VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE PLAN

Group Name	**SAN JOAQUIN VALLEY INSURANCE AUTHORITY**
Plan Number	**30028675**
State of Delivery	**CALIFORNIA**
Effective Date	**JANUARY 1, 2016**
Plan Term	**TWENTY-FOUR (24) MONTHS**
Premium Due Date	**FIRST DAY OF MONTH**

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN ("VSP") agrees to provide certain individuals under this Group Vision Care Plan ("Plan") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Plan is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Plan.

SAN JOAQUIN VALLY INSURANCE AUTHORITY

By: Rhonda Goshorn

Name: Rhonda Goshorn

Date: 4-27-16

VISION SERVICE PLAN

By: Kate Renwick

Name: Kate Renwick- Espinosa

Date: January 25, 2016

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I.
DEFINITIONS

Key terms used in this Plan are defined:

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

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

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

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

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

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

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

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

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

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

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

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

1.13. MEMBER DOCTOR: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision

care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

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

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

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

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

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

II.
TERM, TERMINATION, AND RENEWAL

2.01. Plan Term: This Plan is effective on the Effective Date and shall remain in effect for the Plan Term. At the end 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 terminate at 11:59 p.m. on the last day of the Plan Term unless the parties agree on its renewal of the Plan. If the Plan continues on a month to month basis after the Plan Term, either party may terminate the Plan upon thirty (30) days advance notice to the other party.

If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Plan Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Plan Term, this Plan shall terminate at 11:59 p.m. on the last day of the Plan Term.

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

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 who shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Group to complete, sign and forward to VSP a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

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

3.02. Provision of Plan Benefits: Through its Member Doctors (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the Member Doctor to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Group and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

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

3.03. Provision of Information to Covered Persons: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Plan shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons. VSP shall provide Group with an updated list of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Member Doctor directory through contacting VSP's Customer Service Department's toll-free Customer Service telephone line, VSP's Web site at www.vsp.com, or by written request.

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

3.05. Emergency Vision Care: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the 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.

IV.
OBLIGATIONS OF THE GROUP

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

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

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

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

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

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

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

4.05. 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.

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

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

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

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

5.03. Obtaining Services from Member Doctors: Benefit Authorization must be obtained prior to receiving Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits, the Covered Person must select a Member Doctor, schedule an appointment, and identify himself as a Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. Should the Covered Person receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Member Doctor will be considered a Non-Member Provider and the benefits available will be limited to those for a Non-Member Provider, if any.

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

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

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

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

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

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

c) Other Remedies: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(l)(B)], Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

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

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

VI.
ELIGIBILITY FOR COVERAGE

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

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

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

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

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

(1) the legal spouse of any Enrollee, and

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

(3) as further defined by Group.

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

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

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

6.04. Change of Participation Requirements, Contribution of Fees, and Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Plan, and Group's contribution and eligibility requirements, are all material to VSP's obligations under this Plan. During the term of this Plan, Group must provide VSP with written notice of changes to its composition, percentage of Enrollees covered, contribution and eligibility requirements. Any change which materially affects VSP's obligations under this Plan must be agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Plan for purposes of Paragraph 4.02. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Plan.

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

VII.
CONTINUATION OF COVERAGE

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

VIII.
ARBITRATION OF DISPUTES

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

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

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

IX.
NOTICES

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

X.
MISCELLANEOUS

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

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

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

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

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

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

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

10.08. Equal Opportunity: VSP is an Equal Opportunity and Affirmative Action employer.

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

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

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

EXHIBIT A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
County of Tulare

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

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

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

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

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*

Available once every 12 months.

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

Available once every 24 months.
*Less any applicable Copayment.

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

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

CONTACT LENSES

Contact lenses are available once every 12 months 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.

Necessary-

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees** and Materials	Professional Fees and Materials
Up to $120.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

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

COPAYMENT

There shall be 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 $25.00 Copayment payable at the time the materials are ordered. The Copayment for materials 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)

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $120.00 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: 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
SCHEDULE OF BENEFITS
VSP Choice Plan
City of Shafter

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

A Copayment amount of $10.00 shall be payable by the Covered Person to the Member Doctor at the time services are rendered.

