Medical Eye Services, Inc.
P.O. Box 25209
Santa Ana, CA 92799-5209
(800) 877-6372 or (714) 619-4660
www.MES*Vision*.com

GROUP VISION PLAN CONTRACT

between
Ventura County Community College District
("the Group")

and

Medical Eye Services, Inc.
("the Plan")

In consideration of the applications and the timely payment of premiums, Medical Eye Services, Inc. agrees to provide benefits of this Contract to Covered Employees and their Covered Dependents.

This Contract shall be effective as of **July 1, 2015**, during the term of this Contract, and for successive one-year periods thereafter, unless terminated or not renewed, subject to the provisions entitled, **"CHANGES: ENTIRE CONTRACT"**.

SYLVIA L. URBANIEC

_____
Corporate Secretary

Group Number: **02716**

Original Effective Date: **October 1, 1993**

MEDICAL EYE SERVICES, INC.

GROUP VISION SERVICE CONTRACT

BY:Ventura County Community College District
255 W. Stanley Avenue, #150
Ventura, CA 93001

This Contract for **Ventura County Community College District**, number **02716,** herein after referred to as "the Group", shall be effective **July 1, 2015**. It has been read and approved, and the terms and conditions are accepted by the Group.

The Group, on behalf of itself and its Employees, hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Group and Medical Eye Services, Inc. (hereafter referred to as "the Plan"). The Plan is an independent corporation in the State of California. The Group further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Plan and that no person, entity or organization other than the Plan shall be held accountable or liable to the Group or its Employees for any of the Plan's obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Contract.

This contract is signed in duplicate. **The Group shall sign, date and return both original contracts to Medical Eye Services, Inc. P.O. Box 25209, Santa Ana, California 92799-5209. Attention: Contract Administration Department**. An executed original contract will be returned to the Group.

It is agreed that this contract supersedes any previous contract for this Contract.

Dated on this _____day of _____20_____

_____
(Legal Name of Group)

_____
(Authorized Group Signature)

_____ _____
(Printed Name) (Title)

Please note, the Group is responsible for communicating to Employees as soon as possible, and no later than five (5) business days after receipt, changes in benefits or in any provisions affecting benefits, and within fifteen (15) calendar days prior to termination of a benefit contract.

Inquiries regarding the administration of this Contract should be directed to Medical Eye Services, Inc. at the above address.

PART I - TABLE OF CONTENTS

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INTRODUCTION

MEDICAL EYE SERVICES VISION PLAN

This booklet describes benefits only for Covered Services from the Plan's Participating Providers and, if applicable, Non-Participating Providers. This Contract provides benefits only for Covered Services from Participating Providers of the Plan. The Plan's Participating Provider network includes Ophthalmologists, Opticians, and Optometrists. The Plan arranges for the provision of Covered Services by contracting with Participating Providers to serve Enrollees in an organized and cost-effective manner. The Enrollee should verify that their provider of choice is a Participating Provider before Covered Services are received. A directory of the Plan's Participating Providers is available to all covered Enrollees on the Plan's website (www.MES*Vision*.com) or by calling 1-800-877-6372 or through the Group's Benefit Administrator.

The Plan's Participating Providers agree to accept payment by the Plan plus the Enrollee's applicable Copayment, if any, as ***payment in full*** for Covered Services.

IMPORTANT

No Enrollee has the right to receive the benefits of this Contract for Covered Services furnished following termination of coverage, except as specifically provided in EXTENSION OF BENEFITS PROVISION PART IX. Benefits of this Contract are available only for Covered Services furnished during the term it is in effect and while the Enrollee claiming benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under GENERAL PROVISIONS, PART XII, or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Covered Services furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Contract.

CONTINUATION OF COVERAGE NOTICE

Enrollees should examine their options carefully before declining this coverage. Enrollees should be aware that companies selling individual health insurance typically require a review of their medical history that could result in a higher premium or they could be denied coverage entirely.

PART I - DEFINITIONS

Whenever any of the following terms are capitalized in this Contract, they will have the meaning below:

Act - The California Knox-Keene Health Care Service Plan Act of 1975 as amended, as set forth in Chapter 2.2 of Division 2 of the California Health and Safety Code (beginning with Section 1340), and its implementing regulations, as set forth in Title 28 of the California Code of Regulations.

Anisometropia - a condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

Calendar Year - a period beginning on January 1 of any year and ending on December 31 of the same year.

Claim Form - the form which shows amounts charged for vision care services to be submitted to the Plan for reimbursement.

Close Relative - the spouse, child, brother, sister, or parent of an Employee or Dependent.

Coated Lenses - a substance which is added to a finished lens on one or both surfaces.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - COBRA is a Federal law that applies to employers and group health plans that cover 20 or more employees. It provides extended coverage under the group benefit plan in which an eligible employee or eligible dependent is currently enrolled, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

Cal-COBRA – is a California Law that applies to employers and group health plans that cover 2 to 19 eligible employees. The Enrollee may keep their vision coverage insurance up to 36 months.

Contract - includes this Contract between the Plan and the Group, the Evidence of Coverage and Disclosure Form, the Employee's enrollment card and any addenda or amendments thereto.

Contract Month - a period beginning on the first day of any calendar month and continuing to the last day of the same calendar month.

Coordination of Benefits - allocation of responsibility to pay for vision care between two or more group vision plans covering the same Enrollee.

Copayment - an Enrollee's share of costs for Covered Services, usually paid to the Participating Provider at the time care is rendered. This specific amount, paid by the Enrollee, applies to the various Covered Services for the selected benefit variation listed in the Schedule of Allowances.

Covered Services - vision care services and/or materials which are specified as benefits in this Contract.

Department of Managed Health Care (the Department) - an administrative agency of the California Government responsible for regulation of health care service plans licensed under the Knox-Keene Act.

Dependent - means

1. An Employee's legally married spouse or registered domestic partner who is:
   a. not covered for benefits as an Employee;
   b. not legally separated from the Employee;
   c. not on active duty with the Armed Forces; or
2. An Employee's registered domestic partner who is an adult of the same sex and meets all of the requirements of California Family Code 297 as applicable.
   a. Both persons file a Declaration of Domestic Partnership with the Secretary of State;
   b. Both persons have a common residence;
   c. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
   d. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated;
   e. The two persons not related by blood in a way that would prevent them from being married to each other;
   f. Both persons are at least 18 years of age;
   g. Either of the following: both persons are members of the same sex or one or both persons are over the age of 62; and
   h. Both persons are capable of consenting to the domestic partnership.

3. An Employee's unmarried child (including any stepchild, children of domestic partner, or legally adopted child), not covered for benefits as an Employee, not on active duty with the Armed Forces, and
   a. primarily dependent upon the Employee for support and maintenance; or
   b. dependent upon the Employee for medical support pursuant to a court order; or
   c. less than 26 years of age;or
   d. those individuals in an Enrollee's immediate family who meet the criteria of the definition of a Dependent as used in the current United States Internal Revenue Code and Regulations of the United States and who have been enrolled and accepted by the Plan as a Dependent and have maintained membership under the terms of the Plan.

Disability - an injury or illness (including a nervous or mental disorder) or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one Disability;
2. all illnesses existing simultaneously which are due to the same or related causes will be considered one Disability;
3. if any illness is due to causes which are the same as or related to the causes of any prior illnesses, the succeeding illness will be considered a continuation of the previous Disability and not a separate Disability.

Elective Plan - a voluntary vision plan offered to an Employer group which permits each eligible Employee the option to elect to enroll or not.

Employee - an individual who is defined by the Group as a full-time employee, and who receives compensation from the Group in the form of salary, wages or commissions, and whose regular work

week with the Group meets the Group's required number of hours, and whose duties in such employment are performed at the Group's usual place of business except salespersons and others whose duties are of a kind and nature that require them to be performed away from such usual place of business.

Enrollee - an individual who meets all applicable eligibility requirements specified within this Contract is enrolled with the Plan and for whom the required premium actually has been received and accepted by the Plan.

Experimental or Investigational - any treatment, therapy, procedure, drug or drug usage, biological product, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which the Plan has determined in its sole discretion, not to have been demonstrated in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of illness, injury or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials or other studies on human patients, shall be considered Experimental or Investigational in nature. "Experimental or Investigational" also includes services, supplies, drugs and procedures that are determined by the Plan to be educational or the subject of a clinical trial.

The fact that a Participating Provider, or medical professional may prescribe, order, recommend, recognize or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device or materials does not in itself make the service or materials non-Experimental or non-Investigational within this definition.

Group - the entity for whose Employees Covered Services are being provided.

Keratoconus - a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissues in its central area.

Mentally Disabled- (**or Mental Disability**) - only those persons, not psychotic, who are so Mentally Disabled from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control and care for their own welfare or for the welfare of others or for the welfare of the community.

Non-Elective Plan - a vision plan variation offered to an Employer group which does not permit each eligible Employee the option to elect to enroll or not, that is, all eligible Employees are enrolled.

