Vision Care for Life

VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE POLICY

Group Name	**LEE COUNTY**
Policy Number	**30084530**
State of Delivery	**FLORIDA**
Effective Date	**JANUARY 1, 2019**
Policy Term	**THIRTY-SIX (36) MONTHS**

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Group 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.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date last below written.

WITNESS:

Signed By: Tammi Bennett

Print Name: Tammi Bennett

Vision Service Plan Insurance Company

Signed By: Kate Renwick-Espinosa

Print Name: Kate Renwick-Espinosa

Title: President

Date: December 18, 2018

LEE COUNTY

BOARD OF COUNTY COMMISSIONERS

OF LEE COUNTY, FLORIDA

BY: Brian Hamman

Vice CHAIR

DATE: 1/2/19

ATTEST:

CLERK OF THE CIRCUIT COURT

Linda Doggett, Clerk

BY: Chris Lee

DEPUTY CLERK

BOARD OF COUNTY COMMISSIONERS SEAL LEE COUNTY, FLORIDA

APPROVED AS TO FORM FOR THE RELIANCE OF LEE COUNTY ONLY:

BY: Andrea R. Fraser

OFFICE OF THE COUNTY ATTORNEY

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VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY

I.

DEFINITIONS

The key terms in this Policy are defined:

1.01. **ADDITIONAL BENEFIT RIDER**: The document, attached as Exhibit C to this Policy (if purchased by Group), 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 Group in conjunction with a Plan Benefit offered under Exhibit A.

1.02. **ADMINISTRATIVE SERVICES PROGRAM**: A group vision care plan whereby Group pays VSP for the Plan Benefits in addition to a monthly administrative fee.

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

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

1.05. **COORDINATION OF BENEFITS**: Procedure which allows more than one insurance plan to consider Covered Person's vision care claims for payment or reimbursement.

1.06. **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 provided.

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

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

1.09. **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.

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

1.11. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care

profession, as determined by VSP.

1.12. EVIDENCE OF COVERAGE: A summary of the Policy provisions, prepared by VSP and provided to Group for distribution to Enrollee.

1.13. GROUP: An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

1.14. 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.

1.15. GROUP VISION CARE Policy (also, "The Policy"): The **Policy** 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 Policy.

1.16. VSP NETWORK DOCTOR: 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.

1.17. NON-VSP 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.

1.18. 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 purchased by Group, the Additional Benefit Rider (Exhibit C), attached hereto.

1.19. RENEWAL DATE: The date when the Policy shall renew, or terminate if proper notice is given.

1.20. 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.

1.21. 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.

II.

TERM, TERMINATION, AND RENEWAL

2.01. This Policy is effective on the Effective Date and shall remain in effect for the Policy Term. The Policy shall terminate at 11:59 p.m. in the state of delivery on the last day of the Policy Term unless the parties mutually agree on its renewal of the Policy.

If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Policy Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Policy Term, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Term. The initial Policy shall be a period of one (1) year with the option of three (3) additional one (1) year renewals, subject to the mutual written agreement of both parties. The rate established in the initial one-year term is guaranteed for three years and shall not increase during the Policy Term.

2.02. **Early Termination Provision**: The premium rate payable by Group under this Policy is based on an assumption that VSP will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If Group terminates this Policy before the end of the Policy Term or before the end of any subsequent renewal terms, for any reason other than material breach by VSP, then 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 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 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. VSP shall return any unearned premiums to Group upon termination.

III.

OBLIGATIONS OF VSP

3.01. **Coverage of Insureds**: VSP will enroll for coverage 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 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 and a copy of the Evidence of Coverage, with Exhibits, for distribution to Covered Persons. Such Member Benefit Summaries and Evidence of Coverage will summarize the terms and conditions set forth in this Policy.

3.02. **Provision of Plan Benefits**: Through its VSP Network Doctors (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-VSP Provider), VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A) or, when purchased by Group, Additional Benefit Rider (Schedule C) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a VSP Network Doctor. When a Covered Person seeks Plan Benefits from a VSP Network Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person, so the VSP Network Doctor can obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the VSP Network Doctor 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 Doctor 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.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, but not more than thirty (30) calendar days after VSP has received a completed claim, unless special circumstances require additional time. If VSP requires additional information in order to pay or deny all or any portion of a claim, VSP will notify the person submitting the claim within forty-five (45) days after the receipt of the claim. Upon receipt of the requested information, VSP will pay or deny the claim within sixty (60) days. All claims shall be paid or denied by VSP within one hundred twenty (120) days after receipt of claim.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-VSP PROVIDERS ARE USED.

