USAvision
Illuminating Coverage, Inspiring Confidence

TraditionalVisionPlan

SignatureNetwork

ContractingKit

Not including this cover page, return only the first 4 pages of this Contract Kit, plus Member Enrollment Forms, via one of the following methods:

PO Box 2181, Lowell AR 72745

888 959 4393

groupsupport@usavision.net

20230831

USAvision
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Group Application

Instructions

Items marked with an * are required.

Complete form using **Blue** or **Black** ink only.

Failure to complete this form correctly may result in a delayed start to coverage.

What Next?

Send only completed pages 1, 2, 3 & 4, along with all Member Enrollment Forms via one of the following methods:

PO Box 2181, Lowell AR 72745
888 959 4393
agentsupport@usavision.net

If emailing, only send using secure email service.
This is to protect PHI and to ensure compliance with HIPAA.
If needed, you may request a secure link from **agentsupport@usavision.net**

GROUP

FEIN* ___ - ___ - ____ **Requested Start Date*** __/01/20__

Group Name*

Sub-Group Name

PLAN SELECTION

TraditionalPlan **Signature**Network	○ **Select** **Employer Sponsored** 7.74 Employee Only 13.48 Spouse & Employee 13.98 Child(ren) & Employee 23.74 Family	○ **Select** **Voluntary** 9.74 Employee Only 14.98 Spouse & Employee 14.98 Child(ren) & Employee 23.74 Family
TraditionalPlan **Signature**Network with **Progressive Lens** Enhancement	○ **Select** **Employer Sponsored** 8.74 Employee Only 14.98 Spouse & Employee 15.48 Child(ren) & Employee 26.48 Family	○ **Select** **Voluntary** 10.74 Employee Only 16.48 Spouse & Employee 16.98 Child(ren) & Employee 26.98 Family
TraditionalPlan **Signature**Network with **Computer VisionCare** Enhancement	○ **Select** **Employer Sponsored** 9.74 Employee Only 15.48 Spouse & Employee 15.98 Child(ren) & Employee 25.74 Family	○ **Select** **Voluntary** 11.98 Employee Only 16.98 Spouse & Employee 17.48 Child(ren) & Employee 26.24 Family
TraditionalPlan **Signature**Network with **Progressive Lens** & **Computer VisionCare** Enhancements	○ **Select** **Employer Sponsored** 10.74 Employee Only 17.24 Spouse & Employee 17.98 Child(ren) & Employee 29.74 Family	○ **Select** **Voluntary** 13.48 Employee Only 18.98 Spouse & Employee 19.48 Child(ren) & Employee 30.24 Family

Voluntary or Employer Sponsored?

Employer Sponsored Rates
For groups of **2 or more** enrolled employees, where the employer pays at least **51**% of the employees premium portion and at least **75**% participation (minimum 2) eligible employees is maintained.

Voluntary Rates
For all other groups maintaining participation of **2 or more** enrolled employees.

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Group Application

CONTACT # 1

Name*

Email Address*

Phone* Ext. FAX

CONTACT # 2

Name

Email Address

Phone Ext. FAX

ADDRESSES

Mailing Address*

City, State & ZIP*

Shipping Address

City, State & ZIP

GROUP DETAILS

Employee Counts Total* Eligible* Enrolling*

Open Enrollment Month*
If Applicable

Does your group have a Section 125 Cafeteria Plan?* (Y) (N)

California groups with upto 19 employees
Is your group subject to Federal COBRA or CAL-COBRA ? ◯ Federal COBRA ◯ CAL-COBRA ◯ Not Applicable

INVOICING & PAYMENTS

USAvision **only** communicates monthly invoices via secure email on or near the 1st day of each month.

Email*

Payment Method* ◯ Automated Premium Payments via ACH Debit **Preferred Method** 10th Day of Each Month

◯ Check Due Upon Receipt of Invoice

Note:1st Month's Premium is Due Immediately, and by Check. Please Send Payment to Address Shown on Coverpage.

AUTOMATED PREMIUM PATMENTS

To assist in simplifying monthly invoicing and payment remittance, USAvision offers automated payments for premiums via direct debit. To authorize payment of premiums by ACH debit on the 10th of each month, please provide the following information. **Note**: USAvision will still communicate a monthly invoice detailing enrolled members, their current coverage level, premium amount, and details of any changes made during the invoice period.

By completing the following, you hereby authorize USAvision Inc., to debit your group's account, the details of which are listed below, for any premium amounts due or over due. You further understand that this authority will remain in effect until such time as USAvision Inc., and/or the financial institution listed below, has received written notification from an authorized account signatory of it's termination, and in such a manner as to afford USAvision Inc. and the financial institution at least twenty-one (21) days to act upon it.

