JANUARY 8, 2015

Vision Care for Life

LISA BORDELON
LOCKTON COMPANIES, LLC
5847 SAN FELIPE ST STE 320
HOUSTON, TX 77057-3183

RE: GALLIANO MARINE SERVICE, LLC, GROUP #30052281
JANUARY 1, 2015 DOCUMENTS

Attention Lisa Bordelon:

Enclosed are the JANUARY 1, 2015 documents for the above Client. Please retain a copy for your records and forward the additional copy to the Client.

This new document supersedes any existing document your Client has with VSP. If you or your Client have any questions, or need additional information, please do not hesitate to contact us at 866-213-2249, and a VSP representative will assist you.

Enclosures

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

GROUP VISION CARE PLAN

Group Name	**GALLIANO MARINE SERVICE, LLC**
Plan Number	**30052281**
State of Delivery	**LOUISIANA**
Effective Date	**JANUARY 1, 2015**
Plan Term	**FORTY-EIGHT (48) 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 INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Group Vision Care Plan ("Plan") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Plan is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Plan.

James M. McGrann, Secretary

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VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE PLAN
SECTION I.
DEFINITIONS

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

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

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

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

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

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

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

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

1.08. 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.

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

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

1.11. 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.

1.12. 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.

1.13. GROUP VISION CARE PLAN (also, "The Plan"): The Plan issued by VSP in favor of 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.

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

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

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

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

1.18. PLAN BENEFITS: The vision care services and vision care materials that 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.

1.19. PREMIUMS: The payments made to VSP by Group on behalf of Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached hereto as Exhibit B.

1.20. RENEWAL DATE: The date on which the Plan shall renew, or expire if proper notice is given.

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

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

SECTION II.
TERM, TERMINATION, AND RENEWAL

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

2.02. **Early Termination Provision**: The premium rate(s) payable by Group under this Agreement 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 this Agreement is terminated by Group before the end of the Plan Term or 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.

SECTION III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons**: VSP will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Group may be required by VSP to complete and sign a Group Application and forward such application to VSP, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Covered Person, VSP will make available to all Covered Persons a Member Benefit Summary. Such Member Benefit Summary 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 the Covered Person chooses to receive Plan Benefits from a Non-Member Provider), VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), subject to any limitations, exclusions, or Copayments therein stated. When the Covered Person desires to receive Plan Benefits from a Member Doctor, the Covered Person shall contact VSP or the Member Doctor. VSP shall provide Benefit Authorization to the Member Doctor or to the eligible Covered Person for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by VSP in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made. VSP shall not be held liable to Group for any Benefit Authorizations so issued in error. Covered Persons are required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Covered Person obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details).

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

3.03. **Provision of Information to Covered Persons**: VSP shall make available to the Covered Person necessary information describing Plan Benefits and the appropriate method for using 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 who wish to inspect or copy it. VSP shall provide to Covered Persons an updated list of Member Doctors' names, addresses, and telephone numbers.

3.04. **Preservation of Confidentiality**: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Plan, including but not limited to, sharing information with medical information bureaus, or as may otherwise be required by law.

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 Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance 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.

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

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

VSP may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. VSP may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Plan are changed. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan.

Notwithstanding the above, VSP reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the Premiums VSP receives from Group.

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

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

4.04. **Other Information to be Provided**: Group shall furnish to VSP monthly, during the effective period of this Plan, such information as may reasonably be required by VSP for the purposes of this Plan, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form specified by VSP. In addition, Group shall, when requested, make available for inspection by VSP such records as may have bearing on the coverage of Covered Persons under this Plan.

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

4.06. **Risk-to-ASP Conversion Provision**: Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.

SECTION V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

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

All Covered Persons under this Plan shall have the following obligations as a condition of their coverage.

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

5.03. **Authorization of Services**: The Covered Person must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or 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 provider will be considered a Non-Member Provider, and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Complaints and Grievances: Time of Action**: 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. Covered Person may submit written comments or supporting documentation concerning his/her 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 not 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, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

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

SECTION VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria**: Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

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

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

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

(b) **Eligible Dependents**: If dependent coverage is provided, the persons eligible for dependent coverage as dependents shall include:

(1) the legal spouse of any Enrollee; and

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

(3) as further defined by Group.

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

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

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

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

As stated in Section 4.04. herein, VSP may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Covered Person is entitled under the Plan.

