

Group Vision Care Plan



Vision Care for Life

Group Name: WASHINGTON ALLIANCE FOR HEALTHCARE
INSURANCE TRUST
Group Number: 12074233
Effective Date: JANUARY 1, 2016

CERTIFICATE OF COVERAGE

Provided by:

MID-ATLANTIC VISION SERVICE PLAN, INC.

One Union Square Building
600 University Street, Suite 2004
Seattle, Washington 98101-1129

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

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER:

NAME OF PLAN:

PRINCIPAL ADDRESS:

EMPLOYER I.D. #:

PLAN #:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

Benefits are furnished under a vision care Plan purchased by the Group and provided by Vision Service Plan (VSP) under which VSP is financially responsible for the payment of claims.

This Certificate of Coverage is a summary of the provisions of the Plan providing group vision coverage. In the event of any conflict between this Certificate of Coverage and the Plan, the provisions of this Certificate of Coverage will prevail. A copy of the Plan will be furnished on request.

DEFINITIONS:

| | |
|----------------------------------|--|
| ADDITIONAL BENEFITS RIDER | The document, attached as Exhibit C to the Group Plan maintained by the Group Administrator and to this Certificate of Coverage, which lists selected vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan (Available only if purchased by Group). |
| ADVERSE DETERMINATION | A decision made by VSP resulting in the denial, modification, reduction or termination of coverage. |
| 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 | Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided. |
| COVERED PERSON | An Enrollee or Eligible Dependent who meets Group's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan. |
| ELIGIBLE DEPENDENT | Any dependent of an Enrollee of Group who meets the eligibility criteria established by Group. |
| EMERGENCY CONDITION | A condition with sudden onset and acute symptoms, including severe pain, a prudent person without medical training would reasonably believe requires immediate medical attention. |
| ENROLLEE | An employee or member of Group who meets the eligibility criteria specified under Section VI. ELIGIBILITY FOR COVERAGE of the Plan. |
| EXPERIMENTAL NATURE | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP through consideration of whether the procedure or lens is in general use in the medical community in the state of Washington, is under continued scientific testing and research, shows a demonstrable benefit for a particular condition, and whether it is proven to be safe and efficacious. |
| 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. |

| | |
|------------------------------|---|
| VSP NETWORK 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. |
| NON-VSP PROVIDER | Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP. |
| PLAN or PLAN BENEFITS | The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined on the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group). |
| PREMIUMS | The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator. |
| RENEWAL DATE | The date on which the Plan shall renew or terminate if proper notice is given. |
| SCHEDULE OF BENEFITS | The document attached as Exhibit A to the Group Plan maintained by the Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan. |
| SCHEDULE OF PREMIUMS | The document attached as Exhibit B to the Group Plan maintained by the Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits. |

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Group, and meet the established coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible are indicated on the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group). This includes coverage for newborn infant children of Enrollees from and after the moment of birth, including but not limited to coverage for congenital anomalies.

PREMIUMS

Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.

PROCEDURE FOR USING THE PLAN

1. When Covered Person wants to receive Plan Benefits, contact VSP or a VSP Network Doctor. A list of names, addresses and phone numbers of VSP Network Doctors in Covered Person's area can be obtained from Group, the Plan Administrator or VSP. If this list does not cover the area in which Covered Person desires to seek services, call or write the VSP office nearest Covered Person to obtain one that does.
2. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the VSP Network Doctor. If Covered Person contacts the VSP Network Doctor directly, Covered Person must identify him or herself as a VSP member so the doctor can 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 Covered Person's termination of coverage or the termination of the Plan. Should Covered Person receive services from a VSP Network Doctor without such Benefit Authorization or obtain services from a Non-VSP Provider, Covered Person is responsible for payment in full to the provider.
4. Covered Person pays the Copayment (if any), amounts which exceed the Plan Allowances, and any amounts for non-covered services or materials to the VSP Network Doctor for services under this Plan. VSP will pay the VSP Network Doctor directly according to its agreement with the doctor.

Note: If Covered Person is eligible for and obtains Plan Benefits from a Non-VSP Provider, Covered Person should pay the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown on the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group), less any applicable Copayments.

