confidential and shall each be liable for any acts and omissions of their Representatives related thereto. Notwithstanding the foregoing, nothing in Section 5.02 shall prevent either party from compliance with California Public Record Law as it pertains to the Confidential Information.

5.03. Return or Destruction of Confidential Information. The Recipient, including its Personnel, its employees and/or agents shall upon request of Discloser (i) immediately return to Discloser's designated representative any and all documents or other information and materials in whatever form which contain Discloser's Confidential Information, or as permitted by Discloser, (ii) destroy all copies thereof, and certify to Discloser in writing that all copies of such documents or other information and materials have been destroyed; provided, however, that the Recipient may retain one set of such documents and other information and materials for archival purposes only, subject to the continuing confidentiality and security obligations set forth under this Plan. Recipient may disclose Discloser's Confidential Information if and to the extent required by a judicial or governmental request, requirement or order; provided that Recipient will take reasonable steps to give Discloser sufficient prior notice (to the extent that sufficient time is available) of such request, requirement or order for Discloser to contest, limit and/or protect such disclosure.

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

5.05. Survival: The obligations laid down in Section 5 shall continue and survive beyond the termination of this Plan.

VI.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

6.01. **General**: By this Plan, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Plan may be amended or terminated by agreement between VSP and Group as indicated herein, without the consent or concurrence of Covered Persons. This Plan, and all Exhibits, Riders and attachments hereto, constitute VSP's sole and entire undertaking to Covered Persons under this Plan.

As conditions of coverage, all Covered Persons under this Plan have the following obligations:

6.02 **Other Charges**: Any Copayments required under this Plan 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.

6.03. **Choice of VSP Network Provider**: 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 Benefit Authorization from VSP. Should the Covered Person receive Plan Benefits from a VSP Network Provider without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the VSP Network Provider will be considered a Out-of-Network Provider and the benefits available will be limited to those for a Out-of-Network Provider, if any. Covered Person may contact VSP Network Provider for information describing vision care services and vision care materials offered.

6.04. **Reimbursement Provisions/Submission of Non-Member Provider Claims:** If Out-of-Network Provider coverage is indicated in Exhibit A (Schedule of Benefits), written proof (receipt and the Covered Person's identification information) of all claims for services received from Out-of-Network Providers shall be submitted by Covered Persons to VSP within three hundred sixty-five (365) days of the date of service. VSP may reject such claims filed more than three hundred sixty-five (365) days after the date of service. Covered Person would need to submit a claim form, along with copies of any invoices or receipts received from the doctor for the services or materials, to VSP for reimbursement. You may obtain a claim form on vsp.com or by calling (800) 877-7195. Claim forms may be submitted at vsp.com or at the address below:

VSP
Attn: Claims Services
P.O. Box 495933
Cincinnati, OH 45249-5918

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 sixty-five (365) days after the date of service.

6.05. **Liability of Covered Person in the Event of Nonpayment by VSP:** By statute, every contract between VSP and a VSP Network Provider or shall provide that in the event VSP fails to pay a VSP Network Provider, the Covered Person shall not be liable to the VSP Network Provider for any sums owed by VSP.

6.06. **Complaints and Grievances:** Covered Persons shall report any complaints and/or grievances to VSP at the address given herein. 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 complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt.

6.07. **Claim Denial Appeals:** If, under the terms of this Plan, a claim is denied in whole or in part, 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 his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working 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 determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

b) Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) Other Remedies/Review by the Department of Managed Health Care: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 877-7195** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of the proposed service or treatment, coverage decisions for treatments that are experimental, investigational in nature and payment disputes for emergency or urgent medical reviews. The Department also has a toll-free telephone number **(1-888-466-2219)**, a TDD line **(1-877-688-9891)** for the speech and hearing impaired and its Internet Web site (<http://www.dmhc.ca.gov>) has complaint forms online. The Department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to Covered Persons, and the failure to use these procedures does not preclude Covered Person's use of any other remedy provided by law. You are not required to use a specific form to submit a grievance to the department. If a member or group contract holder submits a grievance to the plan or the department before the effective date of a cancellation, rescission, or nonrenewal for reasons other than nonpayment of premiums, the plan shall continue to provide coverage until a final determination regarding the request for review has been made.