Bank Name*

Account Number*

Routing Number*

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Group Enrollment Form

GROUP EXECUTION

The undersigned represent that they have revealed ALL information in full and to the best of their knowledge, understand and agree that the information required on all eligible persons requesting coverage will be verified after the submittal of the application, and from time to time as necessary. Furthermore, the undersigned attest to the fact that they have been provided with a full and complete copy of the 1 year contract and summary of plan benefits, and do hereby enter into it freely and willfully, agreeing to all its stipulations.

Name*

Title*

Signature*

Date* / /

AGENT

Name*

Email*

Phone* - -

Writing Number*

General Agent

Signature*

Date* / /

USAVISION

Name*

Title*

Signature*

Date* / /

TraditionalPlan
Schedule of Benefits

USAvision
Illuminating Coverage, Inspiring Confidence

Network	
Name	**VSP Signature**
Eye Exam	
Frequency	**12** Months
Exam	$**15 Co-Pay**
Digital Retinal Scan	$**39 Co-Pay**
Materials	
Frequency	**12** Months
Deductible	$**25**
Lenses	
Frequency	**12** Months
Single Vision	**Free** after **Deductible**
Lined Bi-Focal	**Free** after **Deductible**
Lined Tri-Focal	**Free** after **Deductible**
Standard Progressives (No-Line)	**Free** after **Deductible**
Premium Progressives (No-Line)	$**80**-$**90 Co-Pay**
Custom Progressives (No-Line)	$**120**-$**160 Co-Pay**
High Index	**40**% Average **Discount**
Polarized	**40**% Average **Discount**
Impact-Resistant	**40**% Average **Discount**
Lens Customizations	
Polycarbonates for Children	**Free**
Polycarbonate for Adults	**40**% Average **Discount**
Transitional (Photochromic)	**40**% Average **Discount**
Tinting	**40**% Average **Discount**
Scratch-Resistant	**40**% Average **Discount**
Anti-Reflective Coatings	**40**% Average **Discount**
UV Coatings	**40**% Average **Discount**
Other Lens Customizations	**40**% Average **Discount**
Frames	
Frequency	**24** Months
Coverage	$**120 Allowance**
Featured Brand Coverage	$**140 Allowance**
Coverage After Allowance	**20**% **Discount**
Extra Savings	
Additional Glasses or Sunglasses	**20**% **Discount**
Blue-Light Filtering Glasses	**20**% **Discount**
Contact Lenses **(Instead of Lenses and/or Frames)**	
Frequency	**12** Months
Coverage	$**120 Allowance**
Fitting & Evaluation Exam	**15**% **Discount**
Medically Necessary Contacts	**Free**
Laser Vision Surgery	
Coverage	**Discounted**
Essential Medical Eye Care Services	
Coverage	$**20 Co-Pay**
Hearing	
Frequency	**12** Months
TruHearing Digital Hearing Aids	Up to **60**% **Discount**
Online Hearing Test	**Free**
Hearing Aid Batteries	**120** for $**39**
Out-of-Network	
Exam	Up to $ **50**
Frames	Up to $ **70**
Single Vision Lenses	Up to $ **50**
Bifocal Lenses (Lined & No-Lines)	Up to $ **75**
Trifocal Lenses (Lined & No-Lines)	Up to $**100**
Progressive Lenses	Up to $ **75**
Lenticular Lenses	Up to $**125**
Contacts	Up to $**105**
Medically Necessary Contacts	Up to $**210**

Coverage with a participating retail chain may be different. Once your benefit is effective, visit www.vsp.com for details. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Essential Medical Eye Care Services

Included in all our base plans, for only a $**20 Co-Pay**, get so much more than a vision exam. VSP network doctor can diagnose and treat conditions including conjunctivitis, dry eye disease, eye trauma, sudden changes in vision, and more. Covered services include:

- **Retinal Screening** for members with diabetes.
- **Medical Exams & Services** for diagnosis, treatment, and management of chronic conditions, such as diabetic eye disease, glaucoma, and age-related macular degeneration.
- **Treatment for Urgent Conditions** such as eye infections, foreign body and abrasions, eye injuries, and eye or eyelid chemical exposure.
- **Medical Tests** for diagnosis and treatment of sudden vision changes, such as eye flashes, floaters, and sudden vision loss.
- **Other Vision Medical Services**

Group Vision

Contract & Evidence of Coverage

Administrated & Marketed by:

In Alliance with:

Administrated & Marketed by:
USAvision, Inc.
PO Box 2181
Lowell AR 72745
groupsupport@usavision.net

Provided & Underwritten by:
Vision Services Plan, Inc., Oklahoma
3333 Quality Drive
Rancho Cordova, CA 95670
800.877.7195

Disclosure Form & Evidence of Coverage

1. **Monthly Premium:** Your group is responsible for payment to USAvision Inc. of the periodic charges for your coverage. You will be notified of your share of the charges by USAvision Inc.