Warning: Limited benefits will be paid when non-VSP providers are used.

Covered Persons should be aware that when they elect to utilize the services of a Non-VSP Provider for a covered service in non-emergency situations, benefit payments for services from such Non-VSP Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Non-VSP Provider fee schedule.

Covered Persons can expect to be liable for more than the copayment amount defined in the attached schedule of benefits or additional benefit rider (when purchased by the Group) after the Plan has paid its required portion.

When payment is made to the Non-VSP Provider, the provider may bill Covered Person for any amount up to the billed charge after the Plan has paid its portion of the bill. VSP Network Doctors have agreed to accept discounted payments for services with no additional billing to the Covered Person other than copayments, co-insurance and non-covered services or materials. Covered Persons may obtain further information about the participating status of providers and information on out-of-pocket expenses through vsp.com, or by calling VSP's Customer Service Department at 1-800-877-7195.

5. In emergency conditions, when immediate vision care of a medical nature is necessary Covered Person can obtain covered services by contacting a VSP Network Doctor or Non-VSP Provider. No prior authorization from VSP is required for Covered Person to obtain covered vision care for Emergency Conditions of a medical nature.

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.

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

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

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Please refer to the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group) for a summary of the level of coverage provided to Covered Person by Group.

BENEFITS AND COVERAGES

Through its VSP Network Doctors, VSP provides Plan Benefits to Covered Persons subject to the limitations, exclusions and Copayment(s) described herein. When Covered Person wishes to obtain Plan Benefits from a VSP Network Doctor, Covered Person may contact any VSP Network Doctor, identify Covered Person as a VSP member, and schedule an appointment. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization for Covered Person directly to the VSP Network Doctor prior to Covered Person's appointment.

Specific benefits for which Covered Person is covered are described on the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group).

COPAYMENT

The benefits described herein are available to Covered Person subject to Covered Person's payment of any applicable Copayments as described in this Certificate of Coverage, the Schedule of Benefits and Additional Benefit Rider (when purchased by Group). Amounts which exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

Any additional care, service and/or materials not covered by this plan may be arranged between Covered Person and the Doctor.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Persons' VSP plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in the information and only where such is not prohibited by law.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This vision service plan is designed to cover *visual needs rather than cosmetic materials*.

Some professional services and/or materials are not covered under this Plan. Please refer to the NOT COVERED section of the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Group) for details.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of our Optometric Consultants this is necessary for the visual welfare of the Covered Person.

LIABILITY IN EVENT OF NON-PAYMENT

In the event VSP fails to pay the provider, Covered Person shall not be liable for any sums owed by VSP other than those not covered by the Plan.

COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's 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 the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP, verbally or in writing, by using the complaint form, which may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons 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 the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

APPEALS OF ADVERSE DETERMINATIONS

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

REQUESTS FOR APPEALS

If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of claim, Covered Person may make an oral 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. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person 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. Covered Person or Covered Person's 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 the Covered Person within thirty (30) days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from date of determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of review of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

CLAIM APPEALS FOR SERVICES OF AN EXPERIMENTAL NATURE

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

TERMINATION OF BENEFITS

After the Plan Term, this Plan will continue on a month to month basis or until terminated by either party giving the other party sixty (60) days notice. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by your Group or by VSP due to nonpayment of Premium.

If Covered Person is receiving service 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.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

LABOR DISPUTES

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

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

EXHIBIT A

SCHEDULE OF BENEFITS SIGNATURE PLAN – VP Plus

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of MID-ATLANTIC VISION SERVICE PLAN, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Plan and Certificate of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are available and received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.*
- Any child of Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, the child of the spouse/domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible.
- The domestic partner of the same or opposite gender as Enrollee.