When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise Covered Person to contact the U.S. Department of Labor. 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 review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

6.08. **Time of Action**: No action in law or in equity shall be brought to recover on the Plan prior to the Covered Person exhausting his/her grievance rights under this Plan and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices were submitted to VSP, in accordance with the terms of this Plan.

6.09. **Insurance Fraud**: Any Group and/or Person who intends to defraud, knowingly facilitates a fraud or submits an application or files a claim containing false or deceptive information, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Plan for the Group or individual that committed the fraud.

VII.
ELIGIBILITY FOR COVERAGE

7.01. **Eligibility Criteria:** Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees:** To be eligible for coverage, a person must:

(1) currently be an employee or member of the Group, and

(2) meet the criteria established in 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:

(1) the legal spouse of any Enrollee, and

(2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependent shall be eligible until the end of the month in which they attain the age of 26 years.

(3) as further defined by Group.

If a dependent unmarried 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. Coverage will continue as long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED 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.

7.02. **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 Social Security 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. As stated in Paragraph 4.01 above, VSP may elect to audit Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Plan.

7.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. 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.

7.04. **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 4.02. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Plan.

7.05. **Change in Family 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.) Group shall provide notice

of such change to VSP via the next eligibility listing required under Paragraph 4.01. 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 thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or 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 thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to VSP.

VIII.
CONTINUATION OF COVERAGE

8.01. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

8.02. **Individual Continuation of Benefits**: This Plan is available to groups of a minimum of two (2) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

IX.
ARBITRATION OF DISPUTES

9.01. **Dispute Resolution:**

VSP and Group agree that all disputes arising out of or relating to this Plan 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.

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

X.
NOTICES

10.01. **Required Notices:** Any notices required under this Plan to either Group or VSP shall be in written format. Notices sent to Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by the Group. Notices sent to VSP shall be sent to the address shown on the first page of this Plan. 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.

XI.
MISCELLANEOUS

11.01. **Entire Plan:** This Plan, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Plan must be approved by an officer of VSP and attached hereto to be valid. No agent has the authority to change this Plan or waive any of its provisions. Communication materials prepared by Group for distribution to Enrollees do not constitute a part of this Plan.

11.02. **Indemnity:** VSP agrees to indemnify, defend and hold harmless Group, 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 or covenants specified herein, including without limitation, breach of confidentiality. Group agrees to indemnify, defend and hold harmless VSP, its members or Covered Persons, 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 Group, its officers or employees to perform any of the duties, responsibilities or covenants specified herein, including without limitation, breach of confidentiality.

11.03. **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 Group 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 Plan.

11.04. **Assignment:** Neither this Plan 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.

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

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

11.07. **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.

11.08. **Equal Opportunity:** VSP is an Equal Opportunity and Affirmative Action employer.

11.09. **Communication Materials:** Communication materials created by Group which relate to this vision care Plan must adhere to VSP's Member Communication Guidelines distributed to Group by VSP. Such communication materials may be sent to VSP for review and approval prior to use. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Group's materials meet any applicable legal or regulatory requirements, including but not limited to, ERISA requirements.

11.10. **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.

EXHIBIT A

VISION SERVICE PLAN SCHEDULE OF BENEFITS VSP Signature Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein and forms a part of the Plan or Evidence of Coverage & Disclosure Form to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

If a dependent, unmarried 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 or at such other times as VSP may request proof, but not more frequently than annually.

**PLAN BENEFITS
VSP NETWORK PROVIDERS**

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

COVERED SERVICES

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

Comprehensive examination of visual functions.

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

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

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

Standard Progressive lenses are covered in full.

FRAMES: Covered up to \$150.00* towards the retail cost of the frame once every 24 months for adults and once every 12 months** for dependent children up to the end of the month in which they turn 26.**

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.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

*Less any applicable Copayment.

