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

GROUP VISION CARE PLAN
ADMINISTRATIVE SERVICES PROGRAM

Group Name	COUNTY OF SAN MATEO
Plan Number	00256000
State of Delivery	CALIFORNIA
Effective Date	JANUARY 1, 2022
Plan Term	THIRTY-SIX (36) MONTHS
Premium Due Date	FIRST DAY OF MONTH

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by Group of the administrative fees and other amounts due as herein provided, VISION SERVICE PLAN ("VSP") agrees to provide certain individuals under this Group Vision Care Plan ("Plan") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Plan is delivered in and governed by the laws of the State of Delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Plan.

TABLE OF CONTENTS

I.

DEFINITIONS

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

DEFINITIONS

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

1.01. ADMINISTRATIVE SERVICES PROGRAM: A group vision care plan whereby Group pays VSP for the Plan Benefits in addition to a monthly Administrative Fee.

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

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

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

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

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

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

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

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

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

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

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

1.13. GROUP APPLICATION: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of VSP.

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

1.15. MEMBER DOCTOR: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

1.16. NON-MEMBER PROVIDER: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

1.17. PLAN BENEFITS: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Plan, as defined in the Schedule of Benefits attached hereto as Exhibit A.

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

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

1.20. SCHEDULE OF ADVANCE PAYMENT AND ADMINISTRATIVE FEE: The document, attached hereto as Exhibit B, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him to Plan Benefits.

II.
TERM, TERMINATION, AND RENEWAL

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

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

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

III.
OBLIGATIONS OF VSP

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

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

3.02. Provision of Plan Benefits: Through its Member Doctors (or through other licensed vision care providers in cases where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A hereto, subject to any limitations, exclusions, or Copayments therein stated.

Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Member Doctor. When a Covered Person desires to receive Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person in order for the Member Doctor to obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the Member Doctor to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, allowing a specific period of time for the Covered Person to obtain Plan Benefits. Benefit Authorization shall be issued by VSP in accordance with the latest eligibility information furnished by Group and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made. VSP shall not be held liable to Group for any Benefit Authorization issued in error in reliance on the latest eligibility information available to VSP as provided by the Group. Notwithstanding any other provision, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits, and when purchased by Client, the Additional Benefit Rider. Retail chains may not offer all Plan Benefits. Covered Person may contact Member Doctor for information describing vision care services and vision care materials offered.

VSP is the claims administrator for vision care claims. VSP will serve as claim fiduciary in the administration of the vision plan consistent with ERISA. VSP does not serve as fiduciary with respect to eligibility issues or the extent of coverage purchased by the Group as the Group is the "plan fiduciary". VSP shall pay or deny claims for Plan Benefits provided to

Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP has received a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. Provision of Information to Covered Persons: Upon request, VSP will make available to Covered Persons necessary information describing Plan Benefits and procedures. A copy of this Plan will be placed with Group. The Plan will also be available at the offices of VSP for copying or inspection by Covered Persons. VSP shall provide Group with an updated list twice annually of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons. Covered Persons may also obtain a copy of the latest Member Doctor list by contacting VSP's Customer Service Department in writing or via the toll-free Customer Service telephone line, or by visiting VSP's Web site at www.vsp.com.

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

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

deemed to include any and all confidential information defined as Confidential Matters hereunder, the treatment of which shall be as set forth in Paragraph 3.04 of this Plan.

b) Non-Disclosure and Non-Use of Confidential Information. Recipient shall not, directly or indirectly, without the prior written approval of Discloser in each instance or unless otherwise expressly permitted herein,

use for its own benefit, publish or otherwise disclose to others, or authorize the use by others for their benefit, or to the detriment of Discloser, any of Discloser's Confidential Information. Recipient shall carefully restrict access to Discloser's Confidential Information to only those of its and its Affiliates' officers, directors, employees, agents and representatives (collectively, "Representatives") who (i) clearly require such access in order to enable to perform their respective obligations under this Plan (ii) who are bound by confidentiality obligations that protect third party information which are at least as restrictive and protective as those contained in this Plan, and (iii) are not (or do not work for) direct competitors of Discloser. Recipient shall not use, copy, distribute and/or remove any of Discloser's Confidential Information from Recipient's premises except to the extent necessary or appropriate to carry out its respective obligations under the Plan, without the prior consent of Discloser. Recipient and its Representatives will employ all security measures used for their own proprietary information of similar nature but in no event using less than a reasonable degree of care. Recipient agrees to advise and require its Representatives of their obligations to keep such information confidential and shall each be liable for any acts and omissions of their Representatives related thereto.

