Client Vision Care Plan

vsp vision care

Client Name: **LEIDOS HOLDINGS INC.**
Client Number: **12180678**
Effective Date: **JANUARY 1, 2026**

EVIDENCE OF COVERAGE

Provided by:

VSP VISION CARE, INC.
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

VSP VISION CARE, INC., is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. If an Open Access Provider agrees to submit a claim to VSP on behalf of Covered Person, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Written notice of claim must be given to VSP within 20 days after the occurrence or commencement of a loss covered by this Policy, or as soon after the loss as is reasonably possible. Notice given by or on behalf of the Covered Person or the beneficiary to VSP at Claims Processing P. O. Box 385018, Birmingham, AL 35238-5018 or to any authorized agent of VSP, with information sufficient to identify the Covered Person, is considered notice to VSP.

CLAIM FORMS

You may obtain a claim form on vsp.com or call (800) 877-7195 to request a hard copy. VSP will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If the forms are not furnished within ten working days after such request, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

PROOF OF LOSS

For reimbursement of any loss under this Policy, proof of loss must be provided to VSP at vsp.com or at the address stated below no more than three hundred sixty-five (365) calendar days after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise requried, except in the event of legal incapacity.

To provide proof of loss, submit a claim form, along with copies of any invoices or receipts received from the doctor for the services or materials, to VSP for reimbursement. You may obtain a claim form on vsp.com or by calling (800) 877-7195. Claim forms may be submitted at vsp.com or at the address below:

VSP
Attn: Claims Processing
P. O. Box 385018
Birmingham, AL 35238-5018

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

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

COORDINATION OF BENEFITS

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

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain plan Benefits by contacting a VSP PREFERRED Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP PREFERRED Provider, other than those sums not covered by the plan.

COMPLAINTS AND GRIEVANCES

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

NOTICE: If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance at P.O. Box 1157, Richmond, Virginia 23218, (877)310-6560, ombudsman@scc.virginia.gov .

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days. If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

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

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to VSP must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state and federal laws and regulations. VSP's communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies:

When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

External Review: VSP is regulated by the Department of Insurance and Financial Services. If Covered Person has a grievance against VSP, they should telephone VSP at (800) 877-7195 and use VSP's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to Covered Person. Covered Person has the right to file a request for an external review of an adverse determination or claim denial. Covered Person has 127 days after receiving an adverse determination to request an external review. When filing a request for an external review, Covered Person will be required to authorize the release of any medical records that may be required to be reviewed to reach a decision on the external review. Covered Person may request an external review of adverse determination or claim denial in writing at the address included below:

DIFS Contact Info:
Department of Insurance and Financial Services
Office of General Counsel – Appeals Section (by mail)
P.O. Box 30220 Lansing, MI 48909-7720 (by courier/delivery)
530 W. Allegan Street, 7th Floor Lansing MI 48933
E-mail: DIFS-HealthAppeal@michigan.gov
Online Portal: https://difs.state.mi.us/Complaints/ExternalReview.aspx
Phone: (877)-999-6442

Legal Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. A Covered Person must not bring an action at law or in equity after the expiration of 3 years after the time written proof of loss is required to be furnished.

INDIVIDUAL CONTINUATION OF BENEFITS

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

VSP
3333 Quality Drive,
Rancho Cordova, CA 95670
(800) 852-7600

If you have been unable to contact or obtain satisfaction from VSP or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia State Corporation Commission's Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218-1157
(800) 552-7945
(804) 371-9691
(877) 310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

CONTINUATION OF BENEFITS FOR ENROLLEES

There are 2 options available to Client that provide for the continuation of benefits for Enrollees:

Option 1: If an Enrollee's coverage under this Policy ceases because of the termination of the Enrollee's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits, unless such termination is due to termination of the this Policy under circumstances in which the Enrollee is insurable under other replacement group coverage without waiting periods and preexisting conditions, VSP will issue, without evidence of insurability, an individual insurance policy in the event VSP offers such policy. If Client elects option 1, the following requirements apply:

(a) The application for the individual policy shall be made, and the first premium paid to the VSP within thirty-one days after issuance of the written notice, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
(b) The premium on the individual policy shall be at VSP's then customary rate applicable: to such policies and to the class of risk to which the person then belongs.
(c) The individual policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;
(d) The benefits under the individual policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;
(e) The policy shall extend coverage to the same family members that were insured under this Policy; and
(f) Coverage under this option shall be effected in such a way as to result in continuous coverage from the date of

the Enrollee's termination of eligibility for such insured if requested and paid for by the Enrollee.