**beginning with the first date of service

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$130.00 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 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 visual problems that cannot be corrected with regular lenses, including

Supplemental Testing: Covered in full*

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

Supplemental Aids: 75% of VSP 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 Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the LightCare enhancement, if purchased by Group.
3. Two pair of glasses instead of bifocals.
4. 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.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

**REIMBURSEMENT SCHEDULE
FOR OUT-OF-NETWORK
PROVIDERS**

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

COVERED SERVICES

EYE EXAMINATION: Covered up to \$45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Lens Allowances	VSP Provider	Out of Network
Single Vision	Covered after Copay	up to \$45
Lined Bifocal	Covered after Copay	up to \$65
Lined Trifocal	Covered after Copay	up to \$85
Lenticular	Covered after Copay	up to \$125

FRAMES: Covered up to \$70.00* once every 24 months for adults and once every 12 months** for dependent children up to the end of the month in which they turn 26.**

CONTACT LENSES

Elective

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

Necessary

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

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

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

*Less any applicable Copayment.

**beginning with the first date of service

LOW VISION

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

Supplemental Testing: Up to \$125.00*

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

Supplemental Aids: 75% of Out-Of-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 Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

EXHIBIT B

**VISION SERVICE PLAN
SCHEDULE OF PREMIUMS
SIGNATURE 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:

\$ 14.29 per month for each eligible Enrollee (includes coverage for Eligible Dependents)

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

ADDENDUM

VISION SERVICE PLAN ADDITIONAL BENEFIT COMPUTER VISION CARE PLAN

GENERAL

This Rider lists the vision care benefits to which Covered Persons of Vision Service Plan (“VSP”) are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated and forms a part of the Plan and Evidence of Coverage & Disclosure Form to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED BELOW AND WHO UTILIZE A COMPUTER MONITOR SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.

ELIGIBILITY

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

- Enrollee

COVERED PERSONS WHO UTILIZE A COMPUTER MONITOR AND/OR DIGITAL MEDIA SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.

Covered Persons are eligible for CVC Plan Benefits if they have been diagnosed by an eye care professional as having a vision condition affecting computer and/or digital media use.

**PLAN BENEFITS
VSP NETWORK PROVIDERS**

COPAYMENT

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal. Specific Near Variable Focus and Occupational Progressives lenses specifically designed for working on a computer and /or digital media in glass/plastic materials,

FRAMES: Covered up to \$150.00* once every 24 months**

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

Associated Vision Therapy (specific to Computer and/or digital media use): Covered up to \$200.00 per year once every 12 months**

Includes any supplemental testing with treatment.

Plan Benefits for Vision Therapy are limited to Covered Persons who are eligible for CVC coverage and who are diagnosed as having one of the following conditions:

Accommodative Infacility: The inability (or the inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at objects up closely.

Convergence Insufficiency: The eye muscles' inability to point the eye straight when working up close.

Accommodative Spasm: a condition that causes the eye muscle to accommodate or focus constantly and automatically.

*Less any applicable Copayment.

**beginning with the first date of service

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 Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

1. Everyday eyewear glasses instead of computer glasses
2. Services and/or materials not specifically included in this schedule as covered Plan Benefits.
3. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
4. Non-covered lens enhancements defined in the lens section (example: Photochromic lenses, Sunglasses)
5. Two pair of glasses instead of bifocals.
6. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when Plan Benefits are otherwise available.
7. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer and/or digital media.
8. Medical or surgical treatment of the eyes.
9. Contact lenses.
10. Laminated lenses or tints greater than 20%.
11. Coordination of benefits (e.g., CVC coverage may not be used to cover extras from other plans and other VSP plans may not be used to cover CVC extras)
12. The patient must be eligible for lenses to obtain materials
13. If the patient cannot adjust to the occupational progressive lens, benefits will not be reinstated. Payment becomes a private transaction between the patient and the doctor.
14. Patients qualify for CVC materials only if the prescription differs by ± 0.50 diopters from glasses prescribed for every day use. Materials should be designed to be worn for computer and/or use only.
15. Local, state and/or federal taxes, except where VSP is required by law to pay

ADDENDUM

VISION SERVICE PLAN ADDITIONAL BENEFIT RIDER SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

If a dependent, unmarried 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 or at such other times as VSP may request proof, but not more frequently than annually.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care 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 available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("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, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

**PLAN BENEFITS
MEMBER DOCTORS**

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of \$20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

ADDENDUM

VISION SERVICE PLAN ADDITIONAL BENEFIT RIDER Kidscare Plan

GENERAL

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

Persons covered under this additional benefit are entitled to an exam and are also entitled to an additional pair of lenses or Necessary Contact Lenses, or Elective Contact Lenses, if:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder, or
- There is a change in the axis of 15 degrees or more, or
- There is a .5 prism diopter change in at least one eye.