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

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:

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

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$20.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

PLAN BENEFITS

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|---|----------------------------|--------------------------|---------------------------------|
| Eye Examination | Covered in full* | Up to \$ 50.00* | Available once each 12 months** |
| Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service. | | | |

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|---|----------------------------|--------------------------|---------------------------------|
| Lenses | | | Available once each 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* | |
| Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first date of service. | | | |

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|---|-------------------------------|--------------------------|---------------------------------|
| FRAMES | Covered up to Plan Allowance* | Up to \$ 70.00* | Available once each 24 months** |
| Benefits for lenses and frames include reimbursement for the following necessary professional services: <ol style="list-style-type: none"> 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. | | | |
| *Less any applicable Copayment. **Beginning with the first date of service. Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients. | | | |

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|------------------------------------|----------------------------|--------------------------|---------------------------------|
| ELECTIVE CONTACT LENSES | | | Available once each 12 months** |
| Professional Fees and Materials*** | Up to \$ 130.00 | Up to \$ 105.00 | |

*Less any applicable Copayment

**Beginning with the first date of service.

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

Elective 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 24 months.

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|------------------------------------|----------------------------|--------------------------|---------------------------------|
| NECESSARY CONTACT LENSES | | | Available once each 12 months** |
| Professional Fees and Materials*** | Covered in full * | Up to \$ 210.00* | |

*Less any applicable 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 VSP Network Doctor or Non-VSP Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Visually Necessary 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 24 months.

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | NON-VSP PROVIDER BENEFIT | FREQUENCY |
|--|--|-----------------------------------|-----------|
| LOW VISION | | | |
| Professional services for severe visual problems not correctable with regular lenses, including: | | | |
| Supplemental Testing | Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.) | Up to \$125.00* | * |
| Supplemental Aids | 75% of amount up to \$1000.00* | 75% of amount up to \$1000.00* | * |
| <p>*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years.</p> <p>Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.</p> <p>There is no assurance that the amount reimbursed will cover 75% of the provider's full fee.</p> | | | |

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 Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

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

NOT COVERED

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

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT).
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
- 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.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials above Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

**PLAN BENEFITS
AFFILIATE PROVIDERS**

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network 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 the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames) are provided, there shall be an additional \$20.00 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)

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

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

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$130.00 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.

*Less any applicable Copayment.

**Beginning with the first date of service.

LOW VISION

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

Supplemental Testing: Covered in full†

-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.

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 VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP 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 C

**ADDITIONAL BENEFIT RIDER
COMPUTER VISIONCARE PLAN – VP Plus Option Only**

GENERAL

This Rider lists the vision care benefits to which Covered Persons of MID-ATLANTIC VISION SERVICE PLAN, INC. ("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 and Certificate of Coverage to which it is attached.

Covered persons who meet the eligibility requirements outlined below and who utilize a computer monitor shall be eligible for the Computer Visioncare (CVC) Plan.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.

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

COPAYMENT

A Copayment amount of \$10.00 shall be payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered

PLAN BENEFITS

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | FREQUENCY |
|--|----------------------------|---------------------------------|
| Eye Examination | Covered in full* | Available once each 12 months** |
| <p>A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use.</p> <p>*Less any applicable Copayment. **Beginning with the first date of service.</p> | | |

| SERVICE OR MATERIALS | VSP NETWORK DOCTOR BENEFIT | FREQUENCY |
|---|----------------------------|---------------------------------|
| Single Vision | Covered in full * | Available once each 12 months** |
| Bifocal | Covered in full * | |
| Trifocal | Covered in full * | |
| Near Variable Focus | Covered in full * | |
| Occupational Progressive | Covered in full * | |
| <p>Plan Benefits for lenses are per complete set, not per lens.</p> <p>*Less any applicable Copayment. **Beginning with the first date of service.</p> | | |

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | FREQUENCY |
|--|--|---------------------------------|
| Frames | Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use. | |
| | Covered up to Plan Allowance* | Available once each 24 months** |
| <p>VSP reserves the right to limit the cost of the frames provided by VSP Network Doctors under the Plan. The current allowance shall be published periodically by VSP to its Network Doctors and will be set at a level to cover a sufficient number of frames in common use.</p> <p>Plan Benefits for lenses are per complete set, not per lens.</p> <p>*Less any applicable Copayment **Beginning with the first date of service.</p> | | |

| SERVICE OR MATERIAL | VSP NETWORK DOCTOR BENEFIT | FREQUENCY |
|--|---|---------------------------------|
| Associated Vision Therapy (specific to computer use) | Up to \$200.00 per year (includes any supplemental testing) | Available once each 12 months** |
| Beginning with the first date of service. | | |
| <p>This benefit is limited to Covered Persons who are eligible for CVC Coverage and who are diagnosed as having one of the following conditions:</p> <p>Accommodative Infacility – The inability (or inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at objects up close.)</p> <p>Convergence Insufficiency – The occasional problem with the eye muscles' ability to point the eye straight when working up close.</p> | | |

