

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

GROUP VISION CARE POLICY

Group Name	<b>GRINNELL COLLEGE</b>
Policy Number	<b>12253031</b>
State of Delivery	<b>IOWA</b>
Effective Date	<b>JANUARY 1, 2005</b>
Policy Term	<b>THIRTY-SIX (36) MONTHS</b>
Premium Due Date	<b>FIRST DAY OF MONTH</b>

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 ("the Company") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") 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, which are a part of this Policy.

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Gary Brooks, Senior Vice President, Operations

**VISION SERVICE PLAN INSURANCE COMPANY  
GROUP VISION CARE POLICY  
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**VISION SERVICE PLAN INSURANCE COMPANY  
GROUP VISION CARE POLICY**

**SECTION I.  
DEFINITIONS**

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

**1.01. ANISOMETROPIA:** A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

**1.02. BENEFIT AUTHORIZATION:** Authorization issued by the Company identifying the individual named as Insured of the Company and identifying those Policy Benefits to which Insured is entitled.

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

**1.04. COPAYMENTS:** Those amounts required to be paid by or on behalf of Insured for Plan Benefits which are not fully covered.

**1.05. ELIGIBLE DEPENDENT:** Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by the Company in Section VI. of this Policy under which such Enrollee is covered.

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

**1.07. ENROLLEE:** An employee or member of Group who meets the criteria for eligibility specified under Section VI. Eligibility For Coverage.

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

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

**1.10. 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 Insureds of the Company.

**1.11. GROUP VISION CARE POLICY (also, "The Policy"):** The Policy issued by the Company in favor of a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Insureds of the Company and receive Plan Benefits in accordance with the terms of such Policy.

**1.12. INSURED:** An Enrollee or Eligible Dependent who meets Insured's eligibility criteria and on whose behalf Premiums have been paid to the Company and who is covered under this Policy.

**1.13. KERATOCONUS:** A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

**1.14. MEMBER DOCTOR:** An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Insureds of the Company.

**1.15. NON-MEMBER PROVIDER:** Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Company to provide vision care services and/or vision care materials to Insureds of the Company.

**1.16. PLAN ADMINISTRATOR:** The person specifically so designated on the application, or if an administrator is not so designated, the Group. The Plan Administrator shall have authority to control and manage the operation and administration of the Policy on behalf of the Group.

**1.17. PLAN BENEFITS:** The vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

**1.18. RENEWAL DATE:** The date on which the Policy shall renew, or expire if proper notice is given.

**1.19. SCHEDULE OF BENEFITS:** The document, attached hereto as Exhibit A, that lists the vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy.

**1.20. SCHEDULE OF PREMIUMS:** The document, attached hereto as Exhibit B, which states the payments to be made to the Company by or on behalf of Insured to entitle him/her to Plan Benefits.

**1.21. VISUALLY NECESSARY OR APPROPRIATE:** Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

**SECTION II.**  
**TERM, TERMINATION, AND RENEWAL**

**2.01. Plan Term:** This Policy shall become effective on the date first above stated, and shall remain in effect for the Policy Term. At the expiration of the Policy Term, the Policy shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term, that such party is unwilling to renew the Policy. If such notice is given, the Policy shall expire at 12:00 midnight on the last day of the Policy Term unless the parties reach mutual agreement on its renewal.

**2.02. Early Termination Provision:** The premium rate(s) payable by Group under this Agreement is based on an assumption that the Company 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 this Agreement is terminated by Group before the end of the Policy Term or any subsequent renewal terms, for any reason other than material breach by the Company, Group shall be liable for the lesser of any deficit incurred by the Company or the remaining payments which Group would have paid for the full Term of the Agreement. A deficit incurred by the Company will be calculated by subtracting the cost of incurred and outstanding claims from the premiums received by the Company from Group. Group agrees to pay the Company within thirty-one (31) days of notification of the amount due.

**SECTION III.**  
**OBLIGATIONS OF THE COMPANY**

**3.01. Coverage of Insureds:** The Company 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 "Insureds." To institute coverage, Group may be required by the Company to complete and sign a Group Application and forward such application to the Company, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Insured, the Company will make available to all Insureds an Evidence of Coverage and a Vision Care Brochure. Such Evidence and Brochure will summarize the terms and conditions set forth in this Policy.