6.03. **Change of Participation Requirements, Contribution of Fees, and Eligibility Rules**: Composition of the Group, percentage of Enrollees covered under the Plan, and eligibility requirements are material to VSP's obligations under this Plan. During the term of this Plan, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects VSP's obligations hereunder unless VSP consents to such change in writing. VSP may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.

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

SECTION VII.
CONTINUATION OF COVERAGE

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

SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

8.01. **Claims Denial Appeals**: If, under the terms of this 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 Enrollee's name, the 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 response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

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

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

c) **Other Remedies**: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(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.

8.02. **Disputes**: 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 allowing such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

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

SECTION IX.
NOTICES

9.01. **Notices**: Any notices required under this Plan to either Group or VSP shall be in written format. Notices sent to the Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by Group. Notices to VSP shall be sent to the address shown on the front 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.

SECTION X.
MISCELLANEOUS

10.01. **Entire Plan**: This Plan, the Group Application, the Evidence of Coverage, and all Exhibits, addenda and attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to the 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.

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

10.03. **Liability**: Under no circumstances shall VSP or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Plan.

10.04. **Right to Reject Claims**: VSP reserves the right to reject any and all claims for services or benefits that are filed with it more than three hundred sixty-five (365) days after completion of services.

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

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

10.07. **Choice of Law**: While recognizing that question(s) and dispute(s) hereunder are to be resolved by arbitration, if there are any matters arising in connection with this Plan that do become the subject of legal process, the applicable law shall be that of the State of Delivery of this Plan.

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

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

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

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan - Base

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Evidence of Coverage to which it is attached.

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

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

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 45.00*

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

*Less any applicable Copayment.
Subsequent regular eye examinations once every **plan year beginning on January 1st.**

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in Full*	Up to $ 30.00*
Bifocal	Covered in Full*	Up to $ 50.00*
Trifocal	Covered in Full*	Up to $ 65.00*
Lenticular	Covered in Full*	Up to $ 100.00*

*Less any applicable Copayment

Available once every plan year beginning on January 1st.

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

*Less any applicable Copayment.

Available once every plan year beginning on January 1st.

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

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

Lens Options

Scratch coating	Covered in full	Not Covered
Polycarbonate Lenses	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 - Covered in Full*	Professional Fees and Materials - Up to $ 210.00*

ELECTIVE

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Materials - Up to $ 150.00 Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $25.00 Copayment.	Professional Fees and Materials - Up to $ 150.00

*Less any applicable Copayment

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

COPAYMENT

The benefits described above are available to each Covered Person from any participating Member Doctor at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

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

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 and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplementary Care	75% of Cost	75% of Cost*
Subsequent low vision therapy.		

Copayment

75% of the benefits payable by the Company and 25% payable by Covered Person.

Benefit Maximum

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

***NON-MEMBER 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/her 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.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

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.

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.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

COPAYMENT

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

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

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

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full once every 12 months**

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

CONTACT LENSES

ELECTIVE

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

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $25.00 Copayment.

NECESSARY

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

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

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

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

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.

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan – Premier

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Evidence of Coverage to which it is attached.

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

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

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	**NON-MEMBER PROVIDER BENEFIT**
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 45.00*

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

*Less any applicable Copayment.
Subsequent regular eye examinations once every **plan year beginning on January 1st.**

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	**NON-MEMBER PROVIDER BENEFIT**
Lenses		
Single Vision	Covered in Full*	Up to $ 30.00*
Bifocal	Covered in Full*	Up to $ 50.00*
Trifocal	Covered in Full*	Up to $ 65.00*
Lenticular	Covered in Full*	Up to $ 100.00*

*Less any applicable Copayment

Available once every plan year beginning on January 1st.

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

*Less any applicable Copayment.

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

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

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

Lens Options

Scratch coating	Covered in full	Not Covered
Polycarbonate Lenses	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 - Covered in Full*	Professional Fees and Materials - Up to $ 210.00*

ELECTIVE

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Materials - Up to $ 150.00 Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $25.00 Copayment.	Professional Fees and Materials - Up to $ 150.00

*Less any applicable Copayment

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

COPAYMENT

The benefits described above are available to each Covered Person from any participating Member Doctor at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

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

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 and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplementary Care	75% of Cost	75% of Cost*
Subsequent low vision therapy.		

Copayment

75% of the benefits payable by the Company and 25% payable by Covered Person.

Benefit Maximum

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

***NON-MEMBER 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/her 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.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

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.

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.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

COPAYMENT

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

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

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

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full once every 12 months**

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

CONTACT LENSES

ELECTIVE

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

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $25.00 Copayment.