2. **Eligibility**: Enrollees & Eligible Dependents: Unmarried dependent children are covered age until the end of the month they turn twenty-six (26) years old, regardless of whether they are full time students. The Waiting Period is the same as your other Health Benefits.

3. **Plan Term:** The Plan Term is twelve (12) months.

4. **Terms, Termination & Renewal:** At the expiration of the Plan Term, coverage will automatically renew for another Plan Term using the latest rate structure, unless the subscriber notifies USAvision in writing, at least thirty (30) days before the end of the Plan Term, that such subscriber is unwilling to renew the Plan.

5. **Type of Administration:** Benefits are furnished under a Vision Care Plan purchased by the Group and provided by Vision Service Plan (VSP) under which VSP is financially responsible for the payment of claims. The vision plan is administered and marketed by USAvision, Inc.

6. **VSP's Address:**
   Vision Service Plan
   3333 Quality Drive
   Rancho Cordova, CA 95670

7. **USAvision's Billing Address:**
   USAvision, Inc. Billing
   PO Box 2181
   Lowell AR 72745

8. **USAvision's Administration Address:**
   USAvision, Inc.
   PO Box 2181
   Lowell AR 72745

Evidence of Coverage

This Evidence of Coverage Constitutes Only a Summary of the Vision Plan.

This form is a summary of the Plan provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Plan itself. A copy of the Plan will be furnished on request.

1. **Definitions**
   a. Additional Benefit Rider: The document attached to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
   b. Anisometropia: A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
   c. Benefit Authorization: Authorization issued by VSP identifying the individual named as a Covered Person of VSP and identifying those Plan Benefits to which a Covered Person is entitled.
   d. Copayments: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits that are not fully covered.
   e. Covered Person: An employee 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.
   f. Eligible Dependent: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under the provisions of the Plan under which such Enrollee is covered.
   g. Emergency Condition: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, nonmedical action.
   h. Enrollee: An employee or member of Group who meets the criteria for eligibility specified under the provisions of the Plan.
   i. Experimental Nature: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
   j. Group: An employer or other entity which contracts with USAvision for coverage under this plan to provide vision care coverage to its Enrollees and their Eligible Dependents.
   k. Keratoconus: A development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.
   l. Member Doctor: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials that are contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
   m. 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.
   n. Plan Benefits: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined in the Vision Plan Provisions or in the Schedule of Benefits included in this Group Plan document maintained by your Group Administrator.
   o. Premiums: The payments made to USAvision by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums maintained by Your Group Administrator.
   p. Renewal Date: The date on which the Plan shall renew or terminate if proper notice is given.

q. Schedule of Benefits: The document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.
r. Schedule of Premiums: The document maintained by your Group Administrator, which states the payments to be made to USAvision by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

2. **Benefits & Coverage:** Important: The benefits described below are typical services and material available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits:
   a. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including prescription of corrective eyewear where indicated.
   b. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
   c. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
   d. Contact Lenses: Visually Necessary contact lenses together with necessary professional services will be provided, as indicated on the Schedule of Benefits, in lieu of spectacle lenses and frames for the current eligibility period. Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider are subject to review and authorization from Company's Optometric Consultants.
   e. Elective Contact Lenses for other than Visually Necessary circumstances are available in lieu of spectacle lenses and frames for the current eligibility as indicated on the Schedule of Benefits.

3. **Additional Discounts:**
Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for twelve (12) months on or following the date of the Patient's last eye exam. Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.
   a. Additional Glasses: Each Covered Person shall be entitled to receive a discount of 20% toward the purchase of non-covered materials from any Member Doctor when a complete pair of additional glasses or sunglasses is dispensed.
   b. Contact Lens Examination Services: Covered Persons shall be entitled to receive a discount of 15% off contact lens examination services from any Member Doctor.

