Client Vision Care Plan

CLIENT NAME: **WESTERN HEALTHCARE INSURANCE TRUST**
CLIENT NUMBER: **07103793**
EFFECTIVE DATE: **JANUARY 1, 2025**

EVIDENCE OF COVERAGE

Provided by:

VSP Vision Care, Inc.
One Union Square Building
600 University Street, Suite 2004
Seattle, Washington 98101-1129

ADMINISTRATIVE OFFICES:
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

This Evidence of Coverage is a summary of the provisions of the Plan providing group vision coverage. In the event of any conflict between this Evidence of Coverage and the Plan, the provisions of this Evidence of Coverage will prevail. A copy of the Plan will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided. This includes coverage for newborn infant children of Enrollees from and after the moment of birth, including but not limited to coverage for congenital anomalies.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Network Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Network Provider will obtain benefit verification from VSP. The VSP Network Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. If an Open Access Provider agrees to submit a claim to VSP on behalf of Covered Person, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within 365 calendar days from the date services are rendered and/or materials provided. Claims received by VSP after 365 days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

1. Coordination Of Benefits ("COB" herein): COB applies when a Covered Person has coverage under more than one Plan. Plan, for the purpose of this Coordination of Benefits Section, is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits according to its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

2. Definition Of Key Terms Used In This Coordination Of Benefits Section:

(a) A Plan is any of the following that provides benefits or services for medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) Plan includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

(3) Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

(b) This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

(c) The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the Total Allowable expense for that claim. This means that when this Plan is Secondary, it must pay the amount which, when combined with what the Primary plan paid, totals 100% of the highest Allowable expense. In addition, if this Plan is Secondary, it must calculate its savings and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable expense under this Plan. If this Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

(d) Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense.

(e) Closed panel plan is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(f) Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

3. Order Of Benefit Determination Rules: When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(a) The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(b) (1) Except as provided in subsection (2), a Plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder.

(c) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(d) Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent, then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

• The Plan covering the Custodial parent, first;
• The Plan covering the spouse of the Custodial parent, second;
• The Plan covering the non-custodial parent, third; and then
• The Plan covering the spouse of the non-custodial parent, last

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

4. Effect Of The Benefits Of This Plan: When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total Allowable expense for that claim Total Allowable expense is the highest Allowable expense of the Primary plan or the Secondary plan. In addition, the Secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

5. Right To Receive And Release Needed Information: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. VSP may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. VSP need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give VSP any facts it needs to apply those rules and determine benefits payable.

6. Facility Of Payment: If payments that should have been made under This plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This plan. To the extent of such payments, the issuer is fully discharged from liability under This plan.

7. Right Of Recovery: The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Network Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Network Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Network Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar 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) calendar 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.

APPEALS OF ADVERSE DETERMINATIONS

A Covered Person must submit an appeal of an Adverse Determination in writing. VSP will reconsider its decision within fourteen (14) days of receipt of the appeal unless VSP notifies the Covered Person that an extension is necessary to complete the appeal. The extension will not delay the decision beyond thirty (30) days of the request for an appeal without the Covered Person's written consent. In the event that a delay would jeopardize the health of a Covered Person, VSP will issue a decision within seventy-two (72) hours after receipt of the appeal. Adverse Determination Appeals follow the same reviewer qualifications standards set forth in Section 5.06 of the Plan Document.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. 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 within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

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

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

CLAIM APPEALS FOR SERVICES OF AN EXPERIMENTAL NATURE

In the event a claim is denied because the vision services requested are of an experimental nature, that appeal determination will be made within twenty (20) working days of receipt of the fully documented appeal. This review period may be extended beyond twenty (20) working days upon written consent of the Covered Person. A person qualified by reasons of training, experience and medical expertise to evaluate it will review the appeal. The person reviewing the appeal will not be the same person who made the initial decision to deny benefits. The Covered Person will be notified of the result of the appeal in writing, which will include the basis for the decision, the name of the reviewer and that person's professional qualifications. In the event that a delay would jeopardize the health of a Covered Person, VSP will issue a decision within seventy-two (72) hours after receipt of the appeal.