**3.02. Provision of Plan Benefits:** Through its Member Doctors (or through other licensed vision care providers where the Insured chooses to receive Plan Benefits from a Non-Member Provider), the Company shall provide Insured such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto) as may be Visually Necessary or Appropriate, subject to any limitations, exclusions, or Copayments therein stated. When the Insured desires to receive Plan Benefits from a Member Doctor, the Insured shall contact the Company or the Member Doctor. The Company shall provide Benefit Authorization to the Member Doctor or to the eligible Insured for use in receiving Plan Benefits from a Member Doctor. Benefit Authorizations shall be issued by the Company in accordance with the latest eligibility information furnished by Group. Any Benefit Authorization so issued by the Company shall constitute a certification to the Member Doctor that payment will be made. The Company shall not be held liable to Group for any Benefit Authorization issued in error. Insureds are required to obtain the Benefit

Authorization prior to obtaining Plan Benefits in cases where the Insured obtains Plan Benefits from a Member Doctor (See Section 5.03 for further details).

The Company shall pay or deny claims for Plan Benefits provided to Insureds, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after the Company has received a completed claim, unless special circumstances require additional time. In such cases, the Company 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. Determination of Visual Necessity:** Plan Benefits are covered only when and to the extent that they are deemed Visually Necessary or Appropriate for the proper treatment of the Insured's condition. Questions involving necessity or appropriateness of treatment shall be decided by the Member Doctor (or Non-Member Provider) responsible for the Insured's care and are subject to review and final determination by the Company. Any objections of the Insured relating to such decisions may be made to the Company at the address given herein.

**3.04. Provision of Information to Insureds:** The Company shall make available to the Insured necessary information describing Plan Benefits and the appropriate method for using them. A copy of this Policy shall be placed with Group and also will be made available at the offices of the Company for any Insured. The Company shall provide to Insureds an updated list of Member Doctors' names, addresses, and telephone numbers.

**3.05. Preservation of Confidentiality:** The Company shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member 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,

including but not limited to sharing information with medical information bureaus, or as may otherwise be required by law.

**3.06. Emergency Vision Care:** When vision care is necessary for Emergency Conditions, Insureds may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from the Company is required for Insured to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Insureds are not covered by the Company for medical services and should contact a physician under Insureds' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Insured should contact the Company's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

**SECTION 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/or as mutually agreed to by the Company and Group. By the effective date of this Policy, Group shall provide the Company with a listing, in a form approved by the Company, of all of its Enrollees who are eligible for coverage under this Policy as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to the Company on or before the last day of each month, in a form approved by the Company, a listing of all Enrollees with a designation of family status who will be added to or deleted from the Company's coverage rosters for the succeeding month.

**4.02. Payment of Premiums:** On or before the first day of each month, Group shall remit to the Company the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy for such succeeding month. The amount of such Premiums for each Insured shall be as provided in the Schedule of Premiums incorporated in this Policy as Exhibit B. Only Insureds for whom Premiums are actually received by the Company shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Insured is not received by the time specified above, the Company reserves the right to terminate all rights of such Insured, and such rights may be reinstated only in accordance with the requirements of this Policy.

The Company may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. The Company may

change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Policy are changed. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy.

Notwithstanding the above, the Company reserves the right to increase Premiums required hereunder 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 Premiums the Company receives from Group.

**4.03. Grace Period:** Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of Premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Insureds covered hereunder.

If Group fails to make any payment of Premiums due by the end of any grace period, the Company may notify Group that the payment of Premiums has not been made, that coverage is canceled and that the Group is responsible for payment of all Plan Benefits provided to Insureds after the last period for which Premiums were fully paid, including the grace period.

**4.04. Other Information to be Provided:** Group shall furnish to the Company monthly, during the effective period of this Policy, such information as may reasonably be required by the Company for the purposes of this Policy, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form specified by the Company. In addition, Group shall,

when requested, make available for inspection by the Company such records as may have bearing on the coverage of Insureds under this Policy.

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

**SECTION V.**  
**OBLIGATIONS OF INSUREDS 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 the Company and Group without the consent or concurrence of the Insureds. This Policy, and all Exhibits, attachments and amendments attached hereto constitute the Company's sole and entire undertaking to Insureds under this Policy.

All Insureds under this Policy 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 Insured receiving the care and must be paid to the Member Doctor on the date the services are rendered.

**5.03. Authorization of Services:** The Insured must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or the Company. Should the Insured receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Insured, 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. Complaints and Grievances: Time of Action:** Insureds shall report any complaints and/or grievances to the Company 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 the Company verbally or in writing. Insured may

submit written comments or supporting documentation concerning his/her complaint or grievance to assist in the Company's review. The Company 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 the Company's receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, the Company will notify the Insured of the expected resolution date. Upon final resolution, the Company will notify the Insured of the outcome in writing.