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

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

e) Survival: The obligations laid down in this Section 3 shall continue and survive beyond the termination of this Plan.

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

IV.
OBLIGATIONS OF THE GROUP

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

4.02. Claims Amounts: Group shall provide all funds necessary to pay the Claims Amount associated with Covered Persons pursuant to this Plan.

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

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

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

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

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

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

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

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

5.02. Copayment for Services Received: Where, as indicated in Exhibit A (Schedule of Benefits), Copayments are required for certain Plan Benefits, Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Member Doctor the date services are rendered.

5.03. Obtaining Services from Member Doctors: Benefit Authorization must be obtained prior to receiving Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits, the Covered Person must select a Member Doctor, schedule an appointment, and identify himself as a Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. Should the Covered Person receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Member Doctor will be considered a Non-Member Provider and the benefits available will be limited to those for a Non-Member Provider, if any. Retail chains may not offer all Plan Benefits. Covered Person may contact Member Doctor for information describing vision care services and vision care materials offered.

5.04. Submission of Non-Member Provider Claims: If Non-Member Provider coverage is indicated in Exhibit A (Schedule of Benefits), written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-Member Providers shall be submitted by Covered Persons to VSP within three hundred sixty-five (365) days of the date of service. VSP may reject such claims filed more than three hundred sixty-five (365) days after the date of service.

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of three hundred sixty-five (365) days after the date of service.

5.05. Complaints and Grievances: Covered Persons shall report any complaints and/or grievances to VSP at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. A Covered Person may submit written comments or supporting documentation concerning the complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt.

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

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

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

c) Other Remedies: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise Covered Person to contact the U.S. Department of Labor 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)(I)(B)], Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

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

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

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 the Group, and

(2) meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

(b) Eligible Dependents: If dependent coverage is provided, the persons eligible for dependent coverage are:

(1) the legal spouse of any Enrollee, and

(1a) The domestic partner of any Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2) any child of an Enrollee or the Enrollee's spouse or domestic partner, 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) who is not enrolled for health care coverage with the child's own employer, and

(B) who has not yet attained the age of 26 years.

(3) as further defined by Group.

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

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

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

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

6.03. Retroactive Eligibility Changes: Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. If coverage is retroactively terminated for an individual, Group shall remain responsible for the Claims Amount associated with any Plan Benefits provided to that individual pursuant to the Benefit Authorization issued by VSP in reliance on the latest eligibility information available to VSP at the time of such Benefit Authorization.

6.04. Change of Participation Requirements, Contribution of Fees, and Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Plan, and Group's contribution and Group's eligibility requirements are all material to VSP's obligations under this Plan. During the term of this Plan, Group must provide VSP with written notice of changes to its composition, percentage of Enrollees covered, contribution or eligibility requirements. Any such change which materially affects VSP's obligations hereunder must be mutually agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Plan for purposes of Paragraph 4.03. Nothing in this section shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.

6.05. Change in Family Status: In the event Group is notified of any change in a Covered Person's family status (by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.) Group shall provide notice of such change to VSP via the next eligibility listing required under Paragraph 4.01. If such notice is given, the change in the Covered Person's status will be effective on the first day of the month following the request for change, or at a requested later date. Notwithstanding any other provision in this section, a newborn child will be covered for thirty-one (31) days after birth and an adopted child will be covered for thirty-one (31) days after the date the Enrollee or Enrollee's spouse acquires the right to control the health care of the child. To continue coverage for a newborn or adopted child beyond the initial thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable amounts due must be paid to VSP on behalf of the child.

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

VII.
CONTINUATION OF COVERAGE

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

VIII.
ARBITRATION OF DISPUTES

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

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

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

IX.
NOTICES

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

X.
MISCELLANEOUS

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

10.02. Indemnity: VSP agrees to indemnify, defend and hold harmless Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Group, its officers or employees to perform any of the duties or responsibilities specified herein.

10.03. Liability: VSP arranges for the provision of vision care services and materials through agreements with Member Doctors, who are independent contractors responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. Under no circumstances shall VSP or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Plan.

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

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

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

10.07. Gender: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

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

10.09. Grievances/Complaints: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 877-7195 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to Covered Persons, and the failure to use these procedures does not preclude Covered Person's use of any other remedy provided by law.

