Group Vision Care Plan

Vision Care for Life

Group Name: **ASSOCIATION OF WASHINGTON CITIES EMPLOYEE BENEFIT TRUST**

Group Number: **07103822—1006**

Effective Date: **JANUARY 1, 2018**

Plan Name: **Vision Enhanced Plan B, $0 Copayment with Second Pair Rider**

Description of Plan Benefits

Plan Benefits Administered by:

VSP VISION CARE, INC.
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 — (800) 877-7195

This booklet is the description of the plan benefits provided under the self-funded vision plan ("Plan") sponsored by the Association of Washington Cities Employee Benefit Trust ("Trust"). The Plan is available to eligible employees of employers participating in the Trust who offer this Plan and to the eligible dependents of such employees. This Plan booklet is effective January 01, 2018.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER The document attached to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

AFFILIATED PROVIDERS Providers of covered services and materials who have not contracted with VSP to become Member Doctors but who have agreed to bill VSP directly for Plan Benefits.

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

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

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

COVERED PERSON An Enrollee or Eligible Dependent who is enrolled in and covered under this plan.

ELIGIBLE DEPENDENT The following dependents of an Enrollee are eligible for the Plan: (1) the employee's legal spouse; (2) the employee's state-registered domestic partner and, if specifically included as eligible by the employer, the employee's non-state registered domestic partner for whom an accurate and complete affidavit of qualifying domestic partnership has been submitted. Contact the Trust at 1-800-562-8981 for questions about whether a non-state registered domestic partner is eligible for the Plan; (3) children under age 26 of the employee, spouse or eligible domestic partner, including adopted children, stepchildren, children for whom the employee has a qualified court order to provide coverage and any other children for whom the employee is the legal guardian.

Eligibility may be extended past the child's 26th birthday if the child is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age, and is chiefly dependent upon the employee for support and maintenance. Enrollment for such a child may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be furnished to Trust upon request, but not more frequently than annually after the 2 year period following the child's attainment of age 26.

When an employee has a newborn child, the newborn child is automatically entitled to Plan benefits from birth through 3 weeks of age. After 3 weeks of age, no Plan benefits are available unless the newborn child is enrolled in the Plan.

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

ENROLLEE An employee of a Participating Employer in the Trust who is eligible for and enrolled in the Plan. For most employers participating in the Trust, bona fide employees are eligible for the Plan if the employee works a minimum of 20 hours per week or 80 hours per month. Please contact the Trust at 1-800-562-8981 for more information about employee eligibility.

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

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.

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

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 and for whose services the Plan provides better benefits than Non-Member Providers.

NON-MEMBER PROVIDER Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP and for whose services the Plan provides fewer benefits than Member Providers.

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 on the attached Schedule of Benefits.

SCHEDULE OF BENEFITS The attached document, which lists benefits for vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this Plan.

TRUST The Association of Washington Cities Employee Benefit Trust.

ELIGIBILITY FOR COVERAGE

Enrollees and Eligible Dependents, as defined above, are eligible to participate in the Plan. All Covered Persons (except for newborns from birth to three weeks of age) must be enrolled in the Plan, as described below.

ENROLLMENT IN THE PLAN

1. **Newly Eligible Employees.** Newly eligible employees and their Eligible Dependents may apply for enrollment with the Trust within 31 days of becoming eligible.

2. **New Dependents.** An application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Trust within 31 days after the dependency occurs. A written application for enrollment of a newborn child must be made to the Trust within 60 days following the date of birth. A written application for enrollment of an adoptive child must be made to the Trust within 60 days from the day the child is placed with the employee for the purpose of adoption or the employee assumes total or partial financial support of the child.

3. **Open Enrollment.** Eligible employees and their Eligible Dependents may enroll in the Plan during an open enrollment period sponsored by the Trust.

4. **Special Enrollment.** The Plan will also allow special enrollment for eligible employees and their Eligible Dependents:

   a. Who initially declined enrollment when otherwise eligible because such persons had other vision plan coverage and have had such other coverage terminated due to one of the following events:

      - Cessation of employer contributions.

      - Exhaustion of COBRA continuation coverage.

      - Loss of eligibility, except for loss of eligibility for cause.

      The Trust may require confirmation of the other coverage. Application for coverage must be made within 31 days of the termination of previous coverage.

   b. Who are eligible in the event one of the following occurs:

      - They become eligibility for premium assistance from Medicaid or a state Children's Health Insurance Program (CHIP), provided such person is otherwise eligible for coverage under this Plan. The request for special enrollment must be made within 60 days of eligibility for such premium assistance.

- Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP.

CONTRIBUTIONS

You may be required to make contributions towards the cost of your Plan coverage. Please contact your employer or the Trust (at 1-800-562-8981) for more information.

PROCEDURE FOR USING THE PLAN

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from the Trust or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.

2. If you are eligible for Plan Benefits, VSP will provide the Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Plan. VSP will pay the Member Doctor directly according to the Plan and its agreement with the doctor.

   Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed Schedule of Benefits, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, you can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates your Plan includes such coverage). No prior approval or authorization from VSP is required for you 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 Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits you are not covered by the Plan for medical services and should contact a physician under your medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, you should contact VSP's Customer Service Department for assistance.

   Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreements with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by member employers to the Trust, which includes the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) provided for you under this Plan. When you request services under this Plan, your prior utilization of Plan Benefits will be reviewed by VSP to determine if you are eligible for new services based upon your Plan's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to you by the Plan.

BENEFITS AND COVERAGES

VSP pays claims for Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP Plans. However, the actual Plan Benefits provided to you by this Plan may be different. Refer to the attached Schedule of Benefits to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

   Necessary contact lenses, together with professional services, will be provided as indicated on the enclosed insert.

   When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown on the enclosed insert. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed Schedule of Benefits, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed Schedule of Benefits): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If you are in this category, you are entitled to benefits for professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed Schedule of Benefits. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable 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.

This vision service Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the attached Schedule of Benefits.

- Optional cosmetic processes.
- Blended lenses.
- Cosmetic lenses.
- Polycarbonate lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

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

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.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 indicated on the enclosed Schedule of Benefits.
- Services/materials not indicated as covered Plan Benefits on the enclosed Schedule of Benefits.

COMPLAINTS AND GRIEVANCES CONCERNING ACCESS TO CARE OR QUALITY OF CARE, TREATMENT, OR SERVICE

If you have a question or problem, your first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the VSP Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

CLAIM PAYMENTS AND APPEALS OF DENIED CLAIMS

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

B. Request for Appeals: If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to you within thirty (30) calendar days after receipt of a request for appeal from you or your authorized representative.

If you disagree with VSP's determination, you may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

EXHAUSTION OF GRIEVANCE AND APPEAL RIGHTS

No action in law or in equity shall be brought to recover Plan benefits unless you have first exhausted your grievance rights and rights to appeal as described in the previous two sections. No such action may be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices may be submitted to VSP in accordance with the terms of this Plan.

TERMINATION OF BENEFITS

Terms and cancellation conditions of your vision care plan are shown on the enclosed Schedule of Benefits. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by the Trust or by VSP.

If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion but in no event beyond six (6) months after the termination date of the Plan.

NO LIABILITY FOR YOUR VISION CARE

The Plan pays benefits for certain vision care services and materials. VSP contracts with Member Doctors, who are independent contractors responsible for your vision care and for exercising independent judgment. Neither VSP, the Trust, nor the Plan directly furnishes vision care services or supplies materials. The Plan, VSP and the Trust are not liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying vision care services or materials to Covered Persons.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible 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, the Trust and VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA. Please contact the Trust at 1-800-562-8981 for more information about COBRA.

SCHEDULE OF BENEFITS
Association of Washington Cities Employee Benefit Trust
Vision Enhanced Plan B, $0 Copayment with Second Pair Rider
Class 1006

GENERAL

This Schedule and any Additional Benefit Rider(s) attached, hereto list the Plan Benefits for vision care services and vision care materials 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, Plan Benefits will be paid for 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.

When Plan Benefits are received from Member Doctors, benefits appearing in the left column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the right column below less any applicable Copayment.

Frequency limitations on Plan Benefits (such as "Covered Once Every 12 Months") are based on the most recent occasion, if any, that you received the Plan Benefit in question. For example, if you have a vision exam on April 1, 2018, the Plan (1) will provide benefits for the exam if the Plan has not paid benefits for a vision exam for you since April 1, 2017; and (2) will not provide benefits for another vision exam for you until April 1, 2019.

The Plan Benefits for contact lenses are in lieu of benefits for lenses and frames.