Option 2: If a Enrollee's coverage under this Policy ceases because of the termination of the Enrollee's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits Enrollee shall continue his or her present

coverage under this Policy for a period of twelve (12) months immediately following the date of the termination of the person's eligibility, without evidence of insurability. (Option 2 is not available if Client is required by federal law to provide continuation of coverage pursuant to COBRA.) If Client elects option 2, the following requirements apply:

(a) The application and payment for the extended coverage is made to Client within 31 days after issuance of written notice, but in no event beyond the 60 day period following the date of the termination of Enrollee's eligibility;
(b) Each premium for such extended coverage is timely paid to the Client on a monthly basis during the twelve-month period;
(c) The premium for continuing the group coverage shall be at VSP's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate; and
(d) Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.
(e) The Client shall provide each employee or other Enrollee under such a policy written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation or conversion of the group policy. Such notice shall be provided within 14 days of Client's knowledge of the employee's or other Enrollee's loss of eligibility under the policy.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP VISION CARE, INC.
VSP Choice Plan®
BASE

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

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

Lens Options, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

Retinal Screening- Covered in full[1] once every 12 months**

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

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

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 12 months**.

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

1. Less $10 Copayment.
*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

CONTACT LENSES

ELECTIVE

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

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

COPAYMENT

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

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Up to $ 30.00-100.00* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 12 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP VISION CARE, INC.
VSP Choice Plan®
0024 (LRJT BASE)

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

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

Lens Options, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

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

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 12 months**.

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE

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

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

COPAYMENT

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

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Up to $ 30.00-100.00* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 12 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP VISION CARE, INC.
VSP Choice Plan®
PLUS

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

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

Lens Options, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

Retinal Screening- Covered in full[1] once every 12 months**

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

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

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 12 months**.

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

1. Less $10 Copayment.
*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

CONTACT LENSES

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

Elective Contact Lenses (materials only) are covered up to $200.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

FRAMES: An Additional Allowance of $100.00 once every 12 months**

OR

LENS ENHANCEMENT
Premium and Custom Progressive lenses: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT
Photochromic: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT
Anti-reflective coating: Covered in full once every 12 months**.

OR

CONTACT LENSES

ELECTIVE: An Additional Allowance of $100.00 once every 12 months.**

*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

COPAYMENT

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

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Up to $ 30.00-100.00* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 12 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

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

EXHIBIT A

SCHEDULE OF BENEFITS
VSP VISION CARE, INC.
VSP Choice Plan®
1024 (LRJT PLUS)

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

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

Lens Options, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

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

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 12 months**.

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

CONTACT LENSES

ELECTIVE

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

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

FRAMES: An Additional Allowance of $ 100.00 once every 12 months**

OR

LENS ENHANCEMENT
Premium and Custom Progressive lenses: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT
Photochromic: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT
Anti-reflective coating: Covered in full once every 12 months**.

OR

CONTACT LENSES

ELECTIVE: An Additional Allowance of $100.00 once every 12 months.**

*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

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

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at

the normal intervals when Plan Benefits are otherwise available.

5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

COPAYMENT

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

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Up to $ 30.00-100.00* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 12 months**

Frame allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services

rendered by Open Access Providers.

