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Group Vision Certificate of Insurance

About Your Insurance – This Certificate explains the vision insurance coverage under the Policy issued to the Policyholder. The Policy provides benefits for the Covered Insured. Read it closely to become familiar with Your plan.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate Provisions sections and are capitalized in this Certificate.

Important Notice – Benefits are payable only for listed Covered Charges that were both started and completed while the Covered Insured is insured under the Policy.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Insured who claims rights or benefits under the Policy.

The Policy provides the benefits described in this Certificate for Covered Insured. This Certificate with any attached Riders, Endorsements, Amendments as well as the Application and Enrollment form make up this Certificate of Insurance. It replaces any prior Certificates issued under the Policy.

Canopy Insurance Corporation (CIC) has signed this Certificate on the Policy's Effective Date.

President

Secretary

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SCHEDULE OF BENEFITS

Policyholder:	ALVMA Health and Welfare Trust
Policyholder Effective Date:	January 1, 2026
Policy Number:	CIC0070236
Policyholder's Address:	2660 Eastchase Ln Ste 300 Montgomery, AL 36117
Initial Term:	24 Months
Eligible Classes:	All Actively at Work Eligible Members working at least 30 hours per week, and their Eligible Dependents completing the Eligibility Period
Eligibility Period:	1st of Month Following 30 Days
Mode of Premium Payment:	Monthly
Premium Due Date:	1st of every month
Plan Year:	January 1 - December 31
Additional Benefits:	Low Vision Supplemental Essential Medical Eye Care

For details on these benefits, please refer to Exhibit 1.

This Schedule of Benefits lists the vision care services and materials to which Covered Persons are entitled, subject to any Copays and other conditions, limitations and/or exclusions stated herein.

Covered Insureds have the right to obtain vision care from the Provider of their choice. Covered Charges will be reimbursed according to the following schedule.

FREQUENCY OF SERVICES		
Your Certificate is on a Rolling Benefit Plan Basis		
	In-Network	Out-of-Network
Vision Exam:	Once every 12 months	Once every 12 months
Eyeglass Lenses:	Once every 12 months	Once every 12 months
Frames:	Once every 12 months	Once every 12 months
Contact Lenses:	Once every 12 months	Once every 12 months
Contact Lens Fit:	Once every 12 months	Not Covered

CO-PAY¹ (PER INSURED)		
	In-Network	Out-of-Network
Vision Eye Exam:	\$10	\$10
Eyeglass Lenses/Frames ² :	\$15	\$15
Contact Lens Fitting	Up to \$60	Included in Allowance ³

BENEFITS AND ALLOWANCES⁴		
	In-Network	Out-of-Network
Vision Exam	Covered in Full	Up to \$45 Allowance
Eyeglass Lenses⁵:		
Single Vision	Covered in Full	Up to \$30 Allowance
Bifocals	Covered in Full	Up to \$50 Allowance
Trifocals	Covered in Full	Up to \$65 Allowance
Lenticular	Covered in Full	Up to \$100 Allowance
Standard Progressive ⁶	Covered in Full	Up to \$50 Allowance
Polycarbonate for Dependent Children	Covered in Full	Not Covered
Frames⁷:	Up to \$130 Allowance	Up to \$70 Allowance
Contact Lenses:		
Elective	Up to \$130 Allowance	Up to \$105 Allowance
Necessary	Covered in Full after \$15 Co-pay	Up to \$210 Allowance

¹ Co-pays apply to in and out of-network benefits.

² Frames and/or Lenses are limited to only 1 co-pay.

³ At Out-of-Network Providers, the Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

⁴ Member is responsible for paying any charges in excess of the "Allowance".

⁵ Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

⁶ When Standard Progressives are Covered in Full, Covered Insured receives an allowance based on the provider's charges for Standard Progressives if they elect premium progressive lenses.

⁷ Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

DEFINITIONS

Active or Actively at Work mean the Employee is able and available for active performance of all their regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active at Work provided the Employee is able and available for active performance of all his or her regular duties and was working the day immediately prior to the date of his or her absence.

