County Health Pool

Vision
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF VISION BENEFITS
2021

CTSI
Serving Colorado's Counties

vsp

Covered Benefits	IN-NETWORK
	This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the County Health Pool/VSP Plan Document. The VSP/CHP Plan Document is available at www.ctsi.org
EXAMINATION	$15 Co-pay A complete exam once every 12 months
EYEGLASS LENSES AND FRAMES	$15 Co-pay Necessary lenses once every 12 months Frame allowance, once every 24 months ($150 allowance) · $$150 allowance for wide selection of frames ($80 allowance at Costco) · $$170 allowance for featured frame brands · 20% savings on the amount over your allowance
CONTACT LENSES	No Co-pay Once every 12 months in lieu of eyeglasses • $150 allowance for contacts • $60 maximum OOP contact lens exam (fitting and evaluation)
COVERED PROVIDERS	Vision Service Plan(VSP) Preferred PPO Consult www.vsp.com or call Customer Service at 1-800-877-7195
EXTRA DISCOUNTS AND SAVINGS	**Laser Vision Correction Discounts** • (15% off regular price or 5% off promotional price. Only available at contracted facilities.) **Prescription Eyeglasses, Sunglasses** • Up to 20% to 25% savings on lens extras such as scratch resistant, anti-reflective coatings and progressives. 20% off additional prescription glasses and sunglasses, including lens enhancements from the VSP provider on the same day as your Well Vision Exam, or receive 20% discount from any VSP provider within 12 months of your last Well Vision Exam • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. **Contacts** • 15% off cost of contact lens exam (fitting and evaluation)

Covered Benefits	IN-NETWORK
Non VSP Provider Coverage	**Exam……up to $45** **Frame …… up to $70** **Single Vision Lenses…...up to $30** **Lined Bifocal Lenses… up to $50** **Lined Trifocal Lenses.....up to$65** **Progressive Lenses…....up to $50** **Contacts……..up to$110**

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I.
DEFINITIONS

Key terms used in this Plan are defined and shall have the meaning set forth as follows, unless the context of a term's usage clearly requires otherwise.

1.01 ADMINISTRATIVE FEE: The payments made to VSP by or on behalf of Group in consideration of administrative services rendered.

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. ADVANCE PAYMENT: The amount paid in advance to VSP by or on behalf of Group to cover the estimated benefit costs of Group for one (1) month.

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

1.05. CLAIMS AMOUNT: Total charges for benefits delivered, including the cost of professional services and ophthalmic materials, charges for VSP services related to materials purchased, and taxes.

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

1.07. COPAYMENTS: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

1.08. COVERED PERSON: An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and who is covered under this Plan.

1.09. 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.

1.10. 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.

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

1.12. EXPERIMENTAL NATURE: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

1.13. 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.

1.14. 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 PLAN (also, "THE PLAN"): The Plan provided by VSP in favor of a Group, under which its Enrollees, and their Eligible Dependents are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Plan.

1.16. MEMBER 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-MEMBER 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 BENEFITS: The vision care services and vision care materials which a 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.

1.19. RENEWAL DATE: The date on which the Plan shall renew, or terminate if proper notice is given.

1.20. SCHEDULE OF BENEFITS: The document, attached hereto as Exhibit A, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this Plan.

1.21. SCHEDULE OF ADVANCE PAYMENT AND ADMINISTRATIVE FEE: 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 to Plan Benefits.

II.
TERM, TERMINATION, AND RENEWAL

2.01. Plan Term: This Plan shall become effective on the Effective Date and shall remain in effect for the Plan Term. At the end of the Plan Term, it will renew on a month to month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Plan Term, that the party is unwilling to renew the Plan. If such notice is given, the Plan will terminate at 12:00 midnight on the last day of the Plan Term, unless the parties reach mutual agreement on its renewal. If the Plan continues on a month to month basis after the Plan Term, either Party may thereafter terminate the Plan upon thirty (30) days advance written notice to the other party.

If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Plan Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Plan Term, this Plan shall terminate at 12:00 midnight on the last day of the Plan Term as noted above.