When Covered Persons elect to utilize the services of a Non-VSP Provider for a covered service in non-emergency situations, benefit payments for services from such Non-VSP Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Policy's Non-VSP Provider fee schedule. COVERED PERSONS CAN EXPECT TO BE LIABLE FOR MORE THAN THE COPAYMENT AMOUNT DEFINED IN THE ATTACHED SCHEDULE OF BENEFITS OR ADDITIONAL BENEFITS RIDER (when purchased by Group) AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

When payment is made to the Non-VSP Provider, the provider may bill Covered Persons for any amount up to the billed charges after the Plan has paid its portion of the bill. VSP Network Doctors have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Copayments, co-insurance and any amounts for non-covered services and/or materials. Covered Persons may obtain further information about the participating status of providers and information on out-of-pocket expenses through www.vsp.com, or by calling VSP's Customer Service Department at 1-800-877-7195.

3.03. 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 Policy 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 Doctors' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the VSP Network Doctor directory through VSP's website at www.vsp.com, VSP's Customer Service Department's toll-free telephone line, or by written request.

3.04. **Preservation of Confidentiality**: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, VSP Network Doctors, 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 Policy, or to comply with applicable law. Covered Persons and/or Groups that want more information on VSP's Confidentiality Policy may obtain a copy of the policy from VSP's website at www.vsp.com or by contacting VSP's Customer Service Department.

3.05. **Emergency Vision Care**: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Network Doctor or Non-VSP 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 Acute EyeCare and Supplemental Primary EyeCare Plans. 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 for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

3.06 **Coordination of Benefits:** When VSP is primary, it will pay benefits according to the terms of the Policy, subject to any applicable state or federal codes, statutes or regulations. When VSP is secondary, it will coordinate those vision care services and materials that were considered by the primary plan ("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.

IV.

OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and as established by Group. By the Effective Date of this Policy, 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 Policy as of that date. Thereafter, Group shall supply to VSP by the 15th day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from VSP's coverage rosters. All additions and deletions shall become effective on the first day of the month specified by Group. 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 Policy.

4.02. **Payment of Premiums**: By the first 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 Policy. The Schedule of Premiums incorporated in this Policy 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 Policy and only for the period for which such payment is received, subject to the grace period provision below.

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 Policy Term unless there is a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Group), or there is a material change in Policy 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 Policy 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 sixty (60) days following the premium payment due date to pay premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Covered Persons of Group. VSP will consider late payments at the time of Policy renewal. Such payment may impact Group's premium rates in future Policy 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 Policy.

4.04. Distribution of Required Documents: Group shall distribute to Enrollees any disclosure forms, Policy summaries or other material required to be given to Policy 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 applicable law.

4.05. Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.

V.

OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

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

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

5.02. **Copayments for Services Received**: Where, as indicated in Exhibit A (Schedule of Benefits) and Exhibit C (Additional Benefit Rider) when purchased by Group, Copayments are required for certain Plan Benefits. Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid at the time services are rendered. Amounts that exceed Plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

5.03. **Obtaining Services from VSP Network Doctors**: Benefit Authorization must be obtained prior to receiving Plan Benefits from a VSP Network Doctor. When a Covered Person seeks Plan Benefits, the Covered Person must select a VSP Network Doctor, schedule an appointment, and identify himself as a Covered Person so the VSP Network Doctor can obtain Benefit Authorization from VSP. Should the Covered Person receive Plan Benefits from a VSP Network Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the VSP Network Doctor will be considered a Non-VSP Provider, and the benefits available will be limited to those for a Non-VSP Provider, if any.

5.04. **Submission of Non-VSP Provider Claims**: If Non-VSP Provider coverage is indicated in Exhibit A (Schedule of Benefits) or Exhibit C (Additional Benefit Rider), when purchased by Group, written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-VSP 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.

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.

5.05. **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/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

5.06. Claim Denial Appeals: If, under the terms of this Policy, 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 their provider, as their 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 response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

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: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. 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.