Administrator, Plan Administrator means the location where the Policy is administered. The Administrator is Southland Benefit Solutions, LLC, 2200 Jack Warner Parkway, Suite 150, Tuscaloosa, AL 35401, 800-476-5044, www.canopyinsurancecorp.com. The Plan Administrator is Vision Service Plan Insurance Company (VSP) 3333 Quality Drive, Rancho Cordova, CA 95670, 800-877-7195, www.vsp.com.

Assignment of Benefits means a written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

Client, Policyholder mean an employer or other entity which contracts with Us for coverage under the Policy in order to offer vision care coverage to its Employees and their Eligible Dependents, if such dependent coverage is provided.

Contact Lenses, Elective means contact lenses a Covered Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

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

Coordination of Benefits means a procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.

Co-Pay, Copayments mean the designated amount, if any, each Covered Insured must pay to a Provider at the time services are rendered or materials ordered, before benefits are payable for a Plan Benefit per Benefit Frequency.

Covered Insured, Covered Person mean the Eligible Employee and Dependents who has qualified for coverage and for whom coverage under the Policy has become effective.

Dependent, Eligible Dependent mean:

1. a Primary Insured's Spouse; or
2. a Dependent Child under 26 years of age; and
3. each unmarried child over 26 who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Primary Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to Us within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Dependent Child(ren) means: (a) the Primary Insured's natural child from moment of birth; (b) the Primary Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Primary Insured's home pending such an order; (c) any child living with the Primary Insured in a regular parent-child relationship and primarily dependent on the Primary Insured for support and maintenance, or (d) any child for whom We have notice, pursuant to a medical support order, that the Primary Insured must provide support in the form of vision insurance from the date of such notice. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Primary Insured to provide a child financial support in the form of vision insurance.

Eligible Class means a group of people who are eligible for coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify for insurance on the date they complete the required Eligibility Period.

Eligible Employee means an Employee who, is Actively at Work, meets the qualification of an Eligible Class and has completed any Eligibility Period, is eligible for coverage under the Policy.

Eligibility Period means a period of continuously Actively at Work/continuous Membership that an Employee must serve in order to qualify for coverage under this Certificate. The length of an Eligibility Period, if any, is shown in the Schedule of Benefits.

Employee means a person permanently employed by the Policyholder for wages or salary and working for the Policyholder on a regular basis.

Eyeglass Lenses means a standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

Immediate Family Member means a Covered Insured's parent, step-parent, Spouse, You or Your Spouse's child, brother or sister.

In-Network Provider , VSP Preferred Provider means an Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Plan Administrator to provide the Covered Charges at an agreed to cost. When an In-Network Provider is used, the Covered Insured will generally incur less out-of-pocket cost for the services rendered. VSP Preferred Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials.

Late Entrant means an Employee enrolling themselves and their Dependents outside the initial Eligibility Period as shown in the Schedule of Benefits. Benefits may be limited for Late Entrants under the Takeover of Existing Coverage section of this Certificate.

Life Status Change means an event recognized by the Policyholder and Us that qualifies the Primary Insured to make changes in coverage at any time other than during Open Enrollment. The following events are all considered Life Status Changes:

1. marriage; partnership in a civil union; domestic partnership;
2. divorce, annulment or legal separation;
3. birth, adoption, or placement of a child;
4. change in a Dependent Child's eligibility;
5. death of a Dependent;
6. other changes as permitted by Us and the Policyholder.

Ophthalmologist means a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be

1. an Immediate Family Member; or
2. retained by the Policyholder.

Optician means a person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be:

1. an Immediate Family Member; or
2. retained by the Policyholder.

The Optician must be licensed by the state in which Covered Charges are rendered if such state requires licensing.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in which Covered Charges are rendered. The Optometrist cannot be:

1. an Immediate Family Member; or
2. retained by the Policyholder.

Out-of-Network Provider, Open Access Provider means an Ophthalmologist, Optometrist, Optician, or other licensed and qualified vision care provider who is not an In-Network Provider. These providers have not entered into an agreement with the Plan Administrator to limit their charges. Covered Persons may be liable for more than the co-payment.

