November 14, 2023

vsp vision care

CASSIDY O'HARA
900 E HAMILTON AVE STE 500
CAMPBELL, CA 95008-0667

RE: CAPCOM USA INC., GROUP #12270283
JANUARY 1, 2024 DOCUMENTS

Attention Cassidy O'Hara:

Enclosed are the JANUARY 1, 2024 documents for the above-referenced Client.

Please retain a copy of the documents for your records and forward the additional copy directly to the group.

This new document supersedes any existing document your client has with VSP. If you have any questions, or need additional information, please do not hesitate to contact us at 800-216-6248, and a VSP representative will assist you.

Enclosures

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

GROUP VISION CARE PLAN

Group Name	**CAPCOM USA INC.**
Plan Number	**12270283**
State of Delivery	**CALIFORNIA**
Effective Date	**JANUARY 1, 2024**
Plan Term	**TWENTY-FOUR (24) 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 the Group of the premiums 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, including any Exhibits or state-specific Addenda, which are a part of this Plan.

Kate Renwick-Espinosa, President

VISION SERVICE PLAN
GROUP VISION CARE PLAN
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I.
DEFINITIONS

Key terms used in this Plan are defined:

1.01 **AFFILIATE**: As to either Party, any corporation or other entity that directly, or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common control with that Party. The term "***Control"*** means the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

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

1.03. **CONFIDENTIAL MATTER**: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons obtained while providing Plan Benefits hereunder.

1.04. **COPAYMENTS**: Any 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.

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

1.06. **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.

1.07. **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.

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

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

1.10. **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.

1.11. **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.

1.12. **GROUP VISION CARE PLAN (also, "THE PLAN")**: The Plan issued by VSP to a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of VSP and receive Plan

Benefits in accordance with the terms of such Plan.

1.13. **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.

1.14. **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.

1.15. **PLAN BENEFITS**: The vision care services and vision care materials which 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.

1.16. **RENEWAL DATE**: The date when the Plan shall renew, or terminate if proper notice is given.

1.17. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Plan, which lists the vision care services and vision care materials which Covered Person is entitled to receive under this Plan.

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

II.
TERM, RENEWAL, AND TERMINATION

2.01. **Term**: This Plan is effective on the Effective Date and shall remain in effect for the Plan Term, also noted on the front page of this plan.

2.02. **Renewal**: VSP shall issue written renewal notice to the Group at least sixty (60) days before the end of the Plan Term and this Plan shall be automatically renewed for an additional period of time and at premium rate(s) specified in such notice. Such renewal shall take effect, without any lapse in coverage, on the first calendar day following the last day of the Plan Term described herein. Group may refuse renewal by notifying VSP in writing prior to renewal. If Group decides to refuse renewal, VSP requests that it receive Group's written refusal at least thirty (30) days prior to the renewal Effective Date.

2.03. **Termination**:

(a) This Plan may be terminated by the Group or VSP upon expiration of the Plan Term as set forth in paragraph 2.02.

(b) The Premium rate payable by Group to VSP under this Plan is based on an assumption that VSP will receive these amounts over the full Plan Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Plan Term. If Group terminates this Plan before the end of the Plan Term or before the end of any subsequent renewal terms, for any reason other than material breach by VSP, Group will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Group would have paid for the remaining term of this Plan, not to exceed one year. A deficit incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay VSP within thirty-one (31) days of notification of the amount due.

(c) Plan Benefits will cease on the date of cancellation or termination of this plan whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to a Covered Person as of the termination or cancellation date of this Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this Plan.

III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons**: VSP will enroll for coverage, as directed by Group, each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of who shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Group to complete, sign and forward to VSP a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

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

3.02. **Provision of Plan Benefits**: Through its Member Doctors (or through other licensed vision care providers 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 (s)) and when purchased by Group, the Additional Benefit Rider (Schedule C (s)) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person so the Member Doctor can 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, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Group and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days by providing notice to the claimant of the reasons for the extension.

3.03. **Provision of Information to Covered Persons**: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Plan shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons. VSP shall provide Group with an

updated list of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Member Doctor directory through contacting VSP's Customer Service Department's toll-free Customer Service telephone line (1-800-877-7195), VSP's Web site at www.vsp.com, or by written request.

3.04. **Preservation of Confidentiality**: VSP shall hold in strict confidence all confidential information concerning the medical, personal, financial, or business affairs of Covered Persons obtained while providing Plan Benefits ("Confidential Matters") and exercise its best efforts to prevent any of its employees, Member Doctors, or agents from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Plan, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on VSP's Confidentiality policy may obtain a copy of the policy by contacting VSP's Customer Service Department or VSP's Web site at www.vsp.com.

3.05. **Emergency Vision Care**: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Member Doctor or Non-Member 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 Supplemental Essential Medical Eye Care Plan. If Group has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Plan.

IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Plan if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by VSP and Group. By the Effective Date of this Plan, Group shall provide VSP with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under this Plan as of that date. Thereafter, Group shall supply to VSP by 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 next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon VSP's request, Group shall make available for inspection records regarding the coverage of Covered Persons under this Plan.

4.02. **Prepayment Fees/Payment of Premiums**: By the last day of each month, Group shall remit to VSP the premiums payable for the next month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Plan. The Schedule of Premiums incorporated in this Plan as Exhibit B provides the premium amount for each Covered Person. Only Covered Persons for whom premiums are actually received by VSP shall be entitled to Plan Benefits under this Plan and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received on time, VSP may terminate all rights of such Covered Person. Such rights may be reinstated only in accordance with the requirements of this Plan.

VSP may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving Group at least sixty (60) days advance written notice. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or there is a material change in Plan terms or conditions, provided any such change is mutually agreed upon in writing by VSP and Group.