5.07. **Time of Action**: No action in law or in equity shall be brought to recover on the Policy 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 any applicable statute of limitations from the time such claim and invoices are required to be given, in accordance with the terms of this Policy.

5.08. **Insurance Fraud**: Any Group and/or person who intends to defraud, knowingly facilitates a fraud, or submits an application, or files a claim with a false or deceptive statement, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Policy for the Group or individual that committed the fraud. In the absence of fraud, all statements made by Group or Enrollees shall be deemed representations and not warranties and no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by Group or Enrollee, a copy of which has been furnished to Group or Enrollee or Enrollee's beneficiary.

VI.

ELIGIBILITY FOR COVERAGE

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

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

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

b.) Eligible Dependents: If dependent coverage is provided, the persons eligible for dependent coverage are specified on the attached Schedule of Benefits and Additional Benefit Riders (if applicable).

If a dependent child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated and at such other times as VSP may request proof, but not more frequently than annually.

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

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

b) for changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein. As stated in paragraph 4.01 above, VSP may elect to audit Group's records 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 to under this Policy.

6.03. 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. As stated in Section 4.01 herein, Group agrees to provide timely eligibility changes to VSP.

6.04. Change of Participation Requirements, Contribution of Fees, and Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Policy, and Group's contribution and eligibility requirements, are all material to VSP's obligations under this Policy. During the term of this Policy, 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 Policy must be agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Policy 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 Policy.

6.05. Change in Family or Employment Status: In the event Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent, etc.] or employment status, Group shall provide notice of such change to VSP via the next eligibility listing required under Paragraph 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 for a period of at least sixty (60) days after birth, and an adopted child will be covered for a period of at least sixty (60) days after the date the Enrollee or the Enrollee's spouse acquires the right to control that child's health care. If Enrollee provides notice to the Group within said sixty (60) day period, VSP shall not deny coverage for said newborn or adopted child. Coverage for an adopted newborn will begin from the moment of birth if an agreement to adopt is entered into by Enrollee or Enrollee's spouse, and the child is ultimately placed in the Enrollee's home. To continue coverage for a newborn or adopted child beyond the initial sixty (60) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to VSP.

VII.

CONTINUATION OF COVERAGE

7.01. **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 to said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to the parties to this Policy, VSP shall make the required COBRA continuation coverage available for purchase in accordance with COBRA.

VIII.

DISPUTES

8.01. **Dispute Resolution**: Any dispute or question arising between VSP and Group involving the application, interpretation, or performance under this Policy shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact-finding and mediation.

8.02. **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 Florida shall be the applicable law.

IX.

NOTICES

9.01. **Notice**: Any notices required under this Policy to either Group or VSP shall be in written format. Notices sent to the Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by Group. 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.

X.

MISCELLANEOUS

10.01. Entire Policy: This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments 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 Policy must be approved by an officer of VSP and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Group for distribution to Enrollees do not constitute a part of this Policy.

10.02. Incorporation of Insured's Solicitation Documents: To procure the products and services supplied by the Insurer, the Insured issued Lee County Solicitation No. RFP180163LKD on March 16, 2018, which is deemed incorporated into this agreement as if attached hereto. The Insurer's submission in response to the Insured's solicitation is also incorporated into this agreement as if attached hereto. In the event of a conflict between this Agreement, VSP's response, and RFP180163LKD, the provisions of RFP180163LKD shall take precedence.

10.03. 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 specified herein. Subject to the provisions of section 768.28 Florida statutes, Group 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 of any nature whatsoever arising or resulting from the failure of Group, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

10.04. Liability: VSP arranges for the provision of vision care services and materials through agreements with VSP Network Doctors. VSP Network Doctors are independent contractors and are responsible for exercising independent judgement. 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 Policy.

10.05. 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.

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

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

10.08. 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.