Non-Participating Provider - an Ophthalmologist, Optician or Optometrist who does not have an agreement with the Plan.

Ophthalmologist - a doctor of medicine (M.D. or D.O.) who specializes in the diagnosis and treatment of defects and diseases of the eye, performing surgery when necessary or prescribing other types of treatment, including glasses or contact lenses and who is duly licensed by the applicable licensing authority.

Optician - an individual who is engaged in the filling or dispensing of ocular prescriptions involving lenses, lens forms, eye glasses, optical devices, contact lenses or any ophthalmic appliances; and in the services related to such filling and dispensing and who is duly licensed by the applicable licensing authority.

Optometrist - a doctor of optometry (O.D.) who is specifically trained to examine the eyes and determine the presence of visual problems, and who may prescribe glasses, contact lenses and other optical aids or eye exercises in treatment of visual disturbances and who is duly licensed by the applicable licensing authority.

Orthoptics - the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular lenses.

Other Plan - for the purpose of Coordination of Benefits, any plan, other than the Plan, providing benefits or services for vision care or treatment whose benefits or services are provided by: (1) any group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under labor-management trustee plans, union welfare plans, or Employee benefit organization plans; (4) any coverage under governmental programs (including Medicare); (5) any coverage required or provided by any statute; (6) any group coverage sponsored by or provided through a school or educational institution; and (7) any self-funded Employee welfare benefit plan or any other coverage on a group basis.

Oversized Lenses – lenses to fit frames with an eyesize of 61 mm or more.

Participating Provider - an Ophthalmologist, Optician or Optometrist who has certified their willingness to accept the terms and conditions and compensations as set forth by the Plan.

Photochromic Lenses - lenses which change color with intensity of sunlight.

Physical Handicap - a physical or mental impairment that results in anatomical physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months in duration.

Physician - a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Plan - Medical Eye Services, Inc., a California corporation. The mailing address is P.O. Box 25209, Santa Ana, California 92799-5209. The telephone numbers are (714) 619-4660 or (800) 877-6372.

Polycarbonate – an impact resistant material. For safety purposes, it is sometimes recommended for children younger than 18 or whenever greater impact resistance is required. This material is thin, light-weight, and has built in UV protection.

Professional Services – routine vision examination, eyewear materials selection, fitting of eyeglasses or contact lenses, related adjustments, etc.

Progressive Lenses - multifocals which do not have a visible dividing line.

Schedule of Allowances - the allowed amounts for Covered Services rendered by Participating Providers.

Service Area - that certain geographic area which the Plan has been licensed to arrange for the provision of Covered Services to Enrollees and within which each Employee must either work or reside to be eligible for coverage under the Plan.

Service Intervals - the specific period of time in which Covered Services are provided as shown in the Schedule of Allowances.

Standard Lenses- Plastic lenses that fit any frame with an eye size less than 61 mm.

Subnormal or Low Vision Aids - devices (optical and non-optical) to assist those persons who are partially sighted.

Tinted Lenses - lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.)

Total Disability (or Totally Disabled) -

1. in the case of an Employee otherwise eligible for coverage as an Employee, a Disability which prevents the Employee from working with reasonable continuity in the Employee's customary employment or in any other employment in which the Employee reasonably might be expected to engage, in view of the Employee's station in life and physical and mental capacity;
2. in the case of a Dependent, a Disability which prevents the Dependent from engaging with normal or reasonable continuity in the Dependent's customary activities or in those in which the Dependent otherwise might be expected to engage, in view of the Dependent's station in life and physical and mental capacity.

PART II - ELIGIBILITY

A. EMPLOYEE ELIGIBILITY REQUIREMENTS

Individuals in the following classes are eligible to become Enrollees**:**

1. All active, regular Employees as herein defined and all Employees who become eligible to continue group coverage as provided under Extension of Benefits, PART IX.

2. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Each such individual employed by the Group on the effective date of this Contract is eligible.
   b. Each such individual who is employed by the Group after the effective date of this Contract is eligible for coverage as an Enrollee on the day following the date the individual completes the waiting period (the number of days of continuous employment required by the Employer) for coverage.
   c. If Item 5 of PART II, A. is amended to add an associated employer to the Group, the effective date of such amendment shall be treated as the effective date of this Contract for

the purpose of determining the date of eligibility of the Employees of such associated employer.

3. If a former Employee is rehired, their period of service prior to termination of employment shall be included in the determination of their date of coverage eligibility, and benefit availability provided:

   a. the Employee has resumed active work within six (6) months after such termination; or
   b. the Employee has resumed active work within the time set for reinstatement of employment rights, if previous employment was terminated due to entry into the Armed Forces; or
   c. the Employee has resumed active work within one month after ceasing to be disabled, if termination was due to Total Disability.

   In all other cases, a former Employee shall be considered as an Employee entering the employ of the Group on the date he resumed work and shall be eligible on the date he completes the period of service specified in Item 2. b above.

4. If an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Group on the date of such transfer. Their services in the ineligible class shall not be included in the determination of their date of eligibility.

5. Employees of the following listed employers associated with the Group as Employees of affiliate are eligible for benefits in accord with this Contract. For the purposes of this Contract only, service with any associated employers shall be considered service with the Group. The Group may act for and on behalf of any associated employers in all matters pertaining to this Contract, and every act done by, contract made with, or notice given to the Group shall bind all associated employers.

(list of associated employers)
NONE

B. DEPENDENT ELIGIBILITY

1. Spouses, domestic partners and children of Employees as herein defined or spouses, domestic partners and children of Employees who continue group coverage as provided under Extension of Benefits, PART IX, and who satisfy the requirements of 1, 2 or 3 under the definition of Dependent, are eligible to become Enrollees in the Plan.

2. For Dependents of Employees who enroll during the initial open enrollment period, the Dependent's date of eligibility is the latest of the following:

   a. The effective date of any PART of this Contract providing Dependent benefits;
   b. The date of eligibility of the Employee;
   c. The date of birth for any newborn infant of the Employee;
   d. The date of placement in the physical custody of the Employee for any adopted children; or
   e. The date the Employee acquires a new Dependent (other than a newborn or newly adopted child) after the Employee's date of eligibility.

3. If husband and wife [or domestic partners] are both eligible to be Employees, their children may be eligible and may be enrolled as Dependents of either parent, but not both.

4. During the term of this Contract, an Employee who is required to contribute to the cost of coverage will not be allowed to enroll any Dependent who was an eligible Dependent, but was not enrolled at the time of the Employee's annual enrollment.

5. A spouse or Dependent child for whom a court has ordered the Employee to provide coverage under the Employee's vision plan shall become effective the date the court order is issued provided the Employee requests enrollment within thirty (30) calendar days after issuance of the court order.

6. Dependent child coverage may continue beyond the dependent maximum age limit of 26 if the child is and continues to meet both of the following criteria: (a) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (b) chiefly dependent upon the subscriber for support and maintenance. For continuation of benefits for this dependent, the Employee must submit to the Group's Benefit Administrator and to the Plan documentation that the child meets the criteria for continuation of a disabled dependent no later than 30 days prior to reaching the maximum age limit (60 days after receiving the 90-day notification). Upon receiving a request by the subscriber for continued coverage of a disabled dependent and proof of the criteria in (a) and (b) above, the Plan will make a determination as to whether the dependent child is entitled to continue coverage before the child reaches the limiting age. If the Plan fails to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to physical or mental disability, injury, illness or condition.

   Notwithstanding any other provision of law, an employer or the Plan shall not deny enrollment of a child under the Plan's coverage of a child's parent on any of the following grounds:

   (1)The child was born out of wedlock.
   (2)The child is not claimed as a dependent on the parent's federal income tax return.
   (3)The child does not reside with the parent or within the Plan's Service Area.

   Notwithstanding any other provision of law, in any case in which a parent is required by a court or administrative order to provide health insurance coverage for a child and the parent is eligible for the Plan's coverage through an employer, the employer or the Plan shall do all of the following, as applicable.

   (1) Permit the parent to enroll any child who is otherwise eligible to enroll for coverage, without regard to any enrollment period restrictions.

   (2) If the parent is enrolled in the Plan but fails to apply to obtain coverage for the child, enroll that child in the Plan upon presentation of the court order or request by the district attorney, the other parent or person having custody of the child, or the Medi-Cal program.

   (3) The employer or the Plan shall not disenroll or eliminate coverage of a child unless either of the following applies:

(A) The employer has eliminated coverage for all Employees or eliminated Dependent coverage.
(B) The employer or the Plan is provided with satisfactory written evidence that either of the following apply:
(i) The court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.
(ii) The child is or will be enrolled in a comparable vision plan through another insurer that will take effect not later than the effective date of the child's disenrollment.

In any case in which health insurance coverage is provided for a child pursuant to a court or administrative order, the Plan shall do all of the following:

(1) Provide any information, including, but not limited to, the child's membership in the Plan, the evidence of coverage and disclosure form, and any other information provided to the covered parent about the child's coverage to the non-covered parent having custody of the child or any other person having custody of the child and to the district attorney when requested by the district attorney.