Notwithstanding the above, VSP may increase premiums during a Plan Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums VSP received from Group.

4.03. **Grace Period**: Group shall be allowed a grace period of thirty-one (31) days following the premium payment due date to pay premiums due under this Plan. During said grace period, this Plan shall remain in full force and effect for all Covered Persons of Group. VSP will consider late payments at the time of Plan renewal. Such payment may impact Group's premium rates in future Plan Terms.

If Group fails to make any premiums payment due by the end of any grace period, VSP may notify Group that the premiums payment has not been made, that coverage is canceled and that Group is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the grace period through the effective date of termination. Group shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Plan.

4.04. **Distribution of Required Documents**: Group shall distribute to Enrollees any disclosure forms, plan summaries or other material 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 the receipt thereof, or as required under state law.

V.
CONFIDENTIALITY AND MUTUAL NON-DISCLOSURE COVENANTS

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:

5.01. 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.

5.02. 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. 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.

5.03. **Return or Destruction of Confidential Information.** The Recipient, 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 Recipient 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.

5.04. **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.

5.05. **Survival:** The obligations laid down in this Section 5 shall continue and survive beyond the termination of this Plan.

VI.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

6.01. **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:

6.02 **Other Charges:** Any Copayments required under this Plan shall be the personal responsible of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed Plan allowances, annual maximum benefits or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

6.03. **Choice of Member Doctor**: 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.

6.04. **Reimbursement Provisions/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. Covered Person would need to submit a claim form, along with copies of any invoices or receipts received from the doctor for the services or materials, to VSP for reimbursement. You may obtain a claim form on vsp.com or by calling (800) 877-7195. Claim forms may be submitted at vsp.com or at the address below:

VSP

Attn: Claims Processing

P.O. Box 495918

Cincinnati, OH 45249-5918

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.

6.05. **Liability of Covered Person in the Event of Nonpayment by VSP**: By statute, every contract between VSP and a Member Doctor shall provide that in the event VSP fails to pay a Member Doctor, the Covered Person shall not be liable to the Member Doctor for any sums owed by VSP.

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

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

a) Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's 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/Review by the Department of Managed Health Care: 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 an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of the proposed service or treatment, coverage decisions for treatments that are experimental, investigational in nature and payment disputes for emergency or urgent medical reviews. The Department also has a toll-free telephone number **(1-888-466-2219)**, a TDD line **(1-877-688-9891)** for the speech and hearing impaired and its Internet Web site (http://www.dmhc.ca.gov) has complaint forms online. The Department's internet website www.dmhc.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. You are not required to use a specific form to submit a grievance to the department. If a member or group contract holder submits a grievance to the plan or the department before the effective date of a cancellation, rescission, or nonrenewal for reasons other than nonpayment of premiums, the plan shall continue to provide coverage until a final determination regarding the request for review has been made.

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. 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.

6.08. **Time of Action**: No action in law or in equity shall be brought to recover on the Plan prior to the Covered Person exhausting his/her 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.

6.09. **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.

VII.
ELIGIBILITY FOR COVERAGE

7.01. **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

(2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

(3) as further defined by Group.

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

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

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

(b) for changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein. As stated in Paragraph 4.01 above, VSP may elect to audit Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Plan.

7.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

7.04. **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 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 and eligibility requirements. Any change which materially affects VSP's obligations under this Plan must be 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 4.02. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Plan.

7.05. **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, etc.] Group shall provide notice of such change to VSP via the next eligibility listing required under Paragraph 4.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or Enrollee's spouse acquires the right to control that child's health care. 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 premiums must be paid to VSP.

VIII.
CONTINUATION OF COVERAGE

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

8.02. **Individual Continuation of Benefits:** This Plan is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

IX.
ARBITRATION OF DISPUTES

9.01. **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.

9.02. **Procedure:** The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

9.03. **Choice of Law:** If any matter arises in connection with this Plan which becomes the subject of arbitration or legal process, the law of the State of Delivery of the Plan shall be the applicable law.

X.
NOTICES

10.01. **Required Notices**: Any notices required under this Plan to either Group or VSP shall be in written format. Notices sent to Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by the Group. Notices sent to VSP shall be sent to the address shown on the first page of this Plan. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

XI.
MISCELLANEOUS

11.01. **Entire Plan:** This Plan, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Plan must be approved by an officer of VSP and attached hereto 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.

11.02. **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 or covenants specified herein, including without limitation, breach of confidentiality. 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 or covenants specified herein, including without limitation, breach of confidentiality.

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

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

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

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

11.07. **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.

11.08. **Equal Opportunity**: VSP is an Equal Opportunity and Affirmative Action employer.

11.09. **Communication Materials**: 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 prior to use. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Group's materials meet any applicable legal or regulatory requirements, including but not limited to, ERISA requirements.

EXHIBIT A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
Signature Plan

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 $30.00 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 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.

Lens Options

Tinted/Photochromic	Covered in full	Not Covered

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 VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	**Professional Fees and Materials**
Covered in full*	Up to $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 $130.00	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 his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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 Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses 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.
- 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 Plan which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

EXHIBIT B

VISION SERVICE PLAN
SCHEDULE OF PREMIUMS
Signature Plan

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

$ 12.56 per month for each eligible Enrollee without Eligible Dependents.
$ 19.51 per month for each eligible Enrollee with one Eligible Dependent.
$ 30.95 per month for each eligible Enrollee with two or more Eligible Dependents.

NOTICE: The premium 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.

ADDENDUM

ADDITIONAL BENEFIT RIDER
VISION SERVICE PLAN
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

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 Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Plan 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.
- 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.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care 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 available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("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, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care 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 Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain 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 the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

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.