2.02. Termination: Either party may terminate the agreement upon a sixty (60) day advance written notice. Group agrees to pay all Claims Amount and Administrative Fees for Plan Benefits provided pursuant to Benefit Authorizations issued prior to the Plan termination date, provided claims for such Plan Benefits are filed with VSP within six (6) months after termination of this Plan.

III.
OBLIGATIONS OF VSP

3.01. Coverage of Covered Persons: VSP will enroll each eligible Enrollee and his Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to as "Covered Persons." To institute coverage, Group may be required to complete and sign a Group Application and forward such application to VSP, along with information regarding Enrollees and Eligible Dependents, and applicable amounts due. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

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

3.02. Provision of Plan Benefits: Through its Member Doctors (or through other licensed vision care providers in cases where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A 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 Member Doctor. When a Covered Person desires to receive Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person in order for the Member Doctor to obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the Member Doctor to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, allowing a specific period of time for the Covered Person to obtain Plan Benefits. Benefit Authorization shall be issued by VSP 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 Member Doctor that payment will be made. VSP shall not be held liable to Group for any Benefit Authorization issued in error in reliance on the latest eligibility information available to VSP as provided by the Group.

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 has received a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. Provision of Information to Covered Persons: Upon request, VSP will make available to Covered Persons necessary information describing Plan Benefits and procedures. A copy of this Plan will be placed with Group. The Plan will also be available at the offices of VSP for copying or inspection by Covered Persons. VSP shall provide

Group with an updated list twice annually of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons. Covered Persons may also obtain a copy of the latest Member Doctor list by contacting VSP's Customer Service Department in writing or via the toll-free Customer Service telephone line, or by visiting VSP's Web site at www.vsp.com.

3.04. Preservation of Confidentiality: VSP will hold in strict confidence all Confidential Matters. VSP will also exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter. An exception would be if 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 as may otherwise be required by 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 by visiting VSP's Web site at www.vsp.com.

3.05. Emergency Vision Care: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Member Doctor 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 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 plans 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 Plan.

IV.
OBLIGATIONS OF THE GROUP

4.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Plan, if he satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by VSP and Group. Group shall provide monthly eligibility information to VSP in a mutually agreed upon format and medium to identify all Enrollees who are eligible for coverage under this Plan. Group will supply to VSP, on or before 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 coming month. The eligibility information shall include designation of family status for each such Enrollee, if dependent coverage is provided. Group shall, when requested, make available for inspection by VSP records having a bearing on the coverage of Covered Persons under this Plan.

4.02. Claims Amounts and Advance of Payment: Group shall provide all funds necessary to pay the Claims Amount associated with Covered Persons pursuant to this Plan. In order to assure timely and adequate payment, Group agrees to make an Advance Payment as outlined on the attached Schedule of Advance Payment and Administrative Fee, Exhibit B. This Advance Payment is an estimate of the Claims Amount for one (1) month. Group agrees to pay the actual Claims Amounts on a monthly basis within ten (10) days after receipt of VSP's statement. The Advance Payment amount may be adjusted each Plan Term if the average of monthly Claims Amount increases or decreases. The parties agree that such Advance Payment is reimbursable to the Group upon termination of this Plan, after the Group's indebtedness to VSP and/or its benefit providers has been satisfied. However, amounts paid to VSP as Advance Payment shall not be considered assets of the Group, and need not be held in trust by VSP.

4.03. Administrative Fee: Additionally, on or before the first day of each month, Group shall remit to VSP an Administrative Fee as outlined on the attached Schedule of Advance Payment and Administrative Fee, Exhibit B. Change will not be made to the Administrative Fee during any Plan Term unless there is a change in the Schedule of Benefits or a material change in any other terms and conditions of the Plan, provided any such change is mutually agreed upon in writing between VSP and Group.

Notwithstanding the above, VSP reserves the right to increase amounts due hereunder during a Plan Term by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the amount due VSP from Group.

4.04. Grace Period: Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of amounts due under this Plan. During the grace period, this Plan will remain in full force and effect for all Covered Persons. Late payments will be considered by VSP at the time of Plan renewal and may impact Group's

Advance Payment and Administrative Fees in future Plan Terms.