INDIVIDUAL CONTINUATION OF BENEFITS

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

LABOR DISPUTES

If an Enrollee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, the Enrollee may pay any premiums due directly to the Group for a period not exceeding six months and at the rate and coverages that the Plan contract provides.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits available to an eligible participant and his or her dependents be made available to said persons upon the termination of employment of said participant, or the termination of the relationship between said participant and his or her dependents. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
ADVERSE DETERMINATION	A decision made by VSP resulting in the denial, modification, reduction or termination of coverage.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COUNTY	All Counties located in the State of Washington.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP through consideration of whether the procedure or lens is in general use in the medical community in the state of Washington, is under continued scientific testing and research, shows a demonstrable benefit for a particular condition, and whether it is proven to be safe and efficacious.
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
PREMIUMS	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group administrator.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP NETWORK PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Signature Plan®

GENERAL

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

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

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

LENS OPTIONS

Blended lenses covered in full once every 12 months.**
Premium and Custom Progressive lenses covered in full once every 12 months.**

FRAMES - Covered up to the Plan allowance* once every 24 months**

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

Supplemental Aids: 75% of VSP Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically under the LightCare enhancement,if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES

EYE EXAMINATION: Up to $ 50.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Up to $50.00 - 125.00 * once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 24 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

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

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

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee.

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Signature Plan®

GENERAL

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

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

LENS OPTIONS

Anti-reflective coating covered in full once every 12 months.**
Blended lenses covered in full once every 12 months.**
Premium and Custom Progressive lenses covered in full once every 12 months.**

FRAMES - Covered up to the Plan allowance* once every 12 months**

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

Supplemental Aids: 75% of VSP Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically under the LightCare enhancement,if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES

EYE EXAMINATION: Up to $ 50.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Up to $50.00 - 125.00 * once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

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

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

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee.

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP Vision Care, Inc.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

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

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

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

LENS OPTIONS

Blended lenses covered in full once every 12 months.**
Premium and Custom Progressive lenses covered in full once every 12 months.**

FRAMES - Covered up to the Plan allowance* once every 24 months**

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

Supplemental Aids: 75% of VSP Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT ENHANCEMENTS

- Optional Cosmetic Processes
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Cosmetic lenses.
- Laminated lenses.
- Polycarbonate lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Refitting of contact lenses after the initial (90-day) fitting period.
8. Contact lens modification, polishing or cleaning.
9. Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES

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

LENSES - Up to $30.00 - 100.00 * once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 24 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

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

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

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee.

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP Vision Care, Inc.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

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

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

FRAMES - Covered up to the Plan allowance* once every 12 months**

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $230.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

FRAMES: An Additional Allowance of $80.00 once every 12 months**

OR

LENS ENHANCEMENT
Premium and Custom Progressive lenses: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT
Anti-reflective coating: Covered in full once every 12 months**.

OR

CONTACT LENSES

ELECTIVE: An Additional Allowance of $100.00 once every 12 months.**

*Less any applicable Copayment.
**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

Supplemental Aids: 75% of VSP Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT ENHANCEMENTS

- Optional Cosmetic Processes
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Polycarbonate lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Refitting of contact lenses after the initial (90-day) fitting period.
8. Contact lens modification, polishing or cleaning.
9. Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

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

COVERED SERVICES

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

LENSES - Up to $30.00 - 100.00 * once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

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

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

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

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

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

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

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee.

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

Exhibit C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VSP Vision Care, Inc. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they attain 26 years of age.

A dependent child over the age of 26 may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Plan Benefits under the Supplemental Primary Eyecare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may 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 which may require management under the PEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis

- pink eye
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB.") Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the Supplemental Primary Eyecare Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Network Provider and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Network Provider, the doctor will refer the Covered Person to another VSP Network Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Network Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from a VSP Network Provider in order to obtain Plan Benefits.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of $20.00.
Special Ophthalmological Services: Covered in Full
Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

SUPPLEMENTAL PRIMARY EYECARE PLAN 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.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
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 eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining 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.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **WESTERN HEALTHCARE INSURANCE TRUST**
Group ID: **07103793**
Effective Date: **JANUARY 1, 2025**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $10.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **WESTERN HEALTHCARE INSURANCE TRUST**
Group ID: **07103793**
Effective Date: **JANUARY 1, 2025**

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees	$20.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: **WESTERN HEALTHCARE INSURANCE TRUST**
Group ID: **07103793**
Effective Date: **JANUARY 1, 2025**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees	$20.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first date of service.

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