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

10.10. Communication Materials: Communication materials created by Group which relate to this vision care Policy 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. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan
Low Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are available and received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

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

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

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

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

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

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

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 45.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.			
*Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Lenses			Available once each 12 months**
Single Vision	Covered in full *	Up to $ 30.00*	
Bifocal	Covered in full *	Up to $ 50.00*	
Trifocal	Covered in full *	Up to $ 65.00*	
Lenticular	Covered in full *	Up to $ 100.00*	
Plan Benefits for lenses are per complete set, not per lens. Polycarbonate lenses are covered in full for dependent children up to age 26 Standard Progressive Lenses covered in full *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Anti reflective Coating	Member cost $41.00	Not covered	
Custom Progressive	Member cost $150.00-$175.00	Not covered	
Premium Progressives	Member cost $95.00-$105.00	Not covered	
Photochromic	Member cost $70.00-$82.00	Not covered	
Scratch coating	Covered in full	Not covered	
Polycarbonate lenses	Covered in full[1]	Not covered	
UV (ultraviolet) protected	Covered in full[1]	Not covered	
1. Less $ 10.00 Copayment. 2. Less $ 10.00 Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 24 months**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $ 120.00	**Professional Fees/Materials** Up to $ 105.00	

**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
NECESSARY CONTACT LENSES			Available once each 12 months**
Professional Fees and Materials	Covered in full *	Up to $ 210.00*	

*Less any applicable Copayment
**Beginning with the first day of the Benefit Period.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
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.)	Up to $125.00*	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCEPTIONS

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

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating Member's cost $41.00
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2. Member's cost $70.00-$82.00
- Premium Progressive multifocal lenses Member's cost $95.00-$105.00
- Custom Progressive multifocal lenses . Member's cost $150.00-$175.00
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

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

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once each 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses

Single Vision, Lined Bifocal or Lined Trifocal,	Covered in Full*	Available once each 12 months**

Polycarbonate lenses are covered in full for dependent children up to age 26
Standard Progressive Lenses covered in full

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full[1] once every 12 months**
UV (ultraviolet) protected-Covered in full once every 12 months**
1. Less $ 10.00 Copayment.

Frames	Covered up to the Plan allowance*	Available once each 24 months**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $ 120.00	Available once each 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 Contact Lenses	Up to $210.00*	Available once each 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.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan
High Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are available and received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

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

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

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

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

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

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

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 45.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Lenses			Available once each 12 months**
Single Vision	Covered in full *	Up to $ 30.00*	
Bifocal	Covered in full *	Up to $ 50.00*	
Trifocal	Covered in full *	Up to $ 65.00*	
Lenticular	Covered in full *	Up to $ 100.00*	
Plan Benefits for lenses are per complete set, not per lens. Polycarbonate lenses are covered in full for dependent children up to age 26 *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Anti-reflective coating	Covered in full	Not covered	
Scratch coating	Covered in full	Not covered	
Polycarbonate lenses	Covered in full	Not covered	
Photochromic lenses	Covered in full	Not covered	
Standard, Custom and Premium Progressive lenses	Covered in full	Up to $ 50.00	
UV (ultraviolet) protected	Covered in full	Not covered	
**Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 24 months**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $ 150.00	**Professional Fees/Materials** Up to $ 105.00	

**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
NECESSARY CONTACT LENSES			Available once each 12 months**
Professional Fees and Materials	Covered in full *	Up to $ 210.00*	

*Less any applicable Copayment
**Beginning with the first day of the Benefit Period.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
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.)	Up to $125.00*	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCEPTIONS

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

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

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

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once each 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses		
Single Vision, Lined Bifocal or Lined Trifocal,	Covered in Full*	Available once each 12 months**

LENS OPTIONS
Anti-reflective Coating-Covered in full once every 12 months**
Scratch Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full once every 12 months**
Photochromic Lenses-Covered in full once every 12 months**
Standard, Premium and Custom Progressive Lenses-Covered in full once every 12 months**
UV (ultraviolet) protected-Covered in full once every 12 months**

Frames	Covered up to the Plan allowance*	Available once each 24 months**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $ 150.00	Available once each 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 Contact Lenses	Up to $210.00*	Available once each 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.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

Exhibit B

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

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

$ 9.62 per month for each eligible Enrollee without dependents
$ 18.75 per month for each eligible Enrollee with eligible dependents

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

Exhibit B

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

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

$ 16.75 per month for each eligible Enrollee without dependents
$ 32.00 per month for each eligible Enrollee with eligible dependents

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.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein 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 Policy, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

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

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

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

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

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

- diabetic retinopathy
- diabetic macular edema
- rubeosis

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 Person do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP NETWORK DOCTORS

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 Person 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 Plan Benefits.
2. Frames, 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.
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 PROGRAM DEFINITIONS

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.