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

LENS OPTIONS

Tinted/Photochromic	Covered in full*	Up to $5.00
Frames	Covered up to Plan Allowance*	Up to $ 70.00*

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

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

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

CONTACT LENSES

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

Necessary-

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $130.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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

A Copayment amount of $10.00 shall be payable by the Covered Person at the time services are rendered.

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

Tinted/Photochromic Covered in full* once every 12 months**

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months.

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered 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 A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
City of Ceres

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

PLAN BENEFITS

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

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

Necessary-

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

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

Elective -

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

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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 for materials 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)

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 $60.00 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 A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
City of San Joaquin, City of Farmersville, City of Hughson

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

PLAN BENEFITS

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

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees** and Materials	Professional Fees and Materials
Up to $150.00	Up to $105.00

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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 for materials 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)

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

CONTACT LENSES

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

The Elective Contact Lens allowance applies to materials only.
NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*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
SCHEDULE OF BENEFITS
VSP Choice Plan
Superior Court of CA, County of Kings and City of Wasco

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

PLAN BENEFITS

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

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees** and Materials	Professional Fees and Materials
Up to $130.00	Up to $105.00

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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 for materials 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)

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 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 A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
SJV Air Pollution Control District & SJVAPCD Cal Cobra

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

A Copayment amount of $10.00 shall be payable by the Covered Person to the Member Doctor at the time services are rendered.

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

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

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

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

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

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

CONTACT LENSES

Contact lenses are available once every other 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 two plan years.

Necessary-

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every other plan year, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $120.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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

A Copayment amount of $10.00 shall be payable by the Covered Person at the time services are rendered.

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 24 months**
Spectacle Lenses (Single, Lined Bifocal, or Lined Trifocal)

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $120.00 once every 24 months.

Elective Contact Lens fitting and evaluation services are covered in full once every 24 months, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 24 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
SCHEDULE OF BENEFITS
VSP Choice Plan
Sutter Superior Court

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

PLAN BENEFITS

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

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

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

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*

Available once every 12 months.

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

Available once every 12 months.
*Less any applicable Copayment.

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

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

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

Necessary-

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees** and Materials	Professional Fees and Materials
Up to $150.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

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

COPAYMENT

There shall be 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 for materials 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)

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

CONTACT LENSES

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

The Elective Contact Lens allowance applies to materials only.
NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*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: 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
SCHEDULE OF BENEFITS
VSP Choice Plan
County of Sutter

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

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

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

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*

Available once every 12 months.

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

Available once every 24 months.
*Less any applicable Copayment.

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

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

CONTACT LENSES

Contact lenses are available once every 12 months 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 12 months.

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees** and Materials	Professional Fees and Materials
Up to $130.00	Up to $105.00

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

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

COPAYMENT

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

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)

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.

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

LOW VISION

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

EXHIBIT A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
County of Fresno

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

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

PLAN BENEFITS

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

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

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

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*

Available once every 12 months.

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

Available once every 24 months.
*Less any applicable Copayment.

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

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

CONTACT LENSES

Contact lenses are available once every 12 months 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 12 months.

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $150.00	Up to $105.00

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

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

COPAYMENT

There shall be 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 for materials 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)

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 $60.00 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 date of service.

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

LOW VISION

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

EXHIBIT A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
SJVAPCD Buy Up 1

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

A Copayment amount of $10.00 shall be payable by the Covered Person to the Member Doctor at the time services are rendered.

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

Necessary-

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

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

Elective -

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

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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

A Copayment amount of $10.00 shall be payable by the Covered Person at the time services are rendered.

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)

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 $60.00 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 A

VISION SERVICE PLAN
SCHEDULE OF BENEFITS
VSP Choice Plan
SJVAPCD-Buy Up 2

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

A Copayment amount of $10.00 shall be payable by the Covered Person to the Member Doctor at the time services are rendered.

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

Necessary-

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

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

Elective -

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

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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

A Copayment amount of $10.00 shall be payable by the Covered Person at the time services are rendered.

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)

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 $60.00 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
SCHEDULE OF BENEFITS
VSP Choice Plan
City of Hanford

GENERAL

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

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 available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of $25.00 payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

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

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

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

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 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*

Available once every plan year beginning on January 1st.

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

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

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

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

CONTACT LENSES

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

Necessary-

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

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

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $130.00	Up to $105.00

*Subject to Copayment

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

LOW VISION BENEFIT

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

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

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

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

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

Benefit Maximum

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

NON-MEMBER PROVIDER BENEFIT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

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

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

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

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

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

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 no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a $ 25.00 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)

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months.