**5.05. Insurance Fraud:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**SECTION 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.

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

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

(2) meet the coverage criteria mutually agreed upon by Group and the

Company.

(b) **Eligible Dependents:** If dependent coverage is provided, the persons

eligible for dependent coverage as dependents shall include:

(1) the legal spouse of any Enrollee; and

(2) any unmarried child of an Enrollee, including any natural child from

the moment of birth, legally adopted child from the moment of placement for adoption with the

Enrollee, or other child for whom a court holds the Enrollee responsible; and

(A) for whose support the Enrollee is legally responsible and who has not yet attained the age of 19 years; or

(B) who is chiefly dependent upon the Enrollee for support, has not yet attained the age of 25 years, and is currently enrolled as a full-time student in good standing actively pursuing a degree or certificate at a recognized educational institution.

(3) as further defined by Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as

he/she remains a dependent and the Enrollee's coverage remains in force; provided however, that satisfactory proof of the dependent's incapacity can be furnished to the Company within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated or at such other times as the Company 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 Social Security Number have been reported by Group to the Company in the manner provided hereunder; and

(b) in the case of changes to a Dependent's status, the change has been reported by the Group to the Company in the manner provided herein.

As stated in Section 4.04. herein, the Company 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 Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Insured is entitled under the Policy.

**6.03. Change of Participation Requirements, Contribution of Fees, and Eligibility**  
**Rules:** Composition of the Group, percentage of Enrollees covered under the Policy, and eligibility requirements are material to the Company's obligations under this Policy. During the term of this Policy, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects the Company's obligations hereunder unless the Company consents to such change in writing. The Company may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of

the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Policy.

**6.04. Change in Family Status:** In the event of any change in the Insured's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to the Company is to be given to the Company by the Insured, or by someone else acting on the Insured's behalf, within thirty-one (31) days of such change. If such notice is given, the change in the Insured's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Insured. A newborn or adopted child will be covered during the thirty-one (31) day period after birth or adoption.

**SECTION 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 eligible 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 that COBRA applies, the Company shall make the statutorily-required COBRA continuation coverage available for purchase in accordance with COBRA.

**SECTION VIII.**  
**CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES**

**8.01. Claims Denial Appeals:** If, under the terms of this Policy, a claim is denied in whole or in part, a request may be submitted to the Company by Insured or Insured's authorized representative for a full review of the denial. Insured may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Insured" include Insured'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 Insured for whom the claim was denied, including the Company Enrollee's name, the Company Enrollee's Member Identification Number, the Insured's name and date of birth, the provider of services and the claim number. The Insured may review, during normal working hours, any documents held by the Company pertinent to the denial. The Insured may also submit written comments or supporting documentation concerning the claim to assist in the Company's review. The Company's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Insured as follows:

1. **Prior Authorization for Visually Necessary or Appropriate Services:** within thirty (30) calendar days after receipt of a request for an appeal from the Insured;

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

**b) Second Level Appeal:** If the Insured disagrees with the response to the initial appeal of the claim, the Insured has a right to a second level appeal. Within sixty (60)

calendar days after receipt of the Company's response to the initial appeal, the Insured may submit a second appeal to the Company along with any pertinent documentation. the Company shall communicate its final determination to the Insured in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies:** When Insured has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Insured 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), Insured 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 Insured disagrees with the outcome.

**SECTION IX.**  
**NOTICES**

**9.01. Notice:** Any notices required to be given under this Policy to either Group or the Company shall be in writing and delivered by United States First Class Mail. Notices sent to Group will be mailed to the address shown on the Group Application. Notices sent to the Company shall be sent to the address shown on this Policy. 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.

**SECTION X.**  
**MISCELLANEOUS**

**10.01. Entire Policy:** This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, addenda and attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede 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 the Company and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions.

**10.02. Indemnity:** The Company 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 the Company, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless the Company, 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:** Under no circumstances shall the Company 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.

**10.04. Right to Reject Claims:** The Company reserves the right to reject any and all claims for services or benefits that are filed with it more than one hundred eighty (180) days after completion of services.

**10.05. Assignment:** Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred, except as may be expressly authorized and provided herein, without the prior written consent of both parties hereto.

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

**10.07. Choice of Law:** If there are any matters arising in connection with this Policy that become the subject of legal process, the applicable law shall be that of the state of delivery of this Policy.

**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:** The Company is an Equal Opportunity and Affirmative Action employer.