(2) Permit the non-covered parent or person having custody of the child, or a provider with the approval of the non-covered parent or person having custody, to submit claims for Covered Services without the approval of the covered parent.

(3) Make payment on claims submitted in accordance with subparagraph (2) directly to the non-covered parent or person having custody (if Non-Participating provider benefits available), to the Participating Provider on behalf of the non-covered parent, or to the Medi-Cal program. Payment on claims for services provided to the child shall be made to the covered parent for claims submitted or paid by the covered parent.

PART III - EFFECTIVE DATES

A. EFFECTIVE DATE FOR EMPLOYEES

1. The benefits of an Employee may become effective only after a request has been received by The Plan on an enrollment form or a method approved by the Plan for all such benefits for which he is eligible. Benefits shall become effective as follows:
   a. The benefits of an Employee who is not required to contribute to the cost of coverage shall become effective on the date of their eligibility.
   b. The benefits of an Employee who is required to contribute to the cost of coverage shall become effective on the date of their eligibility.
   c. An Employee who requests reinstatement of their benefits after he has been discontinued due to voluntary cancellation while he remained eligible, will require approval by the Plan in order to be considered for coverage hereunder. Such benefits shall become effective on the first day of the month following the date of approval by the Plan.

2. If an Employee has taken a leave of absence from active work on the date their benefits would become effective in accordance with PART III, A.1., such benefits shall not become effective until the first day the Employee is actively at work full-time. An Employee shall be considered as actively at work if he reports for work on the date in question at their usual place of

employment, and such usual place of employment is outside of their home. If an Employee does not so report, and if their usual place of business is not outside of their home, they shall be considered as actively at work if they are neither hospital-confined nor disabled to a degree that they could not then have reported to a place of employment outside of their home.

B. TERMINATION OF THE BENEFITS OF AN EMPLOYEE

Except as provided under Extension of Benefits, PART IX, an Employee has no right to receive benefits for Covered Services provided following termination of this Contract, or any PART of it. The benefits of an Employee under any PART of this Contract cease on the first to occur of the following dates:

1. The date of discontinuance of Contract.

2. The date this Contract is amended to terminate the eligibility of any class of Employees of which the Employee is a member.

3. The date the Employee's employer ceases to be an associated employer, if applicable.

4. The end of the last period for which the Employee has made their contribution, if they have notified the Group that their payroll deduction is to be canceled, or otherwise failed to make their contribution when due.

5. The date the Employee enters full-time service in the Armed Forces of the United States.

6. The last day of the month in which the Employee retires, is pensioned, leaves voluntarily or is dismissed from the employ of the Group or otherwise ceases to be a member of a class eligible for coverage; except that

    a. if the Employee ceases active work because of a Total Disability due to illness or bodily injury, payment of premiums for that Employee shall remain in force until the end of such Total Disability or until employment is terminated by the Group, whichever is earlier; or,
    b. if the Employee ceases active work because of an approved leave of absence or temporary layoff, payment of premiums for that Employee shall remain in force for a period of three Contract Months commencing with the first Contract Month following the date on which such approved leave of absence or temporary layoff began. If the Group is subject to the California Family Rights Act of 1991 and or the Federal Family & Medical Leave Ace of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of premiums for that Employee shall keep coverage in force for the duration(s) prescribed by the Acts.

C. EFFECTIVE DATE FOR DEPENDENTS

1. Except as described under PART III, C. Items 3 and 4, Dependents shall become effective only after the Employee has made written application within thirty (30) calendar days of the date the Employee becomes eligible on a form approved by the Plan. Benefits are effective as follows:

a. Dependent benefits, of any Employee who enrolls during the initial enrollment period, shall become effective on the date the Employee becomes eligible.
b. An Employee requesting reinstatement of their dependent benefits after they have been discontinued due to voluntary cancellation while they remained eligible, will require approval by the Plan in order to be considered for coverage hereunder. Such benefits shall become effective on the first day of the month following the date of approval by the Plan.

2. Dependent benefits for a spouse, domestic partner or Dependent child for whom a court has ordered the Employee to provide coverage under the Employee's vision plan shall become effective the date the court order is issued provided the Employee requests enrollment within thirty (30) days after issuance of the court order.

3. Dependent benefits for a newborn child are effective on the child's date of birth. Coverage will cease on the thirty-first (31st) calendar day following the Dependent's effective date of coverage, except that coverage shall not cease if a written application for the addition of the Dependent is filed with the Plan prior to the thirty-first (31st) calendar day following the effective date of coverage.

4. Dependent benefits for an adopted child are effective on the date the Employee or spouse has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. Coverage will cease on the thirty-first (31st) day following the Dependent's effective date of coverage, except that coverage will not cease if a written application for the addition of the Dependent is filed with the Plan prior to the thirty-first (31st) calendar day following the effective date.

5. Dependent benefits may not be effective prior to the date the Employee's benefits are effective.

D. TERMINATION OF DEPENDENT BENEFITS

Except as provided under Extension of Benefits, PART IX., there is no right to receive benefits for Covered Services provided following termination of this Contract, or any PART of it.

The benefits for Dependents under any PART of this Contract cease on the first to occur of the following dates:

1. The date of discontinuance of this Contract.

2. The end of the last period for which the Employee has made their contribution for Dependent benefits, if they have notified the Group that their payroll deduction is to be canceled, or otherwise failed to make their contribution when due.

3. The date of termination of the Employee's coverage.

4. The date the Dependent ceases to qualify as a Dependent, except if coverage for a Dependent child would be terminated solely because of age and the child is both:

   a. incapable of self-sustaining employment by reason of Mental Disability or Physical Handicap and

b. chiefly dependent upon the Employee for support and maintenance, then, coverage for the Dependent will be continued only in accordance with (1) and (2) below:
   (1) The Employee must submit to the Plan a Physician's written certification of Mental Disability or Physical Handicap within thirty (30) days prior to reaching the maximum age limit (60 days after receiving the 90-day notification), and
   (2) Recertification from a Physician may be requested by the Plan twenty-four (24) months after the initial certification and annually thereafter.

In no event will coverage be continued beyond the date that the Dependent child becomes ineligible for coverage for any other reason.

E. TERMINATION

The benefits of an Employee and Dependent also may be terminated for fraud or deception in the use of the Covered Services of the Plan or knowingly permitting such fraud or deception by another. Termination for fraud or deception shall be effective upon mailing of written notice by the Plan to the Employee and to the Group.

F. REVIEW BY DIRECTOR OF DEPARTMENT OF MANAGED HEALTH CARE

In the event that the Plan should cancel or not renew the enrollment of any Enrollee hereunder, and the Enrollee alleges that such cancellation or failure to renew was due to their health status the Enrollee may request a review by the Director. If the Director determines that a proper complaint exists, the Plan will be notified. Within fifteen (15) days of notification by the Director, the Plan will either reinstate the Enrollee retroactively to the time of cancellation or request a hearing to determine if reinstatement is appropriate.

PART IV - VISION CARE BENEFITS

BENEFITS

The Plan will pay the allowed amount in the Participating Provider Schedule of Allowances for Covered Services rendered by Participating Providers less any Copayments. If covered services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of the Non-Participating Schedule of Allowances less any Copayments.

Examination

1. One comprehensive eye examination in a 12 consecutive month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

   Note: In the event that the provider determines that additional diagnostic procedures or treatment plans are indicated, the Enrollee will need to obtain care under her/his medical plan. Enrollees who are covered under their medical plan (HMO, PPO, etc.) should be referred back to their Primary Care Physician or Participating Medical Group.

Lenses

2. One pair of lenses in a 12 consecutive month period; or

3. One pair of contact lenses for cosmetic reasons or for convenience when provided in lieu of other eyewear once in a 12 consecutive month period.

   The contact lenses are in lieu of other eyewear benefits. The Plan will pay up to the amount shown in the Schedule of Allowances toward the contact lens evaluation, fitting costs and materials.

   Disposable Contact Lenses should be purchased up to the maximum allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement; or

4. One pair of non-elective (medically necessary) contact lenses in a 12 consecutive month period when required following cataract surgery; or for certain conditions of Myopia, Hyperopia, or Astigmatism; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus, or 20/60 for certain conditions of Anisometropia, or other various corneal findings and disorders. A completed "Non-Elective (Medically Necessary) Contact Lenses Approval Request Form" along with the patient's history from the provider and approval from the Plan is required. This form can be obtained from the MES*Vision* website at www.MES*Vision*.com. If prior approval is requested, a determination will be made within five (5) business days. If the services have already been rendered, a determination will be made within thirty (30) calendar days.

Frame

5. One frame in a 12 consecutive month period up to the allowed amount shown in the Schedule of Allowances.

   The difference between the allowed amount and the charges for more expensive frames or unusual lenses, such as oversize, will be the responsibility of the Enrollee. Participating Providers allow a selection from frames that retail up to $130.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, the Enrollee is responsible for the additional cost above the $130.00. If the lenses are 61 millimeters and over, any difference between the allowance and the provider's charge is the responsibility of the Enrollee.