If Group fails to make any payment of amounts due by the end of any grace period, VSP may notify Group that the payment of amounts due has not been made, that coverage is canceled and that the Group is responsible for payment for the Claims Amount associated with Plan Benefits provided to Covered Persons after the last period for which amounts due were fully paid, including the grace period and through the effective date of the termination. Group shall also remain responsible for payment, in accordance with Paragraph 2.02, of any Claims Amount associated with Benefit Authorizations outstanding at the time of termination, and for any legal and/or collection fees incurred by VSP in collecting amounts due under this Plan.

4.05. Distribution of Required Documents: Group agrees to distribute to Enrollees any disclosure forms, plan summaries or other materials that may be 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 receipt or as otherwise required under state law.

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

5.01. General: By this Plan, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. This Plan may be amended or terminated by agreement between VSP and Group as otherwise indicated herein. Consent or concurrence of Covered Persons for any such amendment or termination is not necessary. This Plan, and all Exhibits, attachments and amendments, constitute VSP's sole and entire undertaking to Covered Persons under this Plan.

All Covered Persons under this Plan shall have the following obligations as a condition of their coverage.

5.02. Copayments for Services Received: Where, as indicated on the Schedule of Benefits, Exhibit A hereto, Copayments are required for certain Plan Benefits, these Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Member Doctor (or Non-Member Doctor if Non-Member Provider benefits are indicated on the attached Schedule of Benefits at Exhibit A) on the date the services are rendered.

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

5.04. Submission of Non-Member Provider Claims: All claims for services received from Non-Member Providers (if Non-Member Provider coverage is indicated on the attached Schedule of Benefits at Exhibit A) shall be submitted by Covered Persons to VSP within one hundred eighty (180) days of the date of service. VSP reserves the right to reject such claims which are filed more than one hundred eighty (180) days after the date of service. Failure to submit a claim within one hundred eighty (180) days, 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 was reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date.

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 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 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 a 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) Third Level Appeal: This is an appeal of an adverse Utilization Review Determination that has not been resolved to the Enrollee's satisfaction under the Level 2 Appeal process. The Level 3 Appeal must be requested within 30 calendar days after the Enrollee receives the adverse determination of the Level 2 Appeal from Anthem, on behalf of the Plan. Enrollees, or their representative, must send Level 3 Appeals, in writing, to the following address:

County Health Pool Board of Directors
C/O Benefits Manager
800 Grant St., Suite 400
Denver, CO 80203

The Board of Directors will issue a copy of the written decision, if any, to the Enrollee, to the Enrollee's representative, or to the Provider who submits a Level 3 Appeal on the Enrollee's behalf within 60 workdays of the Board of Directors receipt of the Level 3 Appeal request.

5.07. 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 grievance rights as described in Paragraphs 5.05 and 5.06 above 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 may be submitted to VSP, in accordance with the terms of this Plan.

VI.
ELIGIBILITY FOR COVERAGE

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

Employee Participants

An Employee is one who works at least 30 hours per week (full-time employment status) directly in the regular business of and is compensated for services by the Member or Member Affiliated Entity. Elected officials, except for non-salaried elected officials and Licensed Professional Elected Officials, are considered Employees under the Plan. At the option of the Member, permanent part-time and/or any other employees that qualify under the Affordable Care Act working a minimum of 24 hours per week, and Licensed Professional Elected Officials may be eligible for coverage; in such case, such qualified part-time Employees and Licensed Professional Elected Officials are considered Employees under the Plan. Also, at the option of the member, employees that are participants in a retirement incentive program provided through the member, and who are between 62 and 65 years of age with a minimum of 5 consecutive years of employment service, may be eligible for coverage; in such case, Incentivized Retirees are considered Employees under the Plan. Incentivized Retirees eligibility for coverage would be limited to coverage starting as early as the month in which they become 62 years of age and ending at the end of the month in which they become 65 years of age Temporary Employees and retirees are not eligible and cannot be considered for coverage. Eligibility for coverage as an Employee Participant in the Plan begins subsequent to the day a person commences either full-time or qualifying part-time employment, in accordance with individual policies set by Members.

Suspension or denial of eligibility, coverage, and benefits may occur should an Employee Participant fail to do any of the following:

- Pay required contribution, if any, to the Plan.
- Furnish any information, records or releases that the Plan may require in order to adjudicate a claim.
- Cooperate with the procedures and investigations of the Plan.
- Meet the requirements of the Plan Document and Summary Plan Description.