**10.10. Communication Materials:** All communication materials created by Group that relate to this vision care Policy must be approved by the Company in advance of mailing to Enrollees.

**EXHIBIT A**

**VISION SERVICE PLAN INSURANCE COMPANY  
SCHEDULE OF BENEFITS  
ENHANCED PLAN B**

**GENERAL**

This Schedule lists the vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY ("the Company") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. 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 Policy or Certificate of Coverage 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 received from Non-Member Providers, the Insured is reimbursed for such benefits according to the schedule in the second column below subject to any applicable Copayment as stated below. Copayments and fees for vision care services and vision care materials are payable to the Member Doctor or Non-Member Provider at the time the services are rendered and materials are supplied, or as otherwise agreed to between the patient and the vision care provider.

Member Doctors are reimbursed at a contracted rate, whereas Non-Member Providers are not. Should Plan Benefits be unavailable from Member Doctors, Non-Member Providers will be reimbursed at the same rate as are Member Doctors had the Insured received Plan Benefits from a Member Doctor.

**PLAN BENEFITS**

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

**VISION CARE SERVICES**

<b>Eye Examination</b>	Covered in Full	Up to \$ 45.00
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Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations once **every plan year beginning on January 1st.**

**VISION CARE MATERIALS**

	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
<b>Lenses</b>		
Single Vision	Covered in Full	Up to \$ 45.00
Bifocal	Covered in Full	Up to \$ 65.00
Trifocal	Covered in Full	Up to \$ 85.00
Lenticular	Covered in Full	Up to \$ 125.00

**Available once every plan year beginning on January 1st.**

**Frames**

Covered up to Plan Allowance      Up to \$ 47.00

**Available once every other plan year beginning on January 1st.**

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 plan year** in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

**VISUALLY NECESSARY**

When Visually Necessary contact lenses are obtained from a Member Doctor, they will be covered in full with prior authorization from the Company. When Visually Necessary contact lenses are obtained from a Non-Member Provider, the Company will provide an allowance toward the cost as outlined below. Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider are subject to review and authorization from the Company's Optometric Consultants.

**MEMBER DOCTOR  
BENEFIT**

Professional Fees and  
Materials - Covered in Full\*

**NON-MEMBER  
PROVIDER BENEFIT**

Professional Fees and  
Materials - Up to \$ 210.00\*

**ELECTIVE**

Contact lenses for other than Visually Necessary circumstances.

**MEMBER DOCTOR  
BENEFIT**

Professional Fees\*\* and  
Materials - Up to \$ 120.00

**NON-MEMBER  
PROVIDER BENEFIT**

Professional Fees and  
Materials - Up to \$ 105.00

\*Subject to Copayment

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

### **ADDITIONAL DISCOUNT**

Each Insured shall be entitled to receive a discount toward the purchases of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a Member Doctor. Additionally, each Insured shall be entitled to receive a discount off the Member Doctor's professional fees for contact lenses. Contact lens materials are provided at the doctor's usual and customary charges. Discounts are applied to the Member Doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the Member Doctor who provided the covered eye examination.

### **COPAYMENT**

The benefits described herein are available to each Insured from any participating Member Doctor at no cost to the Insured or reimbursement for such benefits according to the non-member schedule when services are obtained from a Non-Member Provider. The Insured should follow the proper procedures by obtaining Benefit Authorization.

There shall be a Copayment of \$10.00 for the examination payable by the Insured 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.

**LOW VISION BENEFIT**

The Low Vision benefit is available to Insureds who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by the Company's Optometric Consultants.

	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
<b>Supplementary Testing</b>	Covered in Full	Up to \$125.00*
Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		

<b>Supplementary Care</b>	75% of Cost	75% of Cost*
Subsequent low vision therapy as Visually Necessary or appropriate.		

**Copayment**

75% of the authorized benefits payable by the Company and 25% payable by Insured.

**Benefit Maximum**

The maximum benefit available is \$1,000.00 (excluding Copayment) every two years.

**\*NON-MEMBER BENEFIT**

Low Vision benefits secured from a doctor who is NOT a member of the Company panel are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Insured should pay the Non-Member Provider his/her full fee. The Insured will be reimbursed in accordance with an amount not to exceed what the Company would pay a Member Doctor in similar circumstances.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

### **PATIENT OPTIONS**

This Policy is designed to cover visual needs rather than cosmetic materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses, and the Insured 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.
- 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 are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a  $\pm 3.8$  diopter power); or 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;
- Any eye examination or any corrective eyewear required by an employer as a condition of employment;
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE COMPANY MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF THE COMPANY'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE INSURED.