Arranging to provide second opinion examinations is part of the Plan's internal quality of care review system. Given the limited scope of coverage of the Plan, the criteria established to approve a second examination is as follows:

1. Dissatisfaction with the original provider's services; or
2. A request to check the accuracy of a prescription.

An Enrollee is to submit a written request to the Plan for the second opinion stating the reasons it is required. Second opinion requests should be addressed to:

MEDICAL EYE SERVICES, INC.
c/o Benefit Resolutions Department
P.O. Box 25209
Santa Ana, CA 92799-5209
(800)-877-6372

A request for a second opinion will be acknowledged within five (5) calendar days of the Plan's receipt of the request. A determination letter will be sent within thirty (30) calendar days of the request. If approved, the Enrollee will be informed to present the approval letter to the Participating Provider of their choice. The Participating Provider rendering the second opinion shall furnish the findings to the Plan. An Enrollee may be entitled to receive a second pair of corrective lenses based upon the findings of the second opinion examination. Any Enrollee whose request for a second opinion is denied shall be informed of the Enrollee's right to file a grievance with the Plan.

Given the limited nature of the coverage under the Plan, if the second opinion relates to pathology or other medical conditions, Enrollees are referred to their medical provider and/or full service health plan for follow-up care.

The Plan does not delegate or assert lien rights. Contracted providers will accept the Plan's payments on behalf of the Enrollee and will not assert against the Enrollee statutory or other lien rights that may exist.

PART V - LIMITATIONS

If specifically covered, benefits with respect to the following services are paid up to the applicable Schedule of Allowances.

1. Contact lenses, except as specifically provided;
2. Contact lens fitting, except as specifically provided;
3. Eyewear when there is no prescription change, except when benefits are otherwise available;
4. Non-standard lenses including, but not limited to, Progressive, Photochromic, Polarized lenses, hi-index, Polycarbonate, occupational lenses, beveled, faceted, coated, or oversize exceeding the allowance for covered lenses;
5. Tints, other than pink or rose #1 or #2, except as specifically provided;
6. Two pair of glasses in lieu of bifocals, unless prescribed;
7. New-patient intermediate (follow-up) examinations: When an Enrollee elects to have comprehensive examination and is only eligible for an intermediate examination or selects a different provider to perform the intermediate (follow-up) examination, the Enrollee will be responsible for the difference between the intermediate (follow-up) examination allowance and the comprehensive examination allowance. To maximize benefits, the patient should return to the original provider; and
8. Non-prescription (plano) eyewear and applicable sales tax, except when specifically provided.

PART VI - EXCLUSIONS

The Contract does not provide benefits with respect to the following services:

1. Any eye examination required by an employer as a condition of employment;
2. Any Covered Services provided by another vision plan;
3. Conditions covered by Workers' Compensation;
4. Contact lens insurance or care kits;
5. Covered Services which began prior to the Enrollee's effective date or after benefits have been terminated;
6. Charges for which the Enrollee is not legally obligated to pay;
7. Covered Services required by any government agency or program, federal, state or subdivision thereof;

8. Covered Services performed by a Close Relative or by an individual who ordinarily resides in the Enrollee's home;
9. Medical or surgical treatment of the eyes;
10. Orthoptics, vision training or Sub-Normal or Low Vision Aids;
11. Services that are Experimental or Investigational in nature;
12. Services for treatment directly related to any totally disabling condition, illness or injury;
13. Frame cases;
14. Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are otherwise available; and
15. In connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.

PART VII - COORDINATION OF BENEFITS

Coordination of Benefits applies when an Enrollee has coverage with more than one vision plan. The benefits payable under the secondary plan shall be reduced so that the sum of such reduced benefits and all other benefits payable do not exceed the total allowable expenses. A plan which has no coordination of benefits provision pays before a plan with said provision.

A. DETERMINING PRIMARY AND SECONDARY COVERAGE

If a plan covers a claimant as an Enrollee or member of an association, it is considered the primary coverage and determines benefits first. The Plan which covers the claimant as a Dependent, pays as the secondary coverage.

The “Birthday Rule” is the generally accepted method of determining primary coverage for dependent children. The Plan of the parent whose birthday is earlier in the year using month and day only is primary for the child. If the parents have the same birthday, the Plan which has covered the parent for the longer period is primary.

For children with divorced or separated parents, primary coverage is determined in the following order:

1. the parent with the court decree stating that he/she has financial responsibility to provide health care,
2. the plan of the parent with custody,
3. the plan of the spouse of the parent with custody,
4. the plan of the parent not having custody.

B. In the event that a Person is both enrolled under this Contract and entitled to benefits under any of the conditions described in paragraphs (1) and (2) of this exclusion, the Plan’s liability for Covered Services provided will be reduced by the amount of benefits paid, or the reasonable value of the Covered Services provided without any liability for the cost thereof, as a result of the Enrollee’s entitlement to such other benefits.

This exclusion is applicable to:

Covered Services provided to the Enrollee by any federal or state governmental agency, or by any municipality, county, or other political subdivision, or for the reasonable costs of Covered

Services provided to the Enrollee at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the Enrollee is not on active duty;

This exclusion is not applicable to any entitlements to Medi-Cal benefits under chapter 7 (commencing with Section 14000) or chapter 8 (commencing with Section 14500) or part 3 of division 9 of the Welfare and Institutions Code, or benefits under the California Crippled Children Services program under Section 10020 of the Welfare and Institutions Code or any other coverage provided for or required by law when, by law, it's benefits are excess to any private insurance or other non-governmental program.

C. RIGHT OF RECOVERY

If payments have been made by the Plan in excess of the maximum amount of payment necessary to satisfy these provisions, the Plan shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

D. RIGHT TO RECEIVE AND RELEASE INFORMATION

The Plan may release to or obtain from any organization or person any information which is necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any Enrollee claiming benefits under the Plan shall furnish the Plan with such information as may be necessary to implement these provisions.

PART VIII – CANCELLATION AND REINSTATEMENT

A. CANCELLATION OF AGREEMENT BETWEEN THE PLAN AND THE GROUP

(1) Failure of the Group to Pay Premiums.
Enrollee Coverage under this Agreement is subject to the terms and conditions of this Agreement. In the event that Premiums are not paid when due, the Plan shall give the Group written Notice of Cancellation in accordance with Section A(5). If the premiums remain unpaid, then Coverage shall end for all Enrollees on the fifteenth (15^{th}) day after the date on which the Notice of Cancellation is sent by the Group to Subscribers. Enrollment will be canceled as of the last day of the month subject to compliance with notice requirements.

(2) Reinstatement of the Group Contract.
Receipt by the Plan from the Group of the proper prepaid or periodic payment after cancellation of this Agreement for non-payment of Premiums shall reinstate the Agreement as though it had never been cancelled if such payment is received on or before the due date of the next prepaid or periodic payment provided, unless one of the following occurs:
(i) In the Notice of Cancellation, the Plan notifies Group that if payment is not received within fifteen (15) calendar days after the date on which the Notice of Cancellation is sent to Group, a new application is required and the conditions under which a new agreement will be issued or the Agreement reinstated; or
(ii) Such payment is received more than fifteen (15) calendar days after the date on which the Notice of Cancellation is mailed to Group, the Plan refunds such payments within twenty (20) business days; or

(iii) Such payment is received more than fifteen (15) days after the date on which the Notice of Cancellation is mailed to Group, the Plan issues to the other party, within twenty (20) business days of receipt of such payment, a new agreement accompanied by written notice stating clearly those respects in which the new agreement differs from this Agreement in benefits, coverage or otherwise.

(3) Termination by Group Without Cause.
The Group shall have the right to terminate this Agreement, with or without cause, upon thirty (30) calendar days prior written notice.

If thirty (30) calendar days written notice of cancellation is not provided to the Plan, the termination date shall be effective after any date(s) of service rendered to members of the Group or the Group's requested termination effective date, whichever is later, subject to Notice requirements.

(4) In the event of cancellation by either the Plan or Group, the Plan shall within thirty (30) calendar days return to the Group any pro rata portion of any money paid to the Plan which corresponds to the period for which payment had been received less any amounts due on claims and/or premium amounts due the Plan, if any.

(5) Group to Mail All Notices of Cancellation. In the event that the Plan cancels or refuses to renew this Agreement prior to the end of the term of this Agreement, the Plan shall send the Group a notice of cancellation ("Notice of Cancellation"). Group shall promptly (but in any event not less than fifteen (15) calendar days prior to the effective date of cancellation as set forth in the Notice of Cancellation) mail to all Subscribers at their current addresses a legible, true copy of any Notice of Cancellation as sent by the Plan to the Group for any reason. Group shall provide to the Plan a signed affidavit as proof of mailing within three (3) business days after mailing. Should Group fail to provide such proof of mailing within the required timeframe, then the Plan shall mail, at Group's expense, a legible, true copy of the Notice of Cancellation to all Subscribers.