ELIGIBILITY

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

- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

If a dependent, unmarried 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 or at such other times as VSP may request proof, but not more frequently than annually.

**PLAN BENEFITS
VSP NETWORK PROVIDERS**

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

COVERED SERVICES

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

Comprehensive examination of visual functions.

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

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

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

Standard Progressive lenses are covered in full.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$130.00 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 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.

FRAMES: Covered up to \$150.00* towards the retail cost of the frame once every 12 months**

*Less any applicable Copayment.

**beginning with the first date of service

EXCLUSIONS AND LIMITATIONS OF BENEFITS

KIDSCARE PLAN ONLY

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the SunCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. 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.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
12. Services and/or materials provided by someone other than a VSP Network Provider

EXHIBIT C

VISION SERVICE PLAN ADDITIONAL BENEFIT RIDER REPAIR/REPLACE BENEFITS

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("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. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

Repair/Replace Benefits provide coverage for materials obtained when the Covered Person is not eligible for materials under the Schedule of Benefits to which this Rider is attached. Covered Persons are eligible if their spectacle lenses or frame are broken or damaged and in need of repair or replacement.

Persons covered under this additional benefit may be entitled to eyeglass frame repairs, which shall include but not be limited to temples only, front only, hinge and miscellaneous repairs, or replacement of complete frame and single vision and multifocal lens repair or replacement.

ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years if a full-time student.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

SERVICES FROM MEMBER DOCTORS

PLAN BENEFITS

VSP may authorize payment under this Rider for materials for Covered Persons more frequently than 24 months if

1. Eyeglass frames are broken or damaged, which shall include but are not limited to temples only, front only, hinge and miscellaneous repairs. Replacement of complete frame may be covered if frame is damaged beyond repair.
2. Single vision and multifocal lens require repair or replacement.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
<p>Lenses</p> <p>Standard Progressive lenses covered in full.</p>	<p>Refer to Schedule of Benefits</p>	<p>Available once each 12 months**</p>
<p>Frames</p> <p>VSP reserves the right to limit the cost of the frames provided by its Member Doctors under the Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.</p> <p>If the Covered Person wishes to select a more expensive frame than that allowed under this Rider, the cost difference shall be by agreement between the Covered Person and Member Doctor.</p> <p>Plan Benefits for lenses are per complete set, not per lens.</p> <p>**Beginning with the first date of service.</p>	<p>Refer to Schedule of Benefits</p>	<p>Available once each 24 months**</p>

EXCLUSIONS AND LIMITATIONS OF BENEFITS

REPAIR/REPLACE BENEFIT ONLY

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

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
3. Two pair of glasses in lieu of bifocals.
4. Medical or surgical treatment of the eyes.
5. Corrective vision treatment of an Experimental Nature.
6. Services or materials of a cosmetic nature.
7. Costs for services and/or materials exceeding Plan Benefit allowances.
8. Services and/or materials not indicated on this Rider as covered Plan Benefits.

ADDENDUM

VISION SERVICE PLAN PERFORMANCE STANDARDS

VSP guarantees the performance standards outlined herein by offering to pay a financial penalty of 1% of quarterly gross premium per unmet standard, up to a total annual maximum of \$100,000 per performance standard. VSP's company-wide quarterly performance results shall be used in determining whether any or all of the performance standards have been met. Any penalties owed shall be accrued quarterly and paid on an annual basis (minimum annual payment threshold is \$250 for sum of all performance standards). Payment of penalties shall be conditioned on VSP's receipt of all premiums due to VSP within established due dates.