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered 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
SCHEDULE OF PREMIUMS
VSP Choice Plan
County of Tulare

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:

$	4.76	per month for each eligible Enrollee without Eligible Dependents.
$	8.04	per month for each eligible Enrollee with an Eligible Spouse.
$	8.51	per month for each eligible Enrollee with Eligible Child(ren).
$	12.68	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
City of Shafter

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:

$	6.18	per month for each eligible Enrollee without Eligible Dependents.
$	12.34	per month for each eligible Enrollee with an Eligible Spouse.
$	13.20	per month for each eligible Enrollee with Eligible Child(ren).
$	21.12	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
City of Ceres

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:

$	6.06	per month for each eligible Enrollee without Eligible Dependents.
$	12.12	per month for each eligible Enrollee with an Eligible Spouse.
$	12.98	per month for each eligible Enrollee with Eligible Child(ren).
$	20.74	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
The City of San Joaquin, City of Farmersville and City of Hughson

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:

$	7.54	per month for each eligible Enrollee without Eligible Dependents.
$	15.08	per month for each eligible Enrollee with an Eligible Spouse.
$	16.14	per month for each eligible Enrollee with Eligible Child(ren).
$	25.78	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
City of Wasco

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:

$ 11.76 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
SCHEDULE OF PREMIUMS
VSP Choice Plan
Superior Court of CA, County of Kings

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:

$	5.88	per month for each eligible Enrollee without Eligible Dependents.
$	11.76	per month for each eligible Enrollee with an Eligible Spouse.
$	12.58	per month for each eligible Enrollee with Eligible Child(ren).
$	20.12	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
SJV Air Pollution Control District

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:

$	4.42	per month for each eligible Enrollee without Eligible Dependents.
$	8.88	per month for each eligible Enrollee with one Eligible Dependent.
$	14.28	per month for each eligible Enrollee with two or more Eligible Dependents.

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

EXHIBIT B

VISION SERVICE PLAN
SCHEDULE OF PREMIUMS
VSP Choice Plan
Sutter Superior Court

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:

$	7.54	per month for each eligible Enrollee without Eligible Dependents.
$	15.08	per month for each eligible Enrollee with an Eligible Spouse.
$	24.28	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
County of Sutter

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:

$ 11.94 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
SCHEDULE OF PREMIUMS
VSP Choice Plan
County of Fresno

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:

$	7.49	per month for each eligible Enrollee without Eligible Dependents.
$	13.46	per month for each eligible Enrollee with an Eligible Spouse.
$	13.19	per month for each eligible Enrollee with Eligible Child(ren).
$	19.32	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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
SCHEDULE OF PREMIUMS
VSP Choice Plan
SJVAPCD Buy Up 1

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:

$	6.85	per month for each eligible Enrollee without Eligible Dependents.
$	13.75	per month for each eligible Enrollee with one Eligible Dependent.
$	22.12	per month for each eligible Enrollee with two or more Eligible Dependents.

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

EXHIBIT B

VISION SERVICE PLAN
SCHEDULE OF PREMIUMS
VSP Choice Plan
SJVAPCD Buy Up 2

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:

$	8.35	per month for each eligible Enrollee without Eligible Dependents.
$	16.77	per month for each eligible Enrollee with one Eligible Dependent.
$	26.96	per month for each eligible Enrollee with two or more Eligible Dependents.

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

EXHIBIT B

VISION SERVICE PLAN
SCHEDULE OF PREMIUMS
VSP Choice Plan
City of Hanford

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:

$	7.96	per month for each eligible Enrollee without Eligible Dependents.
$	12.36	per month for each eligible Enrollee with one Eligible Dependent.
$	19.61	per month for each eligible Enrollee with two or more Eligible Dependents.

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

ADDENDUM

VISION SERVICE PLAN
ADDITIONAL BENEFIT - PRIMARY EYECARE

Primary Eyecare is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the plan, Member Doctors provide treatment and management of urgent and follow-up services. Primary Eyecare also involves management of conditions which require monitoring to prevent future vision loss.