In the event that Group cancels this Agreement, Group shall send the Plan a Notice of Cancellation and shall promptly mail a legible, true copy of the Notice of Cancellation to all Subscribers in accordance with the provisions of this paragraph.

(6) Remaining Duties. After termination of this Agreement each party shall continue to be responsible for completing any performance owed because of obligations incurred pursuant to this Agreement during the period of time prior to such termination.

B. CANCELLATION OF ENROLLEE COVERAGE. The Plan may cancel or refuse to renew an enrollment only for the following reasons:

(i) Fraud or deception in the use of the Plan's services or facilities. Coverage will end immediately on the date that the Plan mails the Notice of Cancellation to Subscriber.

(ii) Failure of Enrollee to pay any required Co-payments or charges owed to a Provider or the Plan for Covered Services. To be subject to cancellation under this provision, Enrollee must have been billed by the Provider or the Plan for two billing cycles and have failed to pay or make appropriate payment arrangements with the Provider or the Plan. Coverage will end on the fifteenth (15th) day after the date the Plan mails the Notice of Cancellation to the Subscriber. If

the Enrollee pays or makes appropriate arrangements to pay within the fifteen (15) day notice period, then the cancellation shall not take effect.

Enrollment will be canceled as of the last day for which payment has been received, subject to compliance with notice requirements.

C. TERMINATION OF ENROLLEE COVERAGE DUE TO INELIGIBILITY.

(1) Coverage shall terminate when the Enrollee no longer meets eligibility requirements established by the Plan or Group. A person shall cease to be an Enrollee on the first day of the month after which the Group identifies such person as ineligible in the Group's vision care program.

(2) Retroactive Disenrollment is not permitted. In the event that the Group determines an Enrollee was ineligible, after previously identifying such Enrollee as eligible, and the Enrollee has obtained services during the ineligible time period, the Group shall remain liable to the Plan for either the Premium or any claims incurred as a result of the Group's late notification of cancellation to the Plan on account of such Enrollee.

D. REVIEW OF DIS-ENROLLMENT BY DEPARTMENT OF MANAGED HEALTH CARE

An Enrollee, who feels that their enrollment has been cancelled because of the Enrollee's health status or requirements for health care services, may request a review by the Director of Department of Managed Health Care. If the Director determines that a proper complaint exists under the provisions of this Section, the Director shall provide notice to the Plan. Within fifteen (15) days after receipt of such notice, the Plan shall either request a hearing or reinstate the Enrollee. If, after the hearing, the Director determines that the cancellation is contrary to the Act, the Director shall order the Plan to reinstate the Enrollee. A reinstatement pursuant to this Section shall be retroactive to the time of cancellation, and the Plan shall be liable for the expenses incurred by the Enrollee for the covered health care services from the date of cancellation to and including the date of reinstatement.

E. RIGHT OF PLAN TO CHANGE BENEFITS

The Plan reserves the right to change the benefits of the Contract, upon thirty (30) calendar days written notice to the Group.

Right of Cancellation

If the Enrollees are making any contributions toward coverage for themselves or their Dependents and they are active Employees they may only cancel such coverage at the end of the second contract year during the Group's open enrollment.

Any premiums paid to the Plan for a period extending beyond the cancellation date will be refunded to the Group. The Group will be responsible to the Plan for unpaid premiums prior to the date of cancellation.

The Plan will honor all claims for Covered Services provided prior to the effective date of

cancellation. The Group will be responsible to the Plan for any Premiums or claims incurred after the date of cancellation as a result of the Group's late notification of cancellation to the Plan.

F. REINSTATEMENT OF ENROLLEE BENEFITS

The Enrollee may apply for reinstatement during open enrollment if the Enrollee had been making contributions toward the Enrollee's coverage and the Enrollee's Dependents and voluntarily canceled such coverage. Reinstatement will be subject to approval by the Plan.

Members of the United States Military Reserve and the National Guard who are called to active duty on or after January 1, 2007 will be reinstated upon payment of premium as a covered Enrollee without a waiting period or exclusions of coverage for pre-existing conditions.

G. PAYMENT ON REFUND OF PREMIUMS

In the event of cancellation, the Group shall promptly pay any outstanding premiums due. The Plan shall not be obligated to provide benefits for Covered Services rendered during the time premiums are unpaid, until all such premiums are paid, except as otherwise specifically required by the Bankruptcy Code. The Plan shall within thirty (30) calendar days of cancellation; (1) return to the Group the amount of any prepaid premiums, if any, that the Plan determines have not been earned as of the effective date of cancellation, and (2) provide benefits of the Plan for Covered Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

H. TERMINATION OF BENEFITS

Benefits for Covered Services rendered after the effective date of cancellation shall not be provided, except as specifically provided under Extension of Benefits, PART IX.

PART IX - EXTENSION OF BENEFITS

A. EXTENSION OF BENEFITS

If the Enrollee becomes Totally Disabled while validly covered under this Contract and continues to be Totally Disabled on the date coverage terminates, the Plan will extend the benefits of this Contract, subject to all exclusions and limitations herein, for Covered Services directly related to the condition, illness, or injury causing such Total Disability until the first to occur of the following:

1. 12:01a.m. on the day following a period of twelve (12) months from the date coverage terminated;
2. the end of the period of Total Disability;
3. the date on which the Enrollee's applicable maximum benefits are reached;
4. the date on which a replacement carrier provides coverage to the Enrollee without limitation as to the Totally Disabling condition.

No extension will be granted unless the Plan receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) within thirty (30) calendar days of the date on which coverage was terminated hereunder, and thereafter at such reasonable intervals as determined by the Plan.

PART X – INDIVIDUAL CONTINUATION OF BENEFITS

The Enrollee should examine their options carefully before declining this coverage. The Enrollee should be aware that companies selling individual health insurance typically require a review of the Enrollee's medical history that could result in a higher premium or the Enrollee could be denied coverage entirely.

Applicable to Enrollee's when the Group is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (groups of 20 or more eligible employees) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA) (groups of 2 to 19 eligible employees). The Group should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), an Enrollee will be entitled to elect to continue group coverage under this Contract if the Enrollee would otherwise lose coverage because of a Qualifying Event that occurs while the Group is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Enrollee if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Enrollee will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Enrollee is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any Pre-existing condition. Under COBRA, an Enrollee will not be entitled to benefits if at the time of the qualifying event such Enrollee is entitled to Medicare.

A. QUALIFYING EVENT

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the subscriber:

   a) the termination of employment (other than by reason of gross misconduct);

   or

   b) the reduction of hours of employment to less than the number of hours required for eligibility.

2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the subscriber, or subscriber's Dependent spouse or Domestic Partner, during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Group is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

   a) the death of the subscriber; or

b) the termination of the subscriber's employment (other than by reason of such subscriber's gross misconduct); or

c) the reduction of the subscriber's hours of employment to less than the number of hours required for eligibility; or

d) the divorce or legal separation of the subscriber from the Dependent spouse or termination of the domestic partnership; or

e) the subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

f) a Dependent child's loss of Dependent status under the Contract.

*Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the subscriber elects to enroll.

3. For COBRA only, with respect to a subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Group's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

B. NOTIFICATION OF A QUALIFYING EVENT

1. With respect to COBRA enrollees:
The enrollee must notify the Group, in writing, of all qualifying events (divorce, legal separation, termination of a domestic partner or a child's loss of Dependent status) within 60 days of the date of the qualifying event. If the Enrollee fails to make the notification to the Group within the required 60 days, the Enrollee will be disqualified from receiving continuation coverage. The Enrollee must elect continuation coverage within the 60 days of either (1) the date that the Enrollee's coverage under the Contract terminated or will terminate by reason of a qualifying event, or (2) the date the Enrollee was sent the notice of the required benefit information, premium information, enrollment forms, and disclosures to allow the qualified beneficiary to formally elect continuation coverage, whichever is later.

The Group is responsible for notifying its COBRA administrator (or Plan administrator if the Group does not have a COBRA administrator) of the enrollee's death, termination, or reduction of hours of employment, the subscriber's Medicare entitlement or the Group's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Enrollee by first class mail of his or her right to continue group coverage under this Contract. The Enrollee must then notify the COBRA administrator within 60 days of the later of: (1) the date of the notice of the Enrollee's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Enrollee does not notify the COBRA administrator within 60 days, the Enrollee's coverage will terminate on the date the Enrollee would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA Enrollees:
   The Enrollee is responsible for notifying the Plan in writing of the Employee's/subscribers death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a child's loss of Dependent status under this Contract. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Contract because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Enrollee from receiving continuation coverage under Cal-COBRA.

   The Group is responsible for notifying the Plan in writing of termination or reduction of hours of employment within 30 days of the Qualifying Event.