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

CLAIMS PROCESSING

Claims processing accuracy

Performance Standard = 99%

Performance Penalty = 1.0%

Claims processing accuracy is calculated on a monthly basis based upon daily audit results. The report of calculation shall be expressed in whole numbers and tenths, to the nearest tenth. The term "processing error" encompasses all errors found in the audit regardless of whether the error caused a financial impact. A field level review of the claims audited during the month is conducted. Each audited field is reviewed to determine if an error exists, this can result in a claim having more than one error. Processing accuracy is calculated at month's end based on the total number of errors found and the total number of fields on the claims audited.

Claims financial accuracy

Performance Standard = 99%

Performance Penalty = 1.0%

Claims financial accuracy is calculated much like that of claims processing accuracy. The same random sampling of claims audited for processing accuracy is also audited for financial accuracy. Any error found that results in a financial impact is recorded as a financial error. At the end of the month, financial errors are totaled and taken as a percentage of the total dollar paid for all claims audited during the given month. There will be a 0.5% allowable margin of error on the results. As an example, if there is a score of 98.5% or above, that shall be considered a passing score such that no performance penalty shall be imposed.

Claims timeliness

Performance Standard:

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

Performance Penalty = 1.0%

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

Performance Penalty = 1.0%

- All claims = 99% processed within 15 business days

Performance Penalty = 1.0%

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

CALL CENTER MANAGEMENT

Abandoned call rate

Performance Standard = Less than or equal to 3%

Performance Penalty = 1.0%

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

Average speed of answer

Performance Standard = Less than or equal to 25 Seconds

Performance Penalty = 1.0%

The average speed of answer (the amount of time a caller is waiting while on hold) is calculated by dividing the total time all calls are on hold (in seconds) by the total number of calls received. The report of calculation shall be expressed in whole numbers and tenths, to the nearest tenth.

Average call blockage rate

Performance Standard = Less than or equal to 2%

Performance Penalty = 1.0%

VSP call blockage is defined as any call blocked by VSP. A blocked call results in the caller receiving a "busy" signal, and is considered unsuccessful. VSP call blockage does not include calls blocked by the long distance carrier due to circumstances beyond VSP's control. VSP call blockage standard is 2% or less of total calls attempted to VSP. The formula for this standard is: The number of blocked calls divided by the total number of calls (received plus blocked) is less than or equal to 2%.

Call resolution (same day response)

Performance Standard = 98%

Performance Penalty = 1.0%

Measurement based on internal VSP system-driven statistics. The percentage of telephone inquiries handled within the same day is obtained by taking the number of inquiries entered into our system and dividing by the number of calls answered in the Call Center and subtracting the result from 1.00.

Complaint acknowledgement within 5 business days

Performance Standard = 96%

"Telephone complaints" not resolved by the end of the following business day must be acknowledged in writing within 5 business days. "Written complaints" not resolved within 5 business days will be acknowledged in writing on the 5th business day from receipt. Complaint acknowledgement compliancy is calculated quarterly. The method for calculating the percentage is: total number of complaints meeting the 5 business day goal divided by total number of complaints.

Complaint resolution within 30 calendar days

Performance Standard = 99%

Performance Penalty = 1.0%

When a complaint is received, in writing or via phone, the person receiving it documents it in our system. The Complaint and Grievance unit monitors this workflow to assure all complaints have been resolved by the 30th calendar day. Complaint resolution compliancy is calculated quarterly. The method for calculating the percentage is: total number of complaints meeting the 30 calendar day goal divided by total number of complaints.

Average response to e-mail inquiries within 2 business days

Performance Standard = 100%

The average time required to send the first reply to an email, in the specified time period.

SATISFACTION

Patient satisfaction (satisfied with level of coverage)

Performance Standard = 96% overall satisfaction with VSP

Performance Penalty = 1.0%

Performance Standard = 96% overall experience with VSP preferred provider

Performance Penalty = 1.0%

VSP conducts patient satisfaction surveys on a quarterly basis. A random sample of claims from the prior three months is chosen that is statistically representative of all claims.