4. **Limitations:**
   a. Discounts do not apply to vision care benefits obtained from Non-Member Providers.
   b. 20% discount applies to complete pairs of glasses only.
   c. Discounts do not apply if prohibited by the manufacturer.
   d. Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

5. **Exclusions & Limitations of Benefits:** This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits:
   a. Optional Cosmetic processes
   b. Anti-reflective coating
   c. Color coating
   d. Mirror coating
   e. Scratch coating
   f. Blended lenses
   g. Cosmetic lenses
   h. Laminated lenses
   i. Oversize lenses
   j. Progressive multifocal lenses
   k. UV (ultraviolet) protected lenses
   l. Certain limitations on low vision care. Although a low vision benefit is available to Insured diagnosed as having severe vision problems (i.e., partial sight), it is subject to limitations. Consult your Member Doctor or Benefits Representative for details.
   m. There is no benefit for professional services or material connected with:
      i. Orthoptics or vision training and any associated supplemental testing; Plano lenses (less than ±.50 Diopter power); or two pair of glasses in lieu of bifocals.
      ii. Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.
      iii. Medical or surgical treatment of the eyes.
      iv. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

6. **Premiums:** The Group is responsible for payments to USAvision, Inc. of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by USAvision, Inc. The entire cost of the program is paid to USAvision, Inc. by the Group.

7. **Copayment:** The benefits described herein are available to you from any participating Member Doctor, provided you follow the proper procedures by obtaining Benefit Authorization. There may be a copayment amount payable by you to the member doctor at the time of the examination. Any additional care, service and/or materials not covered by this plan may be arranged between you and the doctor.

8. **Choice of Providers:** 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. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment). When vision care services are received from a Non-Member Provider, you will be reimbursed for such benefits according to the Schedule of Benefits, less any applicable Copayment.

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

9. **Prior Authorization:** Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved VSP's Utilization Management Committee and Board of Directors:
   a. Initial Determination: VSP will approve or deny requests for prior authorization of services within **fifteen (15) days** of receipt of the request from the Insured's doctor. If a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than **fifteen (15) days**.
   b. Appeals: If VSP denies the doctor's request for prior authorization, the doctor, Insured, or Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within **thirty (30) days** from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within **thirty (30) days**. Covered Person may designate any person, including the provider, as Covered Person's authorized representative. For more information regarding VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's Customer Service Department.

10. **Procedure for Using the Plan:**
   a. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or the Member Doctor. If you are eligible, VSP will provide Benefit Authorization to you or the Member Doctor.
   b. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan despite your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
   c. A list of Member Doctors in your geographic location can be obtained from your Group or Plan Administrator. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographic area in which you desire to seek services, you may call or write VSP office nearest you to obtain one that does or visit the VSP website at www.vsp.com.
   d. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. VSP will pay the Member Doctor directly according to the agreement with the doctor.
   e. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates that Covered Person's Plan includes such coverage). 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 Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's 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. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

11. **Liability in Event of Non-Payment:** In the event company fails to pay the provider, you shall not be liable to the provider for any sums owed by the vision plan other than those not covered by the plan.

12. **Individual Continuation of Benefits:** This program is available to groups of a **minimum of two (2) employees** and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

13. **Termination of Benefits:** Terms and cancellation conditions of your vision care plan are shown on the Vision Plan Provisions. If service is rendered to you as the termination date of the Plan, such service shall be continued to completion, but in no event beyond **six (6) months** after the termination date of the Plan.

14. **Complaints & Grievances:** If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of Covered Person, the Covered Person may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment, or service.

    Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within **thirty (30) days** after receipt unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than **one hundred twenty (120) days** after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within **thirty (30) days**, a letter will be sent to the Insured to indicate VSP's.

15. **Claim Payments & Denials:**
   a. Initial Determination: VSP will pay or deny claims within **thirty (30) days** of the receipt of the claim from the Covered Person or Covered Person's authorized representative. If a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than **fifteen (15) days**.
   b. Request for Appeals: If the Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within **one hundred eighty (180) day**s from receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The

request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, the Covered Person's name and date of birth, the name of the provider of services and claim number. The Covered Person may state the reasons the Insured believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all request for appeals to:

VSP, Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800.877.7195

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

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

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U.S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed.

16. **Other Facts You Should Know About the Plan:** As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
    a. Examine, without charge, at the Plan Administrator's office, all Plan documents such as detailed annual reports and Plan descriptions, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor or the Internal Revenue Service.
    b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
    c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and your claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within **thirty (30) days**, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to **$110 a day** until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

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

The Plan Administrator and the employer are subject to numerous obligations in connection with continuation coverage, including an obligation to notify eligible participants and their dependents of the existence of said continuation coverage. In this regard, the U.S. Department of Labor has issued ERISA Technical Release No. 86-2 dated June 26, 1986, setting forth a Model Statement of the required notice. Providing said notice by first class mail to each covered employee and his or her spouse, if any, at their last known address will constitute a good faith effort at compliance of the notice requirement in the absence of promulgated COBRA regulations.