Plan Year means the period of time shown in the Schedule of Benefits.

Plan or Plan Benefits, Covered Charges mean the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the Schedule of Benefits and any additional benefits (when purchased by Client).

Policy means the contract between Us and Policyholder upon which this Plan is based.

Policy Anniversary means the same month and day as the Policy's Effective Date.

Policy Year means the first year begins on the Policy's Effective Date and ends the day before the next Policy Anniversary. For subsequent years, it is the period of time that begins on the Policy Anniversary and is shown as the Plan Year in the Schedule of Benefits.

Primary Insured means a person who is an Eligible Employee of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

Rolling Benefit Plan means benefits begin anew twelve (12) or twenty-four (24) months from the date of service.

Re-enrollee means any Insured who terminated their coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

Schedule of Benefits means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.

Spouse means a lawfully recognized partner of the Primary Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Primary Insured and shares financial obligations and can provide legal proof of marriage. Spouse also includes the Primary Insured's domestic partner or civil union partner as defined by state law. The Primary Insured must provide the Policyholder with proof of such legal domestic partnership or legal civil union partnership required by state law or Us including as applicable, but not limited to, a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

Urgent Care means services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

Vision Exam means an examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

We, Us, and Our means Canopy Insurance Corporation or an Administrator acting on our behalf, where applicable.

You and Your mean the Primary Insured.

ELIGIBILITY AND ENROLLMENT

To be eligible for coverage under the Policy, an Employee must:

1. be a person of an Eligible Class of the Policyholder, as shown in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Eligible Employee's Dependents are also eligible for coverage, provided that You are insured under the Policy and that Dependent coverage is provided under the Policy. Dual Eligibility Status: If both an Eligible Employee and their Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Dependent Child may also only be enrolled by one parent. If the Spouse carrying Dependent coverage ceases to be eligible, Dependent coverage automatically becomes effective under the other Spouse's coverage enrollment will default to the Policyholder's rules.

Enrollment. An Employee and their Dependents may enroll for coverage:

1. within 31 days of becoming an Eligible Employee,
2. during Open Enrollment, or
3. within 31 days of a Life Status Change.

Late Entrants: Eligible Employees who do not enroll themselves or their Dependents during Open Enrollment, may not enroll until the next Open Enrollment unless there is a Life Status Change.

Newborn and Adopted Children. Insurance for any newborn Dependent Child automatically becomes effective from the moment of birth. Insurance for that Dependent Child automatically ends 31 days later unless the Primary Insured has other Dependent Children insured under this Certificate or within 31 days, makes a request to continue coverage for that child and pays the required premium when due.

An adopted child of the Primary Insured will be covered on the same basis as a newborn child from the date of placement with the Primary Insured for the purpose of adoption. Coverage continues unless the placement is disrupted, and the child is removed from placement with the Primary Insured.

EFFECTIVE AND TERMINATION DATES

A. Primary Insured's Effective and Termination Dates

Primary Insured's Effective Date. On the Policy's Effective Date, each Employee in one of the Eligible Classes shown in the Schedule of Benefits is eligible to be insured on the Policy's Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

After the Policy's Effective Date, coverage for the Eligible Employee under the Policy begins on the latest of:

1. the Policy's Effective Date shown in the Schedule of Benefits;
2. if no portion of the cost of this insurance is to be paid by the Employee, the date the Employee becomes an Eligible Employee; or
3. if any portion of the cost of this insurance is to be paid by the Employee:
 - a. the date We or Our Administrator receives the completed enrollment form; and
 - b. the date the required premium is paid; or
 - c. the date the Eligible Employee enters an Eligible Class.

Deferred Effective Date: If an Eligible Employee is not Actively at Work on the date insurance would otherwise be effective, it will be effective on the date they return to Actively at Work.

Primary Insured's Termination Date. A Primary Insured's coverage under this Certificate ends on the earliest of:

1. the date the Policy is terminated;
2. the date this Certificate is amended or changed to exclude coverage for the Eligible Class to which the Primary Insured belongs;
3. the end of the period for which premium is paid;
4. the date the Primary Insured requests, in writing, that coverage be terminated; or
5. the date the Primary Insured ceases to be eligible.