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***	
VISION CARE SERVICES: Covered Once Every 12 months			
Vision Examination	*Covered in Full*	*Up to $*	*50.00*
VISION CARE MATERIALS			
Lenses: Covered Once Every 12 Months			
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*
Frames: Covered Once every 24 Months	*Covered up to Plan Allowance of $150.00*	*Up to $*	*70.00*

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

CONTACT LENSES: Covered Once Every 12 Months			
Necessary			
Professional Fees and Materials	*Covered in Full*	*Up to $*	*210.00*
Elective: Covered Once Every 12 Months			
*Professional Fees** and Materials*	*Up to $ 150.00*	*Up to $*	*150.00*

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.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

LENS OPTIONS

Anti-reflective coating	Covered in full	Not Covered
Color coating	Covered in full	Not Covered
Mirror coating	Covered in full	Not Covered
Scratch coating	Covered in full	Not Covered
Laminated Lenses	Covered in full	Not Covered
Oversize Lenses	Covered in full	Not Covered
Tinted/Photochromic	Covered in full	Up to $ 5.00

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

COPAYMENT

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

LOW VISION

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	*Covered in Full*	*Up to $125.00*
Supplemental Aids	*75% of cost*	*75% of cost*

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

THE EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

PLAN BENEFITS

AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Person should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

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, or Lined Trifocal)

LENS OPTIONS
Anti-reflective Coating-Covered in full once every 12 months**
Mirror Coating-Covered in full once every 12 months**
Scratch Coating-Covered in full once every 12 months**
Photochromic-Covered in full once every 12 months**

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $150.00 once every 12 months**

The Elective Contact Lens allowance applies to materials only.

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

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

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

**Beginning with the first date of service.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $ 125.00†
-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.

2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.

3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.

4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

ADDITIONAL BENEFIT RIDER
SECOND PAIR

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. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered. The copayment shall not apply to Elective Contact Lenses.

PLAN BENEFITS

MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Covered in full*	Available once each 12 months**
*Less any applicable Copayment. **Beginning with the first date of service. Plan Benefits for lenses are per complete set, not per lens.		
Frames	Covered up to Plan allowance of $150.00*	Available once each 24 months**

Contact Lenses		
Necessary	Covered in full *	Available once every 12 months**
Elective	Up to $ 150.00	Available once every 12 months**

*Less the Copayment.
**Beginning with the first date of service.

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.

Contact lenses are provided 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 again for 12 months and frames for 12 months.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

SECOND PAIR BENEFIT ONLY

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.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Eye examinations.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Plano contact lenses to change eye color cosmetically.
- 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.
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowance.
- Services and/or materials not included on this Rider as covered Plan Benefits.

SERVICES FROM NON-MEMBER PROVIDERS

LIABILITY OF COVERED PERSONS FOR PAYMENT
REIMBURSEMENT PROVISIONS

When a Covered Person chooses to receive services from a Non-Member Provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This Plan then becomes an indemnity plan reimbursing according to a schedule of allowances. The Covered Person should pay the Provider's fee in full. VSP will reimburse the Covered Person in accordance with the following schedule.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL BE SUFFICIENT TO PAY THE EXAMINATION OR THE MATERIALS IN FULL.

AVAILABILITY OF SERVICES UNDER THIS REIMBURSEMENT SCHEDULE IS SUBJECT TO THE SAME TIME LIMITS AND COPAYMENT AS THOSE DESCRIBED FOR MEMBER DOCTORS. SERVICES OBTAINED FROM NON-MEMBER PROVIDERS ARE IN LIEU OF SERVICES FROM A MEMBER DOCTOR.

VSP IS UNABLE TO REQUIRE NON-MEMBER PROVIDERS TO ADHERE TO VSP'S QUALITY STANDARDS.

SCHEDULE OF ALLOWANCES

MATERIAL	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
Lenses		
Single Vision	Up to $ 50.00*	Available once each 12 months**
Bifocal	Up to $ 75.00*	Available once each 12 months**
Trifocal	Up to $ 100.00*	Available once each 12 months**
Lenticular	Up to $ 125.00*	Available once each 12 months**
Frame	Up to $ 70.00*	Available once each 24 months**
*Less the Copayment **Beginning with the first date of service. Plan Benefits for lenses are per complete set, not per lens.		
Contact Lenses		
Necessary	Up to $ 210.00*	Available once each 12 months**
Elective	Up to $ 150.00	Available once each 12 months**

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.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

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

COVERED SERVICES AND MATERIALS

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

Lenses (Single, Lined Bifocal, or Lined Trifocal)

FRAMES: Covered up to the Plan allowance of $150.00* once every 24 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $150.00 once every 12 months**

The Elective Contact Lens allowance applies to materials only.

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

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

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

*Less the Copayment.
**Beginning with the first date of service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.

2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.

3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.

4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.