The Member Doctor is responsible for advising and educating patients on matters of general health and prevention of ocular, as well as systemic disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Member Doctor as a Primary Eyecare Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

SYMPTOMS
Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary Eyecare Plan include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS
Examples of conditions which may require management under the Primary Eyecare Plan, include, but are not limited to:

- ocular hypertension
- glaucoma
- retinal nevus
- cataract
- pink-eye
- macular degeneration
- corneal abrasion
- corneal dystrophy
- blepharitis
- sty

PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES

1. To obtain Primary Eyecare Services, the Covered Person contacts a Member Doctor's office and makes an appointment. If necessary, the Covered Person may call VSP's Customer Service Department first to determine the nearest location of a Member Doctor's office.

2. If urgent care is necessary, the Covered Person may be seen by a Member Doctor immediately.

3. The Covered Person pays the applicable Copayment to the Member Doctor at the time of each Primary Eyecare office visit.

4. When the Member Doctor has completed the services, he will fill out the necessary paperwork and mail it to VSP. VSP will pay the Member Doctor directly according to VSP's agreement with the Doctor.

COPAYMENT

The benefits described herein are available to each Covered Person from any participating Member Doctor at no cost to the Covered Person except there shall be a Copayment amount of $20.00 payable by the Covered Person to the Member Doctor at the time of each Primary Eyecare office visit.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary Eyecare Plan is designed to cover Primary Eyecare services only. There is no coverage provided under the Plan for the following:

1. Costs associated with securing materials such as lenses and frames.
2. Orthoptics or vision training and any associated supplemental testing.
3. Surgical or pathological treatment.
4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
5. Medication.
6. Pre and post-operative services.

REFERRALS BY THE MEMBER DOCTOR

The Member Doctor will refer the patient to another doctor under the following conditions:

1. If the patient requires additional services which are covered by the Primary Eyecare Plan but are not provided in his office, the Member Doctor will refer the patient to another Member Doctor or to the major medical physician whose offices provide the necessary services.

2. If the patient requires services beyond the scope of the Primary Eyecare Plan, the Member Doctor will refer the patient back to the major medical physician.

3. If the patient requires emergency services beyond the scope of the Primary Eyecare Plan, the Member Doctor will make a "STAT" (emergency) referral by calling either another Member Doctor or the major medical physician.

DEFINITIONS

Blepharitis - Inflammation of the eyelids.

Cataract - A cloudiness of the lens of the eye obstructing vision.

Conjunctiva - The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eyeball.

Corneal Abrasion - Irritation of the transparent part of the coat of the eyeball.

Corneal Dystrophy - A disorder involving nervous and muscular tissue of the transparent part of the coat of the eyeball.

Diplopia - The observance by a person of seeing double images of an object.

Eye Muscle Dysfunction - A disorder or weakness of the muscles that control eye movement.

Glaucoma - A disease of the eye marked by increased pressure within the eyeball which causes damage to the optic disc and gradual loss of vision.

Flashes or Floaters - The observance by a person of seeing flashing lights and/or spots.

Macula - A small, yellowish area lying slightly lateral to the center of the retina that constitutes the region of maximum visual acuity.

Macular Degeneration - Degeneration of the macula.

Ocular - Of or relating to the eye or the eyesight.

Ocular Hypertension - Unusually high blood pressure within the eye.

Ocular Conditions - Any condition, problem, or complaint relating to the eyes or eyesight.

Ocular Trauma - A forceful injury to the eye due to a foreign object, e.g., fist, baseball, racquetball, auto accident, etc.

Pink-eye - An acute, highly contagious, conjunctivitis (inflammation of the conjunctiva).

Retinal Nevus - A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.

Sty - An inflamed swelling of the fatty material at the margin of the eyelid.

Systemic Condition - Any condition or problem relating to a person's general health.

Transient Loss of Vision - Temporary loss of vision.

ADDENDUM

VISION SERVICE PLAN
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. 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.
- The domestic partner of the same gender as Enrollee, pursuant to Group's eligibility
- Any child of 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 or administrative agency holds the Enrollee responsible.

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

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

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program (“DEP Plus”) is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's 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 an 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's 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 Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.

PLAN BENEFITS
VSP NETWORK 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.

ADDENDUM

VISION SERVICE PLAN

VI. ELIGIBILITY FOR COVERAGE

6.01 (b) Eligible Dependents, Add the Following:

(1a) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2b) Any children of the domestic partner provided they depend upon the Enrollee for support and maintenance.

ADDENDUM

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

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

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

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

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

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

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