B. Dependent's Effective and Termination Dates

Dependent's Effective Date. A Dependent's coverage under this Certificate begins after written request for coverage has been received and on the latest of:

1. the Primary Insured is eligible, if the Primary Insured has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

In no event will a Dependent be eligible if the Primary Insured is not eligible.

Dependent's Termination Date. A Dependent's coverage will end on the earliest of the date:

1. they no longer meet the Dependent definition;
2. the Primary Insured's coverage ends;
3. the Dependent dies;
4. the date the Primary Insured requests, in writing, that coverage be terminated; or
5. the period ends for which premium has been paid.

Notice Required When Your Coverage Terminates. We must be informed promptly when Your coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the premium for the period for which premiums were paid in error up to a maximum of three Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits after the date Your coverage terminated, the full amount of those benefits may be considered an overpayment which must be repaid to Us.

EXTENSION OF BENEFITS

This provision applies when the Policy replaces coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the Prior Plan. Coverage under this Certificate will not be considered as replacement coverage unless the Policyholder's coverage under the Policy takes effect within 60 days after coverage under the Prior Plan ends.

In the absence of this provision, a Primary Insured who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a hospital.

Each such person will be insured under the Policy if:

1. the Primary Insured was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than fifteen (15) people; and
3. the Primary Insured qualifies under one of the Eligible Classes under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.

CONTINUATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that certain Policyholders offer continued coverage for the Primary Insured and their Dependents whose insurance would end due to a qualifying event.

A Covered Insured must be allowed to continue the same insurance which was in force at the time of a qualifying event. All policy provisions applicable to the insurance elected still apply under continuation.

The Covered Insured must elect continuation during an election period and pay the required premium. The Covered Insured's insurance must have ended due to one of the following qualifying events:

1. a reduction in hours;
2. end of employment with the Policyholder for any reason other than gross misconduct;
3. Primary Insured is no longer eligible for an Eligible Class;
4. death of the Primary Insured;
5. divorce or legal separation from the Primary Insured;
6. entitlement of the Primary Insured to Medicare; or
7. loss of dependent status of any Dependent Child.

Items 3. through 6. may be second qualifying events if a Dependent is already on continuation as a result of the Primary Insured's reduction in hours or termination of employment.

A Covered Insured who is totally disabled may extend continuation coverage if:

1. it has been determined the Covered Insured is totally disabled for Social Security purposes; and
2. the Covered Insured notifies the Policyholder within 60 days of the date the determination is made by the Social Security Administration.

Continuation does not apply to any Covered Insured covered under any other group health plan either as a Primary Insured or as a Dependent or for any Covered Insured entitled to Medicare. Except that a Covered Insured's other group health plan may continue coverage.

Notification Requirements and Election Period. In the case of a Primary Insured's reduction in hours, end of employment, no longer eligible for an Eligible Class, death or entitlement to Medicare the Policyholder must notify Us.

The Primary Insured must notify the Policyholder within 60 days when insurance would end for a Dependent due to divorce, legal separation, or loss of Dependent status for any Dependent Child.

Within 14 days of receiving notification of the qualifying event, the Policyholder must notify the Covered Insured of their right to elect continuation.

The Covered Insured must elect continuation by the later of:

1. 60 days after the Covered Insured's insurance ends; or
2. 60 days after the Covered Insured receives notification from the Policyholder or the Plan Administrator of their right of continuation.

End of Continuation. Continuation will end on the earliest of the following dates:

1. 18 months from the date continuation began for the Covered Insured whose coverage ended because of the Primary Insured's reduction in hours or end of employment, or no longer eligible for an Eligible Class;
2. 29 months from the date continuation began for the Primary Insured's whose coverage was extended due to total disability;
3. 36 months from the date continuation began for the Covered Insured whose coverage ended because of the death of the Primary Insured, divorce or legal separation from the Primary Insured, loss of dependent status for any Dependent Child, or the Primary Insured's entitlement to Medicare;
4. 36 months from the date of the original qualifying event if a second qualifying event occurs;
5. the end of the period for which premium is paid if the Covered Insured fails to make a premium payment on the date specified by the Policyholder;
6. the date the Covered Insured becomes covered under any other group health plan;
7. the date the Covered Insured becomes entitled to Medicare; or
8. the date the group health plan ends.