   When the Plan is notified that a Qualifying Event has occurred, the Plan will, within 14 days, provide written notice to the Enrollee by first class mail of his or her right to continue group coverage under this Contract. The Enrollee must then give The Plan notice in writing of the Enrollee's election of continuation coverage within 60 days of the later of: (1) the date of the notice of the Enrollee's right to continue group coverage, and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to The Plan by first-class mail or other reliable means.

   If the Enrollee does not notify The Plan within 60 days, the Enrollee's coverage will terminate on the date the Enrollee would have lost coverage because of the Qualifying Event.

   If this Contract replaces a previous group plan that was in effect with the the Group's, and the Enrollee had elected Cal-COBRA continuation coverage under the previous plan, the Enrollee may choose to continue to be covered by this Contract for the balance of the period that the Enrollee could have continued to be covered under the previous plan, provided that the Enrollee notify the Plan within 30 days of receiving notice of the termination of the previous group plan.

C. DURATION OF CONTINUATION OF GROUP COVERAGE

Cal-COBRA Enrollees will be eligible to continue coverage under this Contract for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA Enrollees will be eligible to continue coverage under this Contract for 18, 29, or 36 months depending on the type of Qualifying Event. Contact your group for more information.

COBRA Enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Enrollee's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA Enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Enrollee to continue group coverage under this Contract.

D. NOTIFICATION REQUIREMENTS OF CAL-COBRA EXTENSION

The Group or its COBRA administrator is responsible for notifying COBRA Enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA Enrollee should contact The Plan for more information about continuing coverage. If the Enrollee elects to apply for continuation of coverage under Cal-COBRA, the Enrollee must notify the Plan at least 30 days before COBRA termination.

E. PAYMENT OF PREMIUMS

Premiums for the Enrollee continuing coverage shall be 102 percent of the applicable group premium rate if the Enrollee is a COBRA Enrollee, or 110 percent of the applicable group premiums rate if the Enrollee is a Cal-COBRA Enrollee, except for the Enrollee who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 shall be 150 percent of the applicable group premium rate.

Note: For COBRA Enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, premiums for Cal-COBRA coverage shall be 110 percent of the applicable group premiums rate for months 30 through 36.

If the Enrollee is enrolled in COBRA and is contributing to the cost of coverage, the Group shall be responsible for collecting and submitting all premium contributions to the Plan in the manner and for the period established under this Contract.

Cal-COBRA Enrollees must submit premiums directly to the Plan. The initial premiums must be paid within 45 days of the date the Enrollee provided written notification to the Plan of the election to continue coverage and be sent to the Plan through the MESVision website at (www.MES*Vision*.com) or by first-class mail or other reliable means. The premiums payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Enrollee from continuation coverage.

F. EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE

The continuation of coverage will begin on the date the Enrollee's coverage under this Contract would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as premiums are timely paid.

G. TERMINATION OF CONTINUATION OF GROUP COVERAGE

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this Group Vision Insurance Plan Contract (if the Group continues to provide any group vision plan for subscribers, the Enrollee may be able to continue coverage with the other plan);
2. failure to timely and fully pay the amount of required premiums as applicable. Coverage will end as of the end of the period for which premiums were paid;
3. the Enrollee becomes entitled to Medicare;
4. the Enrollee no longer resides in California;
5. the Enrollee commits fraud or deception in the use of the benefits of this Contract.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

H. NOTIFICATION REQUIREMENTS

The Plan must notify a qualified beneficiary during the 180 days prior to the expiration of continuation coverage of (1) the date continuation coverage will terminate and (2) the availability of any conversion coverage that is available.

PART XI - PREMIUMS

A. PREMIUMS: The monthly premiums for Employee and Dependents are shown below.

Composite ..... $**16.47**

B. PREMIUMS: WHEN AND WHERE PAYABLE

1. The initial premiums are due on the effective date of this Contract and Employee's premiums shall be due on the same date of each succeeding month (herein called the payment due date) thereafter.

2. Please send all premiums to the P.O. Box of Medical Eye Services, Inc. in Santa Ana, California or through the Plan's website at www.MES*Vision*.com. The payment of any premiums shall not maintain the benefits under this Contract in force beyond the date immediately preceding the next payment due date except as otherwise provided in PART XI, G. - Grace Period.

C. The terms of this Contract or the premiums payable therefore may be changed from time to time as set forth in GENERAL PROVISIONS, PART XII, M. - CHANGES: ENTIRE CONTRACT.

D. The Group shall remit to the Plan the amounts specified in Paragraph 1 above. These amounts are called the "Base Premiums". If a state or any other taxing authority imposes upon the Plan a tax or license fee which is levied upon or measured by the "Base Premiums" or by the gross receipts of the Plan or any portion of either, the Plan may amend the Contract with respect to premiums to increase the "Base Premiums" by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. Such change shall become effective as of the date stated in the notice, which shall not be earlier than the date of the imposition of such tax or license, by mailing a postage prepaid notice of the amendment to the Group at its address of record with the Plan at least thirty (30) days before the effective date of amendment.

E. If benefit amounts are changed during a Contract Month due to a change in the terms of this Contract or if a tax is levied under PART XI, D., the premiums charged therefore may be made, or the premiums credit therefore may be given, as of the effective date of the amendment.

F. Notice of changes in benefits, and any documents that may be delivered to the Group or the Group's representative for the purpose of informing Employees of the details of their coverage under this Contract, will be distributed by the Group or its representative no later than fifteen (15) days after receipt of such material.

G. Grace Period. A grace period of thirty (30) days will be granted for the payment of premiums accruing other than those due on the effective date of this Contract, during which period the Contract shall continue in force, but the Group shall be liable to the Plan for the payment of the premiums accruing for the period this Contract continues in force.

PART XII - GENERAL PROVISIONS

A. CHOICE OF PROVIDERS

An Enrollee may select any Participating Ophthalmologist, Optometrist or Optician to provide Covered Services hereunder by downloading the Plan's Participating Provider Directory from the Plan's website at www.MES*Vision*.com, or by calling the Plan's Customer Service Department.

B. CLERICAL ERROR

If the Group does not report an Enrollee who has qualified for benefits or for an increase in the amount of their benefits in compliance with the provisions of this Contract, the Enrollee will not be deprived of such benefits or increase. If the Group does not report any termination of benefits or decrease in amount of benefits on any Enrollee, the termination date or decrease in amount of benefits cannot be deferred beyond the date on which it should have occurred in accordance with the provisions of this Contract. In the event of such an error, a premium adjustment shall be made, as follows:

1. Such adjustment shall be retroactive to the date on which the Enrollee's benefits should have become effective, been discontinued or benefits changed in amount, except that in no event will the period for which any refund is made extend beyond the last prior contract anniversary.

2. Such adjustment shall be computed at premium rates applicable for the period of adjustment.

3. Such adjustment shall be applied to premiums for the contract year in which the adjustment is made.

4. Such adjustment shall be applied to premiums owed for the entire month in which services were last obtained.

C. TERMINATION OF ENROLLEE COVERAGE DUE TO INELIGIBILITY

Retroactive Dis-enrollment is not permitted. In the event that the Group determines an Enrollee was ineligible, after previously identifying such Enrollee as eligible, and the Enrollee has obtained

services during the ineligible time period, the Group shall remain liable to the Plan for either the Premium or any claims incurred as a result of the Group's late notification of cancellation to the Plan on account of such Enrollee.

D. RECORDS AND INFORMATION TO BE FURNISHED

The Group shall furnish the Plan with such information as the Plan may require to enable it to administer the benefits provided hereunder, to determine the premiums thereof, and to enable it to carry out the provisions of this Contract. All of the Group's records which have a bearing on the benefits provided hereunder shall be made available for inspection by the Plan when and so often as it may reasonably require, as permitted by law.

E. PAYMENT OF BENEFITS

A Claim Form is available on the Plan's website at www.MES*Vision*.com or at the Participating Provider's office and will be submitted directly to the Plan by the Participating Provider. Participating Providers (Ophthalmologists, Opticians and Optometrists under contract with the Plan) are reimbursed directly by the Plan and will accept payment by the Plan for Covered Services as ***payment in full***, except as noted in the Schedule of Allowances. If services are rendered by a Non-Participating Provider, the claims shall be submitted to the Plan by the Enrollee and payment will be made directly to the Enrollee in accordance with Non-Participating Provider Schedule of Allowances.
It is the Enrollee's responsibility to identify him/herself as having an MES vision plan. The Participating Provider is required to refund the amount the Enrollee paid, less any Copayments or payments for non-covered services, if the Enrollee later (after the date of service) identifies him/herself as an Enrollee of the Plan.

All claims for reimbursements must be submitted to the Plan within six (6) months after the date of service.

The Plan reserves the right to review all claims to determine whether any exclusions or limitations apply.

The Plan may use the services of physician consultants, peer review committees of professional societies and other consultants to evaluate claims.