NECESSARY

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

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

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

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

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

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.

Exhibit B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
VSP Choice Plan - Base

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.

$ 6.15 per month for each eligible Enrollee without Eligible Dependents.
$ 12.80 per month for each eligible Enrollee (includes coverage for 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.

Exhibit B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
VSP Choice Plan - Premier

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.

$ 9.75 per month for each eligible Enrollee without Eligible Dependents.
$ 18.80 per month for each eligible Enrollee (includes coverage for 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

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY 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. Plan Benefits under the Diabetic Eyecare Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the PLAN or 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.
- The legal spouse of Enrollee.
- Any child of an Enrollee, including any 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 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.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Persons group medical plan. Providers will first submit a claim to Covered Persons group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Covered Person Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

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

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

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

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SECOND PAIR
CHOICE NETWORK - Premier

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("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.

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

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of an Enrollee, including any 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 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.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

There shall be a Copayment of $10.00 for materials payable by the Covered Person to the Member Doctor at the time services are rendered.

PLAN BENEFITS

MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Covered in full*	Available once each 12 months**
*Less any applicable Copayment. **Available once every plan year beginning on January 1st. Plan Benefits for lenses are per complete set, not per lens.		

MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lens Options		
Scratch Coating	Covered in full	Available once each 12 months**
Polycarbonate lenses	Covered in full	Available once each 12 months**

Frames	Covered up to Plan allowance*	Available once each 24 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 $ 30.00*	Available once each 12 months
Bifocal	Up to $ 50.00*	Available once each 12 months
Trifocal	Up to $ 65.00*	Available once each 12 months
Lenticular	Up to $ 100.00*	Available once each 12 months
Frame	Up to $ 70.00*	Available once each 24 months**

*Less any applicable Copayment
** Available once every other plan year beginning on January 1st.

Plan Benefits for lenses are per complete set, not per lens.

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

There shall be a Copayment of $10.00 for materials payable by the Covered Person to the Member Doctor 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 Plan allowance* once every 24 months**

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months*
Polycarbonate Lenses-Covered in full once every 12 months*

*Less any applicable Copayment

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

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.

Addendum

ADDITIONAL BENEFIT RIDER
SAFETY EYECARE PLAN

GENERAL

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

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED UNDER ARTICLE VI. OF THE GROUP VISION CARE PLAN AND WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE SAFETY EYECARE PLAN.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

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

If materials (lenses and frames) are provided, there shall be a Copayment of $10.00 payable at the time the materials are ordered.

PLAN BENEFITS

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT
Lenses	Covered in full*

Member Doctors shall ensure that lenses provided under the Safety EyeCare Plan meet the following minimum standards:

- Be no less than 3mm at the thinnest point.
- Be impact-tested with a one-inch steel ball dropped from a height of 50 inches.
- Be engraved by the manufacturer that it is a safety lens.

Available once every plan year beginning on January 1st.

*Less any applicable Copayment

Lens Options

Available once each 12 months**

Polycarbonate Lenses Covered in full

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT
Frames	Covered up to Plan Allowance*

Member Doctors shall ensure that frames provided under the Safety EyeCare Plan meet the following minimum standards:

- Have a "Z-87" stamp on the front and temples.
- Be fabricated of a slow-burning material.
- Have the manufacturer's logo imprint.
- Be constructed so that, if impacted from the front, the lens will not come out through the back of the frame.

Materials will be certified as safe for a work environment by meeting the required test standards as set forth by the American National Standards Institute (ANSI).

VSP reserves the right to limit the cost of the frames provided by Member Doctors under this Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.

Available once every other plan year beginning on January 1st.
*Less any applicable Copayment

EXCLUSIONS AND LIMITATIONS OF BENEFITS

SAFETY EYECARE PLAN

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 vision service plan is designed to cover visual needs rather than cosmetic materials. When a 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.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

NOT COVERED

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

- Subnormal vision aids.
- Orthoptics or vision training and any associated supplementary testing not specifically related to Safety EyeCare.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Replacement of lenses and frames furnished under this {N/P}that 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.
- Examinations above a Limited Level unless the Covered Person: (i) is not eligible for an eye examination under the Plan to which this Rider is attached; (ii) received an eye examination from another Member Doctor during the same eligibility period; or (iii) received an eye examination during the preceding 6 months from a practitioner in the same Member Doctor's office that will be providing the Safety EyeCare examination.
- Rimless frames.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.