While VSP makes recommendations to all prospective Groups on which plan we feel best suits the group's employees, the ultimate decision for selection of a plan rests with the Group. As such, our performance standard is based on patients who are satisfied with the level of coverage provided by their plan. Satisfied patients includes patients who rated their overall level of coverage as "Excellent," "Very Good" and "Good". Dissatisfied patients include patients who rated their overall level of coverage as "Fair" or "Poor".

VSP preferred provider retention rate (based on voluntary turnover)

Performance Standard = 98%

Performance Penalty = 1.0%

VSP preferred provider satisfaction is based on changes in the VSP preferred provider network. On a quarterly basis, the voluntary retention rate of providers (those choosing to stay on the VSP panel) is measured as a percentage of the total number of providers in the network. The annual preferred provider retention rate is equal to the total number of providers on the panel on December 31 divided by the total number of providers on the panel January 1 of that same year.

ACCOUNT ADMINISTRATION

Electronic eligibility online within 24 hours

Performance Standard = 98%

Performance Penalty = 1.0%

Percentage reported based on a measurement against all maintenance files* loaded within that quarter. VSP records both the received and loaded dates for all membership files. The data is calculated quarterly.

*All files measured for this standard must meet the following criteria:

- Identifiable Media: Eligibility file must be labeled properly.
- Proper Format: No change in format from the previously loaded eligibility file.
- Clean File:
 - 1) Electronic Media must have clean and complete data transmission. We must be able to successfully unzip/decrypt the incoming data.
 - 2) All media must contain proper/complete records for members and dependents.

Exclusions to this performance standard are as follows:

- 1) Membership files for open enrollment loaded prior to effective date.
- 2) Group/division restructures for existing groups (1st eligibility load based on the restructure will be excluded from the performance standard measurement).
- 3) Incorrect/Incomplete individual records for members and dependents.
- 4) If instructed to wait for group approval to load the file.

Online reports available by the 25th of the month

Performance Standard = 100%

Performance Penalty = 1.0%

All eligible online reports will be available on VSP's Resource Center by the 25th of each month.

Web portal availability

Performance Standard = 99%

Performance Penalty = 1.0%

Based on a 7 x 24 schedule.

ADDENDUM

VISION SERVICE PLAN THE CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT OF 1997 (CAL-COBRA)

Pursuant to California Health and Safety Code Section 1366.25, the following section is hereby incorporated into the Group Vision Care Plan, if, and only to the extent Cal-COBRA applies to the parties to this Plan:

The California Continuation Benefits Replacement Act of 1997 (**Cal-COBRA**) requires health care service plans providing contracted coverage to employers with 2 to 19 eligible employees to offer continuation coverage for purchase by qualified beneficiaries upon the occurrence of a qualifying event. VSP and Group are subject to the following obligations in connection with continuation coverage:

1. Group agrees to provide VSP with notice of any employee who has had a “qualifying event”, within 31 days of the qualifying event. A “qualifying event” means any of the following events that, but for the election of continuation coverage provided thereunder, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

- The death of the covered employee.
- The termination or reduction of hours of the covered employee’s employment, except that termination for gross misconduct does not constitute a qualifying event.
- The divorce or legal separation of the covered employee from the covered employee’s spouse.
- The loss of dependent status by a dependent enrolled in the group benefit plan.
- With respect to a dependent only, the covered employee’s eligibility for coverage under Title XVIII of the United States Social Security Act (Medicare).

Within 14 days of receipt of the foregoing notice of a qualifying event from Group, VSP will send to the qualified beneficiary’s last known address, as provided by Group, the necessary benefits information, premium information, enrollment forms, and instructions to allow the qualified beneficiary to formally elect continuation coverage.

2. Group agrees to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered under Cal-COBRA, as specified in Health and Safety Code Section 1366.27, a minimum of 30 days prior to the termination, of the qualified beneficiary’s ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. Group agrees to provide qualified beneficiaries subject to this paragraph with the necessary benefits information, premium information, enrollment forms, and instructions to allow the qualified beneficiary to continue coverage. This information shall be sent to the qualified beneficiary’s last known address, as provided by the plan currently providing continuation coverage to the qualified beneficiary.