- Meet the definition Employee as stated above.

Employee Participants may be entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Temporary Employees may be eligible for the plan in accordance with the provisions of the Member's Affordable Care Act Look Back Policy.

Employee Participant's Dependents

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

An Employee Participant's Dependents may include the following:

- An Employee Participant's legal spouse, common-law spouse (unless legally separated) or same-sex domestic partner
- An Employee Participant's Dependent child (including a step-child, legally adopted or disabled child) under 26 years of age. At the end of the birth month in which the child attains turns age 26, the Dependent child is removed from coverage. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for benefits, whether the child lives with the Subscriber or the Subscriber's Spouse. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Plan Document.
- Coverage may be continued for any unmarried Dependent child after the age of 26 if incapable of self-support because of mental retardation or severe physical handicap, provided such Dependent child became so incapable prior to the end of the month in which the child attained the limiting age and is dependent upon the Employee Participant for care and support. Notification and a Physician's statement certifying such incapacity must be submitted to the Plan within 31 days of the date the Dependent child's coverage would otherwise terminate.
- If both husband and wife are employed by the same Member and are eligible as Employee Participants, either Employee spouse may elect to cover the other Employee spouse as a Dependent together with any eligible children.
- Proof of dependent status or legal guardianship may be requested from time to time by the Plan. This proof may be requested in the form of marriage records, birth certificates, and official court certified adoption, legal guardianship and divorce decree documents. A Power of Attorney will not be accepted as proof of dependency.
- The Employee Participant must notify the Member and the Plan within 31 days after any change in status affecting coverage resulting from marriage, birth, adoption, divorce, legal separation, death, a child reaching age 26, or the entrance into or the return from military service.
- Eligibility for Employee Participants and Dependents is additionally limited to persons who are United States citizens by birth or naturalization, or who are legal aliens lawfully residing in the United States.

Employee Participant's Disabled Dependent(s)

Benefits under this Plan for an unmarried Dependent child may be continued if all of the following tests are met:

- The child is incapable of self-sustaining employment because of mental retardation or physical handicap and became so incapacitated prior to such date.
- The child is chiefly dependent on the Employee Participant for support.

- The Member and the Plan are furnished proof of the incapacity not later than 31 days after the date the child attains age 26.

However, benefits as to such child may not be continued beyond the earliest of the following occurrences:

- Cessation of the incapacity.
- Failure to furnish any required proof of continuing incapacity or to submit to any required examination.
- Termination of the child's coverage for any reason other than age.

The Plan has the right to require proof of the continuation of incapacity and the right and opportunity to examine the child as often as is reasonably necessary during the continuation of the incapacity. However, an examination will not be required more often than once a year. The "Mentally or Physically Disabled Dependent Enrollment Request" is available from the Plan or Customer Service and must be completed by a physician with the appropriate medical specialty.

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

(a) in the case of an Enrollee, the individual's name and Social Security Number have been reported by the Group to VSP in the manner provided hereunder, and

(b) in the case of changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein. As indicated in Paragraph 4.01 above, VSP may elect to inspect the Group's records in order to verify eligibility of Enrollees and dependents. Plan Benefits will be available only to persons on whose behalf applicable amounts due have been paid for the current period, or Grace Periods outlined above in Paragraph 4.04. If a clerical error is made, it will not affect the coverage to which the Covered Person is entitled under the Plan.

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. If coverage is retroactively terminated for an individual, Group shall remain responsible for the Claims Amount associated with any Plan Benefits provided to that individual pursuant to the Benefit Authorization issued by VSP in reliance on the latest eligibility information available to VSP at the time of such Benefit Authorization.

6.04. 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 Group's 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 or eligibility requirements. Any such change which materially affects VSP's obligations hereunder must be mutually 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 4.03. Nothing in this section shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.

6.06. Family and Medical Leave Act: The federal Family and Medical Leave Act of 1993 (FMLA), requires that under certain circumstances health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available during certain periods of leave. Benefits will be available at the level and under the conditions coverage would have been provided if the eligible Enrollee had not gone on leave. If, and only to the extent, FMLA applies to the parties to this Plan, VSP shall make the statutorily-required continuation coverage available based on the eligibility information provided by the Group.