EXCLUSIONS AND LIMITATIONS OF BENEFITS

CVC VISIONCARE PLAN

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, and the Covered Person will pay the additional costs for the options.

Optional cosmetic processes.

- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

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 working with a computer.
- Plano lenses. (lenses with refractive correction of less than $\pm .50$ diopter).
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- 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.
- Services or materials of a cosmetic nature.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

EXHIBIT C

ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of MID-ATLANTIC VISION SERVICE PLAN, INC. ("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. Plan Benefits under the Diabetic Eyecare Plus 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 Policy or Certificate of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.*
- Any child of Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, the child of the spouse/domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible.
- The domestic partner of the same or opposite gender as Enrollee.

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

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:

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

SYMPTOMS

Examples of symptoms which may result in a patient seeking services under the Diabetic Eyecare Plus Program may include, but are not limited to:

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

CONDITIONS

Examples of conditions which may require management under the Diabetic Eyecare Plus Program may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

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

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

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

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

1. Covered Person contacts VSP Network Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each Diabetic Eyecare Plus visit and amounts for any additional services not covered by the Plan.

REFERRALS

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

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

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

**PLAN BENEFITS
VSP NETWORK DOCTORS**

COPAYMENT

A Copayment of \$20.00 shall be payable by the Covered Person at the time of each Diabetic Eyecare Plus Program office visit to a VSP Network Doctor.

COVERED SERVICES

Eye Examination: Covered in Full*.

Special Ophthalmological Services†: Covered in Full.

*Less any applicable Copayment.

†Specific procedures under this Diabetic Eyecare Plus Program are provided at the discretion of the physician rendering the services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

1. Services and/or materials not included in this Rider as covered Plan Benefits.
2. Costs associated with securing frames, lenses, contact lenses or any other materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
5. Pathological treatment of any type for any condition.
6. Any eye examination required by an employer 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 PLUS 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. |
| Special Ophthalmological Services | Medical eye care procedures for the investigation and management of ocular disorders associated with diabetic eye disease. |

**PLAN BENEFITS
NON-MEMBER PROVIDERS**

Plan Benefits received from Non-VSP Providers will be reimbursed according to the following schedule.

COPAYMENT

A Copayment of \$20.00 shall be payable by the Covered Person at the time of each Diabetic Eyecare Plus Program office visit to a Non-VSP Provider.

COVERED SERVICES

Eye Examination: Covered up to \$100.00*.

Special Ophthalmological Services†: Covered up to \$120.00.

*Less any applicable Copayment.

†Specific procedures under this Diabetic Eyecare Plus Program are provided at the discretion of the physician rendering the services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

Summary of Benefits and Coverage
SIGNATURE PLAN – VP Plus Option

Prepared for: WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST
Group ID: 12074233
Effective Date: JANUARY 1, 2015

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

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

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations and Exceptions |
|--|----------------------------|---|--|--|
| | | In-Network Provider | Out-of-Network Provider | |
| If you or your dependents (if applicable) need eyecare | Eye Exam | \$10.00 Copay | Reimbursed up to \$50.00 | Exam covered in full every 12 months** |
| | Frames, Lenses or Contacts | Glasses: \$20.00 Copay (lenses and/or frames only); | Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 50.00 Bi-Focal Lenses reimbursed up to \$ 75.00 Tri-Focal Lenses reimbursed up to \$100.00 Lenticular Lenses reimbursed up to \$125.00 ECL reimbursed up to \$105.00 | Frames covered every 24 months** Lenses covered every 12 months** |
| | Fees | | | |

** Beginning with the first date of service.

Your Grievance and Appeals Rights:

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