F. LIMITATION OF LIABILITY

Every contract between the Plan and its Participating Providers stipulates that the Enrollee shall not be responsible to the Participating Provider for compensation with respect to any Covered Services to the extent that they are provided in this Contract. If an Enrollee is receiving Covered Services from a Participating Provider whose agreement with the Plan is terminated, the Enrollee's responsibility to that Provider for Covered Services rendered subsequent to that termination shall be no greater than it was for services rendered immediately prior to that termination date until the first of the following occurs:

1. the date that the Covered Services being rendered by such provider are completed;

2. the date the coverage for such Enrollee is terminated.

G. CONTINUATION OF SERVICES

Upon termination of a Participating Provider agreement, the Plan shall be liable for Covered Services rendered by the Participating Provider (other than for Copayments) to any Enrollee who retains eligibility under this Contract or by operation of law under the care of the Participating Provider at the time of such termination until the Covered Services being rendered to the Enrollee by the Participating Provider are completed, unless the Plan makes a reasonable and medically appropriate arrangement for the assumption of Covered Services by a Participating Provider.

H. GRIEVANCE PROCEDURE AND INDEPENDENT MEDICAL REVIEW

DEFINITIONS:

1. "Grievance" means a written or oral expression of dissatisfaction regarding MES and/or one of its providers, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

2. "Complaint" is the same as "grievance."

3. "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

4. "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the MES' grievance system, including entities with delegated authority.

GROUP RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION:

The Group shall be responsible for the distribution of the Enrollee Grievance Procedure (EGP) at least annually to Plan Enrollees in printed or electronic form. The Group may ensure electronic distribution of the EGP to Enrollees by one of the following methods: (1) by posting the EGP in a read-only format on an intranet site which is accessed by Enrollees of the Group (2) by emailing the EGP directly to Enrollees; or (3) by providing Enrollees with the Plan’s instructions for accessing the EGP from the Plan’s website.

ENROLLEE GRIEVANCE PROCEDURES (EGP):

1. The Plan will notify Enrollees if any services are denied, in whole or in part, stating the specific reasons for the denial based on the pertinent provisions of the Contract or the clinical reasons relating to medical necessity. Notice of the right to review and the procedure to follow under such circumstances will be included. After receipt of a notice of denial, the Enrollee may request a review of such denial by addressing the request to:

   Medical Eye Services
   Attention: Benefit Resolutions Department
   Post Office Box 25209
   Santa Ana, CA 92799-5209
   1-800-877-6372 714/619-4660

2. If the Enrollee wishes to file a grievance, grievance forms may be obtained from the Group, a Participating Provider's office, the Plan's Customer Service Department, or the Plan's website at (www.MES*Vision*.com). A grievance must be filed no later than one hundred-eighty (180) calendar days after the occurrence. A TDD line (1-877-735-2929) is also available for the hearing and speech impaired. Access to interpreters and translations to grievance procedures are available upon request. The Enrollee may contact the Plan's Customer Service Department for assistance in completing the grievance form. The Enrollee should file the form as soon as possible after the occurrence.

   Patients may obtain assistance from the Department of Managed Health Care (DMHC) and seek an Independent Medical Review (IMR) that is available in non-English languages through the Department's website. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

   Patient grievance forms and procedures in the Plan's threshold language(s) are readily available to enrollees and Participating Providers for distribution upon request. A grievance form and IMR form, in English and Spanish, may be completed and submitted directly online through the Medical Eye Services website at www.mesvision.com. Grievance forms may also be obtained from a Participating Provider's office, or by calling Medical Eye Services (MES) Customer Service Department at 1-800-877-6372.

3. The Plan's Benefit Resolutions Department will acknowledge receipt of the Enrollee's request within five (5) calendar days, and follow-up with a complete investigation. Grievances of all types will be reviewed fully and fairly. Attached to the acknowledgment letter is the Notice of Availability of Language Assistance Services advising enrollees how to access interpretation and translation services.

4. The Plan will send a grievance resolution letter within thirty (30) calendar days of receipt along with the Notice of Availability of Language Assistance Services. Record of all such grievances and a file will be maintained for a minimum of five (5) years in the MES office.

   The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone

your plan at (1-800-877-6372) and use the Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may e available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department has also a toll-free telephone number **(1-888-HMO-2219) and a TDD Line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website (http://hmohelp.ca.gov) has grievance forms, IMR application forms, and instructions online.

If the Enrollee receives a denial for requested medically necessary services after utilizing the Plan's grievance process, and the Enrollee believes that these services have been improperly denied, modified or delayed by the Plan or one of its Participating Providers, the Enrollee may request an independent medical review (IMR) of the disputed health care services from the Department. A disputed health care service is any health care service eligible for coverage and payment under the Contract that has been denied, modified or delayed by the Plan or one of its Participating Providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. The Enrollee pays no application or processing fees of any kind for IMR. The Enrollee has the right to provide information in support of the request for IMR. The Plan will provide you with an IMR application form with any grievance disposition letter that denies, modifies or delays medically necessary health care services. A decision not to participate in the IMR process may cause the Enrollee to forfeit any statutory right to pursue legal action against the Plan regarding disputed health care service.

The application for IMR will be reviewed by the Department of Managed Health Care to confirm that:

1. (a) The Participating Provider has recommended a health care service as medically necessary; or
   (b) The Enrollee has received urgent care or emergency services that a Participating Provider determined was medically necessary; or
   (c) The Enrollee has been seen by a Participating or Non-Participating Provider for the diagnosis or treatment of the medical condition for which he seeks independent review. The Provider recommending the disputed health care service may be a Non-Participating Provider, even when services rendered by out-of-plan providers are not covered by the Plan.

2. The disputed health care service has been denied, modified or delayed by the Plan or one of its Participating Providers based in whole or in part on a decision that the health care service is not medically necessary; and

3. The Enrollee has filed a grievance with the Plan or its Participating Provider and the

disputed decision is upheld or the grievance remains unresolved after thirty (30) calendar days. If the grievance requires expedited review, the Enrollee may bring it immediately to the Department's attention. The Department may waive the requirement that the Enrollee follow the Plan's grievance process in extraordinary and compelling cases.

The Enrollee must apply for IMR within 6 months of whichever occurs first: the disputed decision being upheld by the Plan or thirty (30) calendar days after the grievance is filed if no decision is reached within that 30-day period.

If the case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. The Enrollee will receive a copy of the assessment made in the case. If the IMR determines the service is medically necessary, the Plan will provide the health care service.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application and supporting documents. For urgent cases involving imminent and serious threat to the Enrollee's health including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the Enrollee's health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process, or to request an IMR application form, please call the Plan's Customer Service Department at **(800) 877-6372** or **(714) 619-4660**.

5. Health plans as well as vision plans are required by law to resolve, on an expedited basis, grievances involving an imminent and serious threat to the health of the Enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function and will consider the enrollee's medical condition when determining the response time. Although MES does not expect to receive grievances of this nature, since MES only covers services within the scope of routine vision care, MES will immediately inform the Enrollee in writing of their right to notify the Department of Management Health Care (DMHC) of the grievance. MES will provide the Enrollee and the DMHC with a written resolution letter or pending status of the expedited review within three (3) days from receipt of the grievance. Enrollees have a right to an interpreter. The Notice of Availability of Language Assistance Services provides instructions on how to access verbal interpretation services.

I. CUSTOMER SERVICE

If the Enrollee has any questions regarding services, a provider, the benefits or how to use the Plan, the Enrollee may utilize the Plan's website at www. MES*Vision*.com or contact the Plan's Customer Service Department at (800)-877-6372 or (714) 619-4660.

J. NON-ASSIGNABILITY

Coverage or any benefits of this Contract may not be assigned.

K. CLAIM SUBMISSION

All claims for reimbursement must be submitted to the Plan within six (6) months after the date of service.

L. NOT IN LIEU OF WORKERS' COMPENSATION INSURANCE

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

M. CHANGES: ENTIRE CONTRACT

The terms of this Contract or the premiums payable therefore may be changed upon renewal. We will not change the premium rates during the rate guarantee period following the effective date of this Contract. We will give the Group at least 30 days advance written notice of any change in premiums. These changes shall not become effective until at least [thirty (30)] days after written notice of such change is delivered or mailed to the Group's last address as shown on the records of the Plan. Benefits for Services furnished after the effective date of any benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless a written endorsement is issued and approved by an executive officer of the Plan. No other representatives have authority to change this Contract or to waive any of its provisions.

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes this entire Contract between the parties, and any statement made by the Group or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty.

N. TIME OF COMMENCEMENT OR TERMINATION

Wherever this Contract provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective as of 12:01 A.M. Pacific Time of that date.

O. LEGAL PROCESS

Legal process or service upon the Plan must be served upon a corporate officer of the Plan.

P. INQUIRIES AND COMPLAINTS

Inquiries concerning the administration of this Contract should be directed to the Business Development Unit of the Plan at the address or telephone number indicated on the face page of this Contract.

Q. STATUTORY REQUIREMENTS

This Contract is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and its implementing regulations as set forth in Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of such Codes shall be binding upon the Plan whether or not such provision is actually included in this Contract.