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 for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, CHP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VIII.
ARBITRATION OF DISPUTES

8.01. Dispute Resolution: Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this Plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.02. Procedure: The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association in effect at the time of the dispute.

8.03. Choice of Law: Question(s) and dispute(s) hereunder are to be resolved by arbitration. However, if there are any matters arising in connection with this Plan which do become the subject of legal process, the applicable law shall be that of the State of delivery of this Plan.

IX.
NOTICES

9.01. Required Notices: Any notices to be given under this Plan to either the Group or VSP shall be in writing and delivered by United States First Class Mail. Notices sent to the Group will be mailed to the address shown on the Group Application. Notices sent to VSP shall be sent to the address shown on this Plan. Any notices may be hand-delivered by either party to an appropriate representative of the party, with the burden being on the party effecting such hand-delivery, to prove, if questioned, that such delivery was made.

X.
MISCELLANEOUS

10.01. Entire Plan: This Plan, the Group Application, and all Exhibits and attachments, and any amendments hereto, constitute the entire understanding between 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 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.

10.02. 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 specified herein. 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 (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 or responsibilities specified herein.

10.03. Liability: VSP arranges for the provision of vision care services and materials through agreements with Member Doctors, who are independent contractors 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.

10.04. Assignment: Neither this Plan nor any of the rights or obligations of either of the parties may be assigned or transferred, except as noted herein, without the prior written consent of both parties.

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

10.06. 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.

10.07. 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.

10.08. Communication Materials: All 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 in advance of mailing to Enrollees. 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.

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
Signature Plan

GENERAL

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

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $15.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 45.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
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 $ 50.00*

Available once every 12 months.

Frames	Covered up to Plan Allowance*	Up to $ 70.00*

Available once every 24 months.

*Less any applicable Copayment.

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

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

Necessary-

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

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	Professional Fees and Materials
Covered in full*	Up to $110.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation**services are covered in full once every 12 months, after a $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $150.00	Up to $110.00

*Subject to Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
PATIENT OPTIONS

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

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED
There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Plan which 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;

- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

ADDENDUM

ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE 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. Plan Benefits under the Diabetic Eyecare Program ("DEP") are available to Covered Persons who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, and who are covered under the VSP Signature Plan®. The Diabetic Eyecare Program allows Covered Person's Member Doctor to provide diagnostic services not available under the VSP Signature Plan. The Diabetic Eyecare Program does not cover medical treatment for Covered Persons with diabetic or any other medical conditions.

PROCEDURES FOR OBTAINING DIABETIC EYECARE PROGRAM SERVICES

Covered Person's Member Doctor will provide services under the DEP as needed following Covered Person's routine VSP Signature Plan eye examination. No referrals or authorizations are required for services provided under the DEP.

ELIGIBILITY

Covered Persons under this Program are the same as stated in Section VI of this Plan.

COPAYMENT

A Copayment of $5.00 is required for each Ophthalmological Service and Office Visit under the DEP, and is paid to the Member Doctor at the time of service. Other Copayments may apply to services under Covered Person's VSP Signature Plan. Refer to the VSP Signature Plan Schedule of Benefits associated with this Rider.

PLAN BENEFITS

SERVICE*	MEMBER DOCTOR BENEFIT	BENEFIT FREQUENCY†	
Ophthalmological services and Office Visits	Covered in full, less $5.00 Copayment	Once every 12 months	
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	

COVERED SERVICES	(The following list is current as of [7/1/08] and is subject to change without notice.)
Description	Procedure Code
Ophthalmological services	92002, 92004, 92012, 92014
Office Visits	99201 - 99205, 99211 - 99215
Gonioscopy	92021
Extended Ophthalmoscopy	92225, 92226
Fundus Photography	92250

*Service and/or diagnosis limitations apply, or certain procedures require special handling. Member Doctors must consult the *VSP Provider Reference Manual* for details before rendering services.

†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

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 makes insufficient insulin or can't efficiently use it.
Fundus Photography	Taking photos of the inside of the eye that show the optic nerve and retinal vessels.
Extended Ophthalmoscopy	A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.
Gonioscopy	Use of a special contact lens to look at the eye's acqueous drainage area.