Vision Plan Provisions

The Vision Plan Provisions Must be Consulted to Determine the Exact Terms and Conditions of Coverage.

1. Term, Termination & Renewal:

a. Plan Term: This Plan shall become effective on the date stated on the Group Application and shall remain in effect for the Plan Term. The Plan Term of coverage is for **twelve (12) months**. At the expiration of the Plan Term, coverage will automatically renew for another term (at the latest rate structure) unless the subscriber notifies USAvision in writing, at least **thirty (30) days** before the end of the Plan Term, that such subscriber is unwilling to renew the Plan. Your first payment for the next Plan term will be considered your authorization and acceptance of another Plan Term.

b. Early Termination Provision: The premium rates payable by Group to USAvision under this Plan assume that USAvision will receive these amounts over the full Plan Term to cover costs associated with greater utilization that tends to occur during the first portion of a Plan Term. If this Agreement is terminated by Group before the end of the Plan Term or any subsequent renewal terms, for any reason other than a material breach by USAvision, Group shall be liable for an early termination penalty, equal to **two (2) months'** premiums (based on the Group's average premium for the previous **six (6) months**). Group agrees to pay USAvision **within thirty-one (31) days** of notification of the amount due.

2. Obligations of USAvision:

a. Coverage of Covered Persons: USAvision will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Group may be required by USAvision to complete and sign a Group Application and forward such application to USAvision, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. Following the enrollment of the Covered Person, USAvision will make available to all Covered Persons a Vision Care Brochure. Such Brochure will summarize the terms and conditions set forth in this Plan.

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

3. Obligations of the Group:

a. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Plan if he/she satisfies the enrollment criteria specified and/or as mutually agreed to by USAvision and Group. By the effective date of this Plan, Group shall provide USAvision with a listing, in a form approved by USAvision, of all its Enrollees who are eligible for coverage under this Plan as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to USAvision on or before the **last day of each month**, in a form or manner approved by USAvision, a listing of all Enrollees with a designation of family status who will be added to or deleted from USAvision's coverage rosters for the succeeding month.

b. Payment of Premiums: **On or before the first day of each month**, Group shall remit to USAvision the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Plan for such succeeding month. Only Covered Persons for whom Premiums are received by USAvision shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received by the time specified above. USAvision reserves the right to terminate all rights of such Covered Person, and such rights may be reinstated only in accordance with the requirements of this Plan. Email notifications will be sent to notify of payment overdue.

c. Changing of Premiums: USAvision may change the Premiums by giving Group at least **sixty (60) days** advance written notice. USAvision may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Plan are changed. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan. No change will be made more often than once during any **twelve (12) month** period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan. Notwithstanding the above, USAvision reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the Premiums USAvision receives from Group.

d. Grace Period: Group shall be allowed a grace period of **thirty-one (31) days** following the due date for making any payment of Premiums due under this Plan. During said grace period, this Plan shall remain in full force and effect for all Covered Persons covered hereunder. If Group fails to make any payment of Premiums due by the end of any grace period, USAvision may notify Group that the payment of Premiums has not been made, that coverage is canceled and that the Group is responsible for payment of all Plan Benefits provided to Covered Persons after the last period for which Premiums were fully paid, including the grace period.

e. Other Information to be Provided: Group shall furnish to USAvision monthly, during the effective period of this Plan, such information as may reasonably be required by USAvision for the purposes of this Plan, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form or manner specified by USAvision. In addition, Group shall, when requested, make available for inspection by USAvision such records as may have bearing on the coverage of Covered Persons under this Plan. All notification of eligibility changes must be on receipt with USAvision **on or before the 10th day of the month prior** to eligibility change effective date.

f. Minimum Enrollment Requirements: The contract will be cancelled by USAvision if the group does not conform to one or more of the following requirements:

i. Always maintain a **minimum of two (2)** enrolled individuals. If the enrollment drops below the minimum, group shall have **sixty (60) days** to conform to this requirement.

ii. If the contracted plan is of an involuntary (employer paid) type, and **100%** of the premium is paid by the employer, then **100%** participation is required.

iii. If the contracted plan is of an involuntary (employer paid) type, and the employer pays less than **100%** of the premium, then participation is **75%** of all eligible employees.

iv. If the group is comprised of a seasonal workforce, and has a voluntary plan type, then **100%** of the annualized premium is due at enrollment, and eligibility **minimum is 2.**

v. If the group is comprised of a seasonal workforce, and has an involuntary plan type, firstly the minimum enrollment requirements apply as stated. Additionally, one the following would also apply:

(a) If the number of seasonal working months is known and stable each year, then the annualized premium will be divided by number of known working months, and the group will be list billed as normal. The member will get **twelve (12) months** to use the benefit, regardless of whether they are actively at work.
(b) If the number of seasonal working months varies each year, and/or cannot be guaranteed, then **100%** of the annualized premium for the selected plan will be due at the time of enrollment; this will be list billed to the group. The member will get **twelve (12) months** to use the benefit, regardless of whether they are actively at work.
(c) If a group wishes to offer coverage to part-time employees, then they are treated as any fulltime employee would be treated, and subject to our standard underwriting guidelines.
(d) If a group not structured at enrollment as being for a seasonal workforce (or of a seasonal workforce nature but do not make it to their agreed number of working months) were to make wholesale layoffs (equal to or greater than **one-third (1/3)** of the covered employees) during the plan year. Then due to the nature of the structure of the benefit with **100%** of the benefit available day one, then USAvision reserves the right to list bill the group for the additional premium required to offset the remaining unpaid premium needed to mitigate any outstanding underwriting risk for that group.

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

4. Eligibility for Coverage:

a. Eligibility Criteria: Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.
b. Enrollees: To be eligible for coverage, a person must:
   i. Currently be an employee or member of Group; and
   ii. Meet the coverage criteria mutually agreed upon by Group and USAvision.
c. Eligible Dependents: If dependent coverage is provided, the person's eligible for dependent coverage as dependents shall include:
   i. The legal spouse or domestic partner of any Enrollee; and
   ii. Any unmarried 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; and
   iii. For whose support the Enrollee is legally responsible and who has not yet attained the age of **twenty-six (26) years**; or
   iv. If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he/she remains a dependent and the Enrollee's coverage remains in force; provided however, that satisfactory proof of the dependent's incapacity can be furnished to VSP within **thirty-one (31) days** of the date such Dependent's coverage would have otherwise terminated or at such other times as VSP may request proof, but not more frequently than annually.
d. Documentation of Eligibility: Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:
   i. For an Enrollee, the individual's name and Identification Number have been reported by Group to USAvision in the manner provided hereunder; and
   ii. In the case of changes to a Dependent's status, the change has been reported by the Group to USAvision in the manner provided herein. As stated in Section 3 herein, USAvision may elect to inspect the Group's records to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein Section III. If a clerical error is made, it will not affect the coverage to which the Covered Person is entitled under the Plan.
e. Change of Participation Requirements, Contribution of Fees & Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Plan, and eligibility requirements are material to USAvision's obligations under this Plan. During the term of this Plan, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects USAvision's obligations hereunder unless USAvision consents to such change in writing. USAvision may require the Group to make written request for any such change at least **sixty (60) days** prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.
f. Change in Family Status: In the event of any change in the Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to USAvision is to be given to USAvision by the Covered Person, or by someone else acting on the Covered Person's behalf, within **thirty-one (31) days** of such change. If such notice is given, the change in the Covered Person's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Covered Person. A newborn or adopted child will be covered during the **thirty-one (31) day** period after birth or adoption.
g. COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available to said persons upon termination of employment of said Enrollee, or the termination of the relationship between said Enrollee and his or her dependents. If, and only to the extent that COBRA applies to the parties to this Plan, USAvision shall make the statutorily required COBRA continuation coverage available in accordance with COBRA. USAvision shall also make available the use of documents needed to offer COBRA.

5. Miscellaneous

a. Entire Plan: This Plan, the Group Application, the Evidence of Coverage, and all Schedules, addenda and/or attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to the Plan must be approved by an officer of USAvision and attached hereto to be valid. No agent has the authority to change this Plan or waive any of its provisions.
b. Indemnity: USAvision 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 USAvision, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and

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

c. Liability: Under no circumstances shall USAvision 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.

d. Business Associate Agreement: In conformity with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing privacy rule regulations at 45 CFR 160 and 164, Subparts A and E (the Privacy Rule), the above-named party will, in connection with the Contracted Services, have access to, create, and/or receive certain "protected health information" as such term is defined in 45 CFR 164.501. As such, the above-named party will be a "Business Associate" of USAvision to the extent that USAvision, Inc. is a "Covered Entity" within the meaning of 45 CFR, Part 160.

e. This Business Associate Agreement is intended to meet the Business Associate Provisions of the Privacy Rule at 45 CFR 164.504(e) and will govern the terms and conditions under which such Protected Health Information may be used and disclosed by Business Associate and other matters relating to Protected Health Information. Therefore, the parties agree that terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in the Privacy Rule.