10.11 Right to Audit: Each Party may, at its own expense and no more often than once per year, upon a sixty (60) day written notice for mail-in audits and a ninety (90) day written notice for on-site audits, or as required by State and Federal law, and during the other Party's normal business hours, inspect and audit any portion of a Party's records that are relevant for the purpose of verifying compliance with this Agreement, subject to the audited Party's obligations of confidentiality owed to third parties or its own employees.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

VISION SERVICE PLAN	COUNTY OF SAN MATEO
By: 	By: _____
Name: Kate Renwick-Espinosa	Name: _____
Title: President	Title: _____
Date: October 28, 2021	Date: _____

EXHIBIT A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
Signature Plan
Divisions 0022, 0024 and 0026

GENERAL

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

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

COPAYMENT

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

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $10.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 50.00*

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 50.00*
Bifocal	Covered in full*	Up to $ 75.00*
Trifocal	Covered in full*	Up to $ 100.00*
Lenticular	Covered in full*	Up to $ 125.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.
Standard Progressive Lenses covered in full

Available once every plan year beginning on January 1st.

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

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

*Less any applicable Copayment.

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

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

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

CONTACT LENSES

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

Necessary-

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

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	Professional Fees and Materials
Covered in full*	Up to $210.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $150.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

- Replacement of lenses and frames furnished under this Unknown which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

EXHIBIT A

SCHEDULE OF BENEFITS
Signature Plan
Divisions 0036 and 0038

GENERAL

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

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

COPAYMENT

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

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $10.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses. Additionally, a separate Copayment as stated in the Lens Options section of this Schedule of Benefits shall also apply.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 50.00*

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 50.00*
Bifocal	Covered in full*	Up to $ 75.00*
Trifocal	Covered in full*	Up to $ 100.00*
Lenticular	Covered in full*	Up to $ 125.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.
Standard Progressive Lenses covered in full

Available once every plan year beginning on January 1st.

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

Available once every plan year beginning on January 1st.

*Less any applicable Copayment.

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

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.

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.

Lens Options

Anti-reflective coating	Covered in full[1]	Not Covered
UV (ultraviolet) protected	Covered in full	Not Covered

1. Less $35.00 Copayment

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 Covered Person shall not be eligible for lenses and frames again for one plan year.

Necessary-

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

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	Professional Fees and Materials
Covered in full*	Up to $210.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $200.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

- Replacement of lenses and frames furnished under this Unknown which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

EXHIBIT B

SCHEDULE OF PREMIUMS
Signature Plan

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and Eligible Dependents, if any, in the amounts specified below:

Divisions 0022, 0024 and 0026

$ 1.25 per month for each eligible Enrollee (includes coverage for Eligible Dependents)

Divisions 0036 and 0038

$ 2.35 per month for each eligible Enrollee (includes coverage for Eligible Dependents)

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

EXHIBIT C

ADDITIONAL BENEFIT RIDER

SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. 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 Unknown 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 an Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

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 that may require management under the PEC Plan may 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 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 Member Doctor 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 Member Doctor, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the Member Doctor will refer the Covered Person back 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 Member Doctor in order to obtain Plan Benefits.

PLAN BENEFITS
MEMBER DOCTORS

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.

EXHIBIT D

ADDITIONAL BENEFIT RIDER
Kidscare Plan
Divisions 0036 and 0038

GENERAL

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

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

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

ELIGIBILITY

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

- Any unmarried 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.

Unmarried dependent children are covered up to the end of the month they turn age 18.

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

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $10.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses. Additionally, a separate Copayment, as stated in the Lens Options section below, shall also apply.

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**

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

Polycarbonate lenses are covered in full for dependent children up to the end of the month they turn age 18.

Standard Progressive lenses covered in full
*Less any applicable Copayment.

Lens Options

Anti-reflective coating	Covered in full1	Not Covered
UV (ultraviolet) protected	Covered in full	Not Covered

1. Less $35.00 Copayment

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

CONTACT LENSES

Elective

Elective Contact Lenses are covered up to $200.00 once every 12 months.**

The Elective contact lens fitting and evaluation***services are covered in full once every 12 months**,after a maximum $60.00 Copayment.

Necessary

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.

FRAMES: Refer to the Schedule of Benefits under Exhibit A.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
KIDSCARE PLAN ONLY

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.