If continuation coverage terminates because the maximum period of continuation is reached, the Policyholder will notify the Covered Insured of any right to conversion coverage within 180 days prior to the end of continuation.

PREMIUMS

Premium Contributions. You may be required to contribute, either in whole or in part, to the cost of the insurance. This is subject to the terms established by the Policyholder. If required, You contribute to the cost of the insurance through:

1. the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

Premium Changes. We may change the premium rates after the Policy has been in force for 12 months, but not more than once in a 12-month period. If We change premium rates, We can only do so for all Certificates under the Policy. The Policyholder will be given notice by mail 31 days prior to any premium change.

BENEFITS

Covered Charges. Covered Charges are shown in the Schedule of Benefits. In order to be a Covered Charge, it must be furnished to a Covered Insured:

1. to check or improve their vision condition;
2. within the allowable Benefit Frequency shown in the Schedule of Benefits; and
3. by an Ophthalmologist, Optometrist or Optician who is an In-Network Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Charges; or
2. the coverage limits shown in the Schedule of Benefits.

We pay a benefit if a Covered Insured receives Covered Charges from an In-Network Provider at the allowable Benefit Frequency while their coverage under this Certificate is in force. A Covered Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Covered Insured will generally incur less out-of-pocket cost

In-Network Charges. When benefits are payable for Covered Charges received from an In-Network Provider, We will pay the In-Network Provider directly if requested, based on the In-Network benefits shown in the Schedule of Benefits. The Covered Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider.

Both the Co-Pay and the Frequency for Covered Charges are shown in the Schedule of Benefits.

Out-of-Network Charges. If a Covered Insured chooses to use an Out-of-Network Provider, the Covered Insured may be required to pay the Provider in full. When benefits are payable, We will reimburse up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any Co-Pay.

Services provided by an Out-of-Network Provider are not covered under this Certificate.

EXCLUSIONS AND LIMITATIONS

Limitations.

1. The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. A Covered Insured is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame Benefit only after the Contact Lenses benefit Frequency has ended.
2. The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of Contact Lenses benefit. A Covered Insured is eligible to receive benefits under the Contact Lenses Benefit only after the Eyeglass Lenses benefit Frequency has ended.
3. Coverage for a Late Entrant or Re-Enrollee is limited to the Vision Eye Exam benefit during the first 12 months after the Covered Insured's effective date of coverage.
4. Dilation is covered in full under the Vision Eye Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.
5. This Plan is designed to cover "standard" or "basic" eyeglass lenses and frames. Add-on charges for specialty lenses and lens applications are not covered. These extra charges are paid directly to the provider by the Covered Insured. Some items requiring additional charges are listed below under Exclusions.
6. Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP Customer Care Division at (800) 877-7195.

Exclusions. No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. charges for which the Covered Insured is not required to pay;
2. services and/or materials not specifically listed in the Schedule of Benefits;
3. charges that are not within the scope of the treating provider's license;
4. charges received while on active duty with a military service of any country or international organization;
5. charges provided by an employer;
6. charges started before the Covered Insured's effective date;
7. charges not completed before the Covered Insured's termination date;
8. telephone consultation services;
9. charges incurred because of sickness or injury;
10. safety glasses or goggles;
11. plain or prescription sunglasses or other special purpose vision aids;
12. charges for copies of records, charts, x-rays, and any other costs associated with the forwarding or mailing of these copies, or for completing forms;
13. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
14. duplicate lenses or frames;
15. charges for care, including prescribed medications, that would be deemed an eligible expense under the Covered Insured's major medical or other insurance program;
16. charges performed by the Covered Insured's Immediate Family Member or a resident of their home;
17. failure to keep a scheduled appointment or for completion of claim forms;
18. orthoptics or vision training, subnormal vision aids, and any associated supplemental testing;
19. Aniseikonic lenses;
20. medical and/or surgical treatment of the eye, eyes, or supporting structure;
21. non-prescription lenses;
22. two pair of glasses in lieu of bifocals or trifocals;
23. charges received outside of the United States of America; or
24. charges for which benefits are paid by Worker's Compensation.
25. Refitting of contact lenses after the initial (90-day) fitting period.
26. Contact lens modification, polishing or cleaning.
27. Local, state and/or federal taxes, except where We are required by law to pay.
28. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology
29. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.