7. Obligations & Activities of Business Associate: The scope of this agreement is restricted and refers to whatever form or medium (including any electronic medium under Business Associate's custody or control), information is created or received by Business Associate to fulfill the following Obligations and Activities under this agreement:

a. Non-permitted Use or Disclosure: Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

b. Safeguards: Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Mitigate: Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Reporting: Business Associate agrees to report to Covered Entity any use or disclosure of Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Agent or Subcontractor: Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Right to Access: Business Associate agrees to promptly provide access, at the written request of Covered Entity and in the time and manner requested, to Protected Health Information maintained by Business Associate in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual to meet the requirements under 45 CFR 164.524.

g. Right to Amend: Business Associate agrees to promptly make any amendment(s) to Protected Health Information maintained by Business Associate in a Designated Record Set that the Covered Entity directs, or agrees to, pursuant to 45 CFR 164.526, at the written request of Covered Entity or an Individual, and in the time and manner requested.

h. Access & Inspection: Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by, Business Associate on behalf of Covered Entity available to Covered Entity or to the Secretary, in a time and manner requested or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Document Disclosures: Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

j. Accounting of Disclosures: Business Associate agrees to provide to Covered Entity or an Individual, in time and manner requested, information collected in accordance with Section II.I of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

8. Permitted Uses & Disclosures by Business Associate:

a. General Use & Disclosure: Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform Actuarial services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

b. Use for Management & Administration: Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c. Disclosure for Management & Administration: Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Data Aggregation: Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

9. Obligations of Covered Entity:

a. Privacy Practices: Covered Entity shall notify Business Associate in writing of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associates use or disclosure of Protected Health Information.

b. Changes: Covered Entity shall notify Business Associate in writing of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associates use or disclosure of Protected Health Information.

c. Restrictions: Covered Entity shall notify Business Associate in writing of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associates use or disclosure of Protected Health Information. Provided, however, Covered Entity agrees

that it will not commit Business Associate to any restrictions on the use or disclosure of such Protected Health Information without Business Associates written approval.

d. Permissible Requests by Covered Entity: Except for Business Associate's actuarial services, Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

10. Term & Termination:

a. Term: The Term of this Agreement shall become effective immediately and shall continue in effect if Business Associate evaluates Covered Entity for accreditation purposes, unless terminated as provided in Subsection 5.2.

b. Termination for Cause: Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

ii. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

iii. If neither termination nor cures are feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination: Upon termination of this Agreement, Business Associate will, if feasible, return to Covered Entity or destroy all Protected Health Information, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Covered Entity, including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of the Protected Health Information. Business Associate will complete such return or destruction as promptly as possible, but not later than **thirty (30) days** after the effective date of the termination of this Agreement. Business Associate will identify any Protected Health Information that Business Associate created or received for or from Covered Entity that cannot feasibly be returned to Covered Entity and will limit its further use or disclosure of that Protected Health Information to those purposes that make return or destruction of that Protected Health Information infeasible, so long as Business Associate maintains such Protected Health Information.

11. Miscellaneous:

a. Regulatory References: A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

c. Survival: The respective rights and obligations of Business Associate under Section 5.3 of this Agreement shall survive the termination of this Agreement so long as Business Associate or any agent or subcontractor of Business Associate remains in possession of any Protected Health Information and shall expire thereafter.

d. Interpretation: Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Computer VisionCare (CVC) Enhancement Rider

The following coverage details are only relevant if the group has selected the Computer VisionCare (CVC) Enhancement.

1. **General:** This rider lists the vision care benefits to which covered persons of Vision Services Plan, Inc., Oklahoma ("VSP") are entitled, subject to any applicable copayments and other conditions, limitations and/or exclusions stated herein. This rider forms a part of the plan and evidence of coverage to which it is attached. Covered persons who meet the eligibility requirements outlined below, and who utilize a computer monitor shall be eligible for the Computer VisionCare (CVC) Option.

2. **Eligibility:** The following are covered persons under this Enhancement: Enrollee Only.

3. **Materials Deductible:** A Materials Deductible amount of **$25** shall be payable by the covered person at the time services are rendered.

4. **Plan Benefits:**

a. Eye Examination: Covered in full, less any applicable Deductible. Available once each **twelve (12) months**, beginning with the first date of service. A limited level supplemental vision analysis of the eyes and related structures which address the specific visual needs of computer use.

b. Lenses: Available only when the covered person has been diagnosed by an eye care professional as having a vision condition affecting computer use. Plan benefits for lenses are per complete set, not per lens.

c. Single Vision Lenses: Covered in full, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.

d. Bifocal Lenses: Covered in full, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.

e. Trifocal Lenses: Covered in full, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.

f. Selected Occupational Progressive Lenses: Covered in full, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.

g. Frames: Covered up to plan allowance, less any applicable Deductible, available once each **twenty-four (24) months**, beginning with the first date of service. VSP reserves the right to limit the cost of the frames provided by member doctors under the plan. The current allowance shall be published periodically by VSP to its member doctors and will be set at a level to cover a significant number of frames in common use.