2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
12. Services and/or materials provided by someone other than a VSP Network Provider

ADDENDUM

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

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

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

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

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

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

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

ADDENDUM

VISION SERVICE PLAN
PERFORMANCE STANDARDS

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

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

CLAIMS PROCESSING

Claims financial accuracy
Performance Standard = 99% processed without financial error
Performance Penalty = 1.0%

Claims financial accuracy is calculated much like that of claims processing accuracy. The same random sampling of claims audited for processing accuracy is also audited for financial accuracy. Any error found that results in a financial impact is recorded as a financial error. At the end of the month, financial errors are totaled and taken as a percentage of the total dollar paid for all claims audited during the given month.

Claims processing accuracy

Performance Standard = 99% processed without error
Performance Penalty = 1.0%

Claims processing accuracy is calculated on a monthly basis based upon daily audit results. The term "processing error" encompasses all errors found in the audit regardless of whether the error caused a financial impact. At month's end, all processing errors for the month are totaled and taken as a percentage of the total number of claims audited for the month.

Claims timeliness

Performance Standard:
All provider claims = 95% processed within 5 business days
Performance Penalty = 1.0%
All member claims = 95% processed within 5 business days
Performance Penalty = 1.0%
All claims = 99% processed within 15 business days
Performance Penalty = 1.0%

Claims timeliness, or turnaround time, is measured on a monthly basis. Each claim is audited for timeliness. Timeliness is measured by calculating the number of working days for each clean claim elapsing between the received date and the pricing

date. A clean claim is defined as a claim which has no defect, impropriety, or special circumstance, including incomplete documentation or incomplete data fields. When additional information is needed to process a claim, the timeliness date is calculated from the date the information needed to process the claim was received to the pricing date.

CALL CENTER MANAGEMENT

Abandoned call rate

Performance Standard = Less than or equal to 3%
Performance Penalty = 1.0%
The Call Center telephone abandon rate is calculated monthly by taking the total number of abandoned calls before and after sixty (60) seconds, divided by the total number of calls accepted by the Call Center, which includes calls answered via the Interactive Voice Response and Automated Call Distribution systems.

Average speed of answer

Performance Standard = Less than or equal to 25 Seconds
Performance Penalty = 1.0%

The average speed of answer (the amount of time a caller is waiting while on hold) is calculated by dividing the total time all calls are on hold (in seconds) by the total number of calls received.

Average call blockage rate

Performance Standard = Less than or equal to 2%
Performance Penalty = 1.0%

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

Call resolution (same day response)

Performance Standard = 98%
Performance Penalty = 1.0%

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

Complaint acknowledgement within 5 business days

Performance Standard = 96%
Performance Penalty = 1.0%

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

Complaint resolution within 30 calendar days

Performance Standard = 99%
Performance Penalty = 1.0%

When a complaint is received, in writing or via phone, the person receiving it documents it in our online Research Inquiry system. The Complaint and Grievance unit monitors this workflow to assure all complaints have been resolved by the 30th calendar day

Average response to e-mail inquiries within 2 business days
Performance Standard = 100%
Performance Penalty = 1.0%

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

SATISFACTION

Patient satisfaction (satisfied with level of coverage)
Performance Standard = 96% overall satisfaction with VSP
Performance Penalty = 1.0%

Performance Standard = 96% overall experience with VSP preferred provider
Performance Penalty = 1.0%

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

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

VSP preferred provider retention rate (based on voluntary turnover)
Performance Standard = 98%
Performance Penalty = 1.0%

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

ACCOUNT ADMINISTRATION

Electronic eligibility online within 24 hours
Performance Standard = 98%
Performance Penalty = 1.0%

Percentage reported based on a measurement against all maintenance files* loaded within that quarter. VSP records both the received and loaded dates for all membership files. The data is compiled into a monthly report, which is used to calculate the quarterly statistical average.

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

- Identifiable Media: Eligibility file must be labeled properly.
- Proper Format: No change in format from the previously loaded eligibility file.

- Clean File:
    1) Physical Media must be undamaged.
    2) Electronic Media must have clean and complete data transmission. We must be able to successfully unzip/decrypt the incoming data.
    3) All media must contain proper/complete records for members and dependents.

Exclusions to this performance standard are as follows:

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

Online reports available by the 25th of the month
Performance Standard = 100%
Performance Penalty = 1.0%

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

Web portal availability
Performance Standard = 99%
Performance Penalty = 1.0%

Based on a 7 x 24 schedule.