R. COMMENCEMENT OF LEGAL ACTION

Any suit or action to recover benefits under this Contract, or damages concerning the provision of coverage or benefits, the processing of claims, or any other matter arising out of this Contract, shall be commenced no later than two (2) years after the coverage for benefits in question were first denied, unless a shorter period of limitations otherwise applies.

S. PLAN INTERPRETATION

The Plan shall have the power and discretionary authority to construe and interpret the provision of this Contract, to determine the benefits of this Contract and determine eligibility to receive benefits under this Contract.

T. SERVICES FOR EMERGENCY CARE

The scope of this routine vision plan does not cover emergency services. However, Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have an emergency medical condition that requires an emergency response.

U. PUBLIC POLICY COMMITTEE

A Public Policy Committee has been created and procedures have been established to assure the comfort, dignity, and convenience of the Groups who rely on the Plan to arrange for the provision of Covered Services to their Enrollees and to the public. The Plan welcomes comments, suggestions and criticisms from consumers and Enrollees as to how the Plan, as a Knox-Keene Health Care Service Plan licensed entity, may improve service and satisfaction for its Enrollees.

Enrollees are polled each year by a questionnaire which asks their opinion as to:

- services provided
- facility impressions
- personnel attitudes
- the date last services were provided
- whether they would recommend the Plan
- any additional comments

The questionnaire is available on the Plan's website at www.MES*Vision*.com and, upon request, will be sent to all Groups for distribution to Enrollees and will be accompanied by a brief report on Public Policy Committee activities over the preceding year.

The Public Policy Committee is a standing committee of the Board. The committee consists of five (5) members, one of whom shall be a member of the Board of Directors, one of whom shall be a Participating Provider of the Plan who is not a member of the Board of Directors, and the balance shall be Enrollee representatives. None of the Enrollee representatives of the committee may be employees of the Plan or any of its Participating Providers. The Enrollee representatives of the committee shall be drawn from those Groups contracting directly with the Plan. Factors in the selection of individual members include ethnic extraction, demography, occupation and geography. The selection shall be conducted on a fair and reasonable basis.

The Enrollee representatives of the committee are approved by the Board of Directors of The Plan with due consideration to the foregoing factors and shall serve at the pleasure of the Board of Directors. Notwithstanding the foregoing the basic committee term is three years, except however, the initial Enrollee representatives of the Committee shall be divided at random to serve initial one-, two- and three-year terms.

The committee shall meet at least quarterly with meetings to be called with no more than sixty (60) and no less than ten (10) days' written notice from the Chairperson or Vice Chairperson of the committee. Notice of the meeting shall be accompanied by reports of the nature and volume of grievances received by the Plan, directly or through the Department of Managed Health Care, their disposition, pertinent financial information and other information from the corporation regarding public policy. The committee recommendations are reported to the Board of Directors for action at the Board's next meeting. The actions of the Board are recorded in the meeting minutes.

The Plan notifies Enrollees of procedures to encourage their participation in establishing public policy. Any material changes affecting the public policy relating to the Plan are communicated to Enrollees.

V. PRIVACY POLICY

THE PLAN'S "NOTICE OF PRIVACY PRACTICES" DESCRIBING THE PATIENT'S RIGHTS AND THE PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF RECORDS MAY BE DOWNLOADED FROM THE PLAN'S WEBSITE (WWW.MES*Vision*.COM) OR WILL BE FURNISHED TO YOU UPON REQUEST.

Medical Eye Services (the Plan) is committed to protecting and securing the confidentiality of all personal and health information of its Enrollees. All such information created, maintained, stored or disposed of shall be treated in a manner that preserves the confidentiality of the information contained therein. Any disclosure of patient information beyond the provisions of the law is prohibited. Patient information will not be released without the Enrollees' express written authorization, unless permitted by law, and will be used only for the purpose of processing vision claims in accordance with Group and carrier vision plan contracts.

Patients have the following rights with respect to their medical records: access and/or amend, request an accounting of disclosures, request a restriction on uses and disclosures, and request to receive confidential communications. The Plan maintains physical, administrative, and technical security measures to safeguard patient information. Please refer to the "Notice of Privacy Practices" located on the Plan's website at www.MES*Vision*.com for more information.

MEDICAL EYE SERVICES, INC.

XIII. PARTICIPATING PROVIDER SCHEDULE OF ALLOWANCES & MAXIMUM OUT-OF-POCKET

Benefits are provided for Covered Services described below, and are subject to all provisions, Copayments, Exclusions, and Limitations of this Contract. The Patient Maximum Out-of-Pocket may vary based on the provider type selected by the patient.

COVERED SERVICES & BENEFITS	PATIENT MAXIMUM OUT-OF-POCKET
Examination:	
Comprehensive examination	Covered in Full
Contact Lens Fitting & Evaluation[2]	$60.00
Lenses:	
Single Vision	Covered in Full
Bi-focal	Covered in Full
Tri-focal	Covered in Full
Standard Progressive	$30.00
Premium Progressive	$90.00
Polycarbonate for covered children up to age 19	
Single	Covered in Full
Bi-focal	Covered in Full
Tri-focal	Covered in Full
Polycarbonate for Adults	
Single	$10.00
Bi-focal	$25.00
Tri-focal	$30.00
Standard Progressive	$30.00
Premium Progressive	$30.00
Plastic Photochromic	
Single	$65.00
Bi-focal	$65.00
Tri-focal	$65.00
Standard Progressive	$65.00
Premium Progressive	$65.00
Polycarbonate/Plastic Photochromic	
Single	$75.00
Bi-focal	$90.00
Tri-focal	$95.00
Standard Progressive	$95.00
Premium Progressive	$95.00
Aphakic/Lenticular Single Vision	Covered in Full
Aphakic/Lenticular Multifocal	Covered in Full
7.25 diopters or more high powered lenses (per lens) [1]	Covered in Full
Prism – Up to 4 diopters (per lens) [1]	Covered in Full
Prism – 4 ½ to 10 diopters (per lens) [1]	Covered in Full
Slab-off Prism (per lens) [1]	Covered in Full

Coatings [1], [3]	
Scratch	Covered in Full
Ultraviolet	Covered in Full
Anti-reflective	
Basic	$20.00
Premium	$40.00
Tint [1], [3]	$20.00
Contact lenses [4]	
Non-Elective/Medically Necessary (One Pair)	Covered in Full
Elective/Cosmetic	$130.00
Frame [5]	
Selection up to retail amount of	$130.00

[1] These maximum out-of-pocket amounts are added to the lens maximum out-of-pocket amounts.

[2] A standard or premium fitting.

[3] For Groups with optional tint benefits, tints other than pink or rose #1 or #2 are paid according to the patient's benefit allowance. The balance of the charge for standard tints (any solid tint) exceeding the allowance is a provider fee adjustment. The balance of non-standard tints or coatings (such as gradient or double gradient and mirrored) is a patient responsibility.

[4] The contact lenses allowance is in lieu of other eyewear benefits. Any difference between the allowance and the provider's charge is a patient responsibility.

[5] The difference between the benefit amount and the charges for more expensive frames or unusual lenses, such as oversize, will be a patient responsibility. Some designer frames may be restricted by the manufacturer. The retail frame allowance is reduced 30%-35% at provider locations employing wholesale or ware house pricing. Please confirm this benefit before ordering eyewear. These providers are identified in the Provider Directory at www.MES*Vision*.com.

XIII. NON-PARTICIPATING PROVIDER SCHEDULE OF ALLOWANCES

If Covered Services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of the following Schedule of Allowances. Any difference between the allowance and the provider's charge is the patient's responsibility. Patient Maximum Out-of-Pocket limits do not apply when services are rendered by Non-Participating Providers.

		BENEFITS
Examination:		
Comprehensive examination		$40.00
Lenses:		
Single Vision		$30.00
Bi-focal		$50.00
Tri-focal		$65.00
High Power of 7.25 Diopters or more (per lens)		$0
Aphakic/Lenticular Monofocal		$125.00
Aphakic/Lenticular Multifocal		$125.00
Prism 1 ½ to 4 Diopters		$10.00
Prism > 4 Diopters		$16.00
Progressive	up to	$65.00
Polycarbonate for covered children up to age 19[1]		
Single	up to	$55.00
Bi-focal	up to	$55.00
Tri-focal	up to	$55.00
Contact Lenses[1]		
Non-Elective/Medically Necessary		$250.00
Elective/Cosmetic		$130.00
Frame[2]		
Selection up to retail amount of		$75.00

[2] The contact lens allowance is in lieu of other eyewear benefits. The Plan will pay up to the benefit amount toward the contact lens evaluation, fitting costs and materials. Any difference between the allowance and the provider's charge is the responsibility of the enrollee.

[2] The difference between the benefit amount and the charges for more expensive frames or unusual lenses, such as oversize, will be the responsibility of the Enrollee. Some designer frames may be restricted by the manufacturer.

Please refer to the website at www.mesvision.com for benefit eligibility and claim history information.