5. **Associated Vision Therapy**:
Up to **$200** per year, available once each **twelve (12) months** (specific to computer use) (includes any supplemental testing), beginning with the first date of service. This benefit is limited to covered persons who are eligible for Computer VisionCare (CVC) coverage and who are diagnosed as having one of the following conditions:

a. Accommodative In-Facility: The inability (or the inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period-of-time. (Primarily when looking at objects close-up).
b. Convergence Insufficiency: The occasional problem with the eye muscles' ability to point the eye straight when working up close.

Exclusions & Limitations

1. **Exclusions:** There are no benefits for professional services or materials connected with:
   a. Subnormal vision aids.
   b. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer.
   c. Plano lenses.
   d. Two pair of glasses in lieu of bifocals.
   e. Contact lenses.
   f. Photochromic or tints greater than **20%**.
   g. Laminated lenses.
   h. Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
   i. Medical or surgical treatment of the eyes.
   j. Corrective vision treatment of an experimental nature.
   k. Services and/or materials not indicated on this schedule as covered plan benefits.

2. **Limitations:** This plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the plan will pay the basic cost of the allowed lenses, and the covered person will pay the additional costs for the options:
   a. Blended lenses.
   b. Oversize lenses.
   c. Polycarbonate lenses.
   d. Edge, color, and anti-reflective coatings.
   e. Solid and gradient plastic dyes, non-pink, or non-rose tints, **20%** tint or less.
   f. Frames that cost more than the plan allowance.
   g. Cosmetic lenses.
   h. Optional cosmetic processes.
   i. UV (ultraviolet) protected lenses.

Out-of-Network Coverage & Allowances

1. **Out-of-Network Coverage:** When a covered person chooses to receive services from an out-of-network provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This plan then becomes an indemnity plan reimbursing according to a schedule of allowances. The covered person should pay the provider's fee in full. VSP will reimburse the covered person in accordance with the following schedule. There is no assurance that the amount reimbursed will be sufficient to pay the examination or the materials in full. Availability of services under this reimbursement schedule is subject to the same time limits and copayment as those described for member doctors. Services obtained from out-of-network providers are in lieu of services from a member doctor. VSP is unable to require out-of-network providers to adhere to VSP's quality standards.

2. **Out-of-Network Allowances:**
   a. Eye Examination: Up to a comprehensive level exam, up to **$50**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   b. Frames: Up to **$70**, less any applicable Deductible, available once each **twenty-four (24) months**, beginning with the first date of service.
   c. Single Vision Lenses: Up to **$50**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   d. Bifocal Lenses (Lined & No-Line): Up to **$75**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   e. Trifocal Lenses (Lined & No-Line): Up to **$100**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   f. Progressive Lenses: Up to **$75**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   g. Lenticular Lenses: Up to **$125**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   h. Elective Contact Lenses: Up to **$105**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.
   i. Medically Necessary Contact Lenses: Up to **$210**, less any applicable Deductible, available once each **twelve (12) months**, beginning with the first date of service.

Vision Coverage Enrollment

USAvision
Illuminating Coverage, Inspiring Confidence

Items marked * are required. Complete form using **Blue** or **Black** ink only. **If you send this form via email, please send via secure email to protect PHI to ensure compliance with HIPAA. You may request a secure link from membersupport@usavision.net** or send by FAX to **888.959.4393**. Failure to complete this form correctly may result in delayed enrollment and/or a later Coverage Start Date.

NOTIFICATION

Enter Email Addresses of Individual's (Agent or Group Administrator) who will Receive Completion Notification.

Email*

Email

GROUP

Group ID#*

Group Name*

Sub-Group Name

MEMBER

SSN* ___ - ___ - ____ **Coverage Start Date*** __ /01/20__

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

SPOUSE

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

CHILDREN

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

Name* First, MI, Last

Date of Birth* __ / __ / ____ Gender* ___ Vision Coverage* Enroll ◯ Decline ◯

ACKNOWLEDGEMENT

I hereby request coverage as outlined above under USAvision plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with my employers policy provisions. I declare all answers are true and complete. **WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signature*

Date* __ / __ / ____

PO Box 2181, Lowell AR 72745

questions@usavision.net

www.usavision.net

USAvision
Illuminating Coverage, Inspiring Confidence