**EXHIBIT B**

**VISION SERVICE PLAN INSURANCE COMPANY  
SCHEDULE OF PREMIUMS  
ENHANCED PLAN B**

The Company 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.

- \$ 8.51 per month for each eligible Enrollee without dependents.
- \$ 15.18 per month for each eligible Enrollee with one eligible dependent.
- \$ 22.32 per month for each eligible Enrollee with two or more 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 - PRIMARY EYECARE**

Primary Eyecare is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the plan, Member Doctors provide treatment and management of urgent and follow-up services. Primary Eyecare also involves management of conditions that require monitoring to prevent future vision loss.

The Member Doctor is responsible for advising and educating patients on matters of general health and prevention of ocular, as well as systemic disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Member Doctor as a Primary Eyecare Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

#### **SYMPTOMS**

Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary Eyecare Plan include, but are not limited to:

- Ocular discomfort or pain
- Transient loss of vision
- Flashes or floaters
- Ocular trauma
- Diplopia
- Recent onset of eye muscle dysfunction
- Ocular foreign body sensation
- Pain in or around the eyes
- Swollen lids
- Red eyes

#### **CONDITIONS**

Examples of conditions that may require management under the Primary Eyecare Plan, include, but are not limited to:

- Ocular hypertension
- Retinal nevus
- Glaucoma
- Cataract
- Pink-eye
- Macular degeneration
- Corneal dystrophy
- Corneal abrasion
- Blepharitis
- Sty

## **PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES**

1. To obtain Primary Eyecare Services, the Insured contacts a Member Doctor's office and makes an appointment. If necessary, the Insured may call the Company's Customer Service Department first to determine the nearest location of a Member Doctor's office.
2. If urgent care is necessary, the Insured may be seen by a Member Doctor immediately.
3. The Insured pays the applicable Copayment to the Member Doctor at the time of each Primary Eyecare office visit.
4. When the Member Doctor has completed the services, he/she will fill out the necessary paperwork and mail it to the Company. The Company will pay the Member Doctor directly according to the Company's agreement with the Doctor.

## **COPAYMENT**

The benefits described herein are available to each Insured from any participating Member Doctor at no cost to the Insured except there shall be a Copayment amount of \$5.00 payable by the Insured to the Member Doctor at the time of each Primary Eyecare office visit.

## **REFERRALS BY THE MEMBER DOCTOR**

The Member Doctor will refer the patient to another doctor under the following conditions:

1. If the patient requires additional services that are covered by the Primary Eyecare Plan but are not provided in his/her office, the Member Doctor will refer the patient to another Member Doctor or to the major medical physician whose offices provide the necessary services.
2. If the patient requires emergency services beyond the scope of the Primary Eyecare Plan, the Member Doctor will refer the patient back to the major medical physician.
3. If the patient requires emergency services beyond the scope of the Primary Eyecare Plan, the Member Doctor will make a "STAT" (emergency) referral by calling either another Member Doctor or the major medical physician.

## **SERVICES FROM NON-MEMBER PROVIDERS**

If the Insured chooses to obtain services from a Non-Member Provider, the Insured pays the doctor the total cost of the services provided, writes, "Primary Eyecare" on the bill and mails a

copy to the Company for reimbursement. The Company will reimburse the Insured according to the current Primary Eyecare Non-Member Provider reimbursement schedule.

NOTE: There is no assurance that this amount will be sufficient to cover the total cost of the services. Primary Eyecare services obtained from a doctor who is not a member of the Company's panel are subject to the same limitations as described herein for Member Doctor services.

## **DEFINITIONS**

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Corneal Abrasion	Irritation of the transparent part of the coat of the eyeball.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent part of the coat of the eyeball.
Diplopia	The observance by a person of seeing double images of an object.
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eyeball which causes damage to the optic disc and gradual loss of vision.
Macula	The small, yellowish area lying slightly lateral to the center of the retina that constitutes the region of maximum visual acuity.
Macular Degeneration	Degeneration of the macula.
Ocular	Of or relating to the eye or the eyesight.
Ocular Conditions	Any condition, problem, or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object; e.g., fist, baseball, racquetball, auto accident, etc.
Pink-eye	An acute, highly contagious conjunctivitis (inflammation of the conjunctiva).
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Systemic Condition	Any condition or problem relating to a person's general health.
Transient Loss of Vision	Temporary loss of vision.

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