CLAIM PAYMENTS AND DENIALS

Plan Administrator is responsible for claim processing and payment or denial.

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

Claim Denial Appeals. If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal. The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

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

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

Time of Action. No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

COORDINATION OF BENEFITS

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

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to the Plan Administrator VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

GENERAL PROVISIONS

Conformity with State Laws. The insurance laws of some states require that certain Certificate provisions comply with the law of the state for all permanent residents of the state. Any Certificate provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements. However, any such provision is modified only for a Covered Insured who is a permanent resident of the state at the time loss is actually incurred as defined herein.

Entire Contract; Changes. The entire contract consists of the following:

1. the Policy;
2. this Certificate;
3. any riders, endorsements and amendments to the Policy or this Certificate, if any;
4. the application of the Policyholder; and
5. any enrollment forms.

All statements made in the application and enrollment forms, in the absence of fraud, are representations and not warranties. A copy of the application may be requested at any time. We shall provide a copy to you within 15 days after such request. Only written statements by the Policyholder or a Covered Insured and attached to the Policy or Certificate, will be used to void insurance or deny a claim.

No change in the Policy or this Certificate will be effective until approved by one of Our officers, and unless such approval is endorsed and attached to the Policy or this Certificate. No agent has the authority to change the Policy or this Certificate or to waive any of its provisions.

Fraudulent Information. The Policyholder understands that We may void a Covered Insured's coverage under the Policy for fraud or material misrepresentation by the Covered Insured in applying for coverage.

Incontestability. This Certificate will be incontestable, except for non-payment of premium, after it has been in force for two years.

Legal Action: No legal action may be brought against Us to recover benefits for at least 60 days after the written proof of loss is submitted to Us. No such action may be brought more than 6 years after the time written proof of loss is required by this Certificate to be given.

EXHIBIT 1
ADDITIONAL BENEFIT(S)
LOW VISION

1. LOW VISION – VSP Preferred Provider:

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1,000.00 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 VSP Preferred Provider.

2. LOW VISION – VSP Open Access Provider:

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to \$1,000.00*

*Maximum benefit for all Low Vision services and materials is \$1,000.00 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 VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This section lists additional vision care benefits to which Covered Persons are entitled, subject to any applicable Copayments and other conditions, exclusions and/or limitations stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes.

Supplemental Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

1. COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment. This process is referred to as Coordination of Benefits ("COB."). Please refer to the Coordination of Benefits section for additional information regarding COB.

2. COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides Plan Benefits as follows:

- a. Covered Person contacts VSP Preferred Provider and makes an appointment.
- b. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

VSP PREFERRED PROVIDERS

COVERED SERVICES

1. **Medical Eye Examinations:** Covered in Full after a Copayment of \$20.
2. **Urgent/Emergency Care* and Special Ophthalmological Services**:** Covered in Full

*Urgent/Emergency Care refers to covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where We are required by law to pay.
8. Services and/or materials not specifically included as covered Plan Benefits.

EXCLUSIONS AND LIMITATIONS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS section of the Benefits and/or Additional Benefits section (when purchased by Client) for details.

URGENT VISION CARE

Services for conditions of a medical nature are covered only under specific supplemental eye care Plans purchased by Client. When vision care is necessary for urgent conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval is required for the Covered Person to obtain vision care for urgent conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered for medical services and should contact a physician under Covered Persons' medical insurance plan for care.