2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider or an Affiliate Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
VSP VISION CARE, INC.
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE
BASE & PLUS

GENERAL

The Rider lists additional vision care benefits to which Covered Persons of VSP VISION CARE, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, child of a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

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

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

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

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

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

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

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

1. Covered Person contacts VSP Preferred Provider and makes an appointment.

2. Covered Person pays any applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS - VSP PREFERRED PROVIDERS
COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

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

VSP VISION CARE, INC.
ADDITIONAL BENEFIT RIDER
Laser VisionCare® Preferred Plan
BASE & PLUS

GENERAL

This Rider lists the vision care services to which Covered Persons VSP VISION CARE, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated and forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to elgibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic partner of Enrollee
- Any child of Enrollee including a natural child, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

Current guidelines published by the Federal Drug Administration (FDA) may affect Covered Person's eligibility. Also, some Laser VisionCare facilities have established their own eligibility policies regarding laser surgery candidates. Covered Persons should confirm with their VSP LaserVision Care Doctor whether these additional eligibility criteria will apply.

Procedure for obtaining Laser VisionCare Preferred ("LVC") Plan Benefits

Complimentary Screening

A Covered Person considering laser vision correction should first consult a VSP Laser VisionCare Doctor to determine whether Covered Person is a viable candidate for such surgery. Minimum services required include determination of refractive error with a brief discussion about the surgery.

Pre-Operative Exam†

If the VSP Laser VisionCare Doctor determines that Covered Person is a viable candidate and would like to pursue laser vision correction surgery, he/she will perform a comprehensive pre-operative exam including dilation and corneal topography and forward the results to the VSP-contracted laser vision center with which VSP Laser VisionCare Doctor is affiliated.

Consultation†

The VSP-contracted laser vision center will conduct an additional consultation to further evaluate refractive errors, and will confirm Covered Person's benefit eligibility.

Surgery

A participating surgeon affiliated with the VSP-contracted laser vision center will perform the surgical procedure best suited for Covered Person's needs, subject to the conditions stated under Plan Benefits.

Post-Operative Care†

After completion of the surgery, Covered Person will return to the VSP Laser VisionCare Doctor for post-operative care and continued eye health management.

†Depending upon the availability of providers in certain geographical areas, pre- and post-operative care may be provided by professional staff of the center performing the surgery. Covered Person may contact VSP's Customer Care Division for additional information and assistance in locating a participating VSP-contracted laser vision center.

PLAN BENEFITS
VSP LASER VISIONCARE DOCTORS

COPAYMENT

There is no Copayment for LVC services.

COVERED SERVICES

The LVC Plan pays for the following services as part of a combined benefit of up to $100 per eye, payable once per Covered Person per lifetime. Benefits for these services are not payable separately except as indicated.*

- Consultation
- Preoperative ophthalmic exam*
- LASIK, Custom LASIK, Custom PRK, PRK Surgery or All Laser LASIK
- Postoperative care, including an ophthalmic exam and Enhancement Surgery (if required)

*If a Covered Person obtains a pre-operative exam, the cost of the comprehensive pre-operative exam is included in the global surgery fee; however, if the patient does not proceed with the surgery for any reason, the doctor may charge the patient 75% of the usual and customary fees for the exam, not to exceed $100. If the Covered Person is part of the Preferred Program, the exam may be covered in full on their base plan if the patient is eligible. Other claims for exam only services are filed by the facility on behalf of the doctor and if the patient decides to have the surgery performed at a later date, the benefit available will be reduced by the amount paid for the preoperative exam.

DEFINITIONS

CustomLASIK is performed after the flap is made. With CustomLASIK, a customized map is created for each individual eye. This data allows for treatment on tiny imperfections in the eye that can have a significant impact on one's quality of vision. Digital technology identifies and measures imperfections 25 times more precisely than Conventional LASIK.

Enhancement Surgery: One or more surgical procedures performed after covered Laser Vision Correction Surgery for the purpose of making minor adjustments to a patient's visual acuity.

Laser Vision Correction Surgery: Surgical procedures, such as Laser In Situ Keratomileusis or Photorefractive Keratectomy, used to correct vision problems such as nearsightedness, farsightedness or astigmatism, and which are covered under the LVC Plan.

Conventional LASIK (LASIK): After the flap is made; Conventional LASIK uses a cool beam of light from the excimer laser to gently reshape the front surface (cornea) of the eye.

Photorefractive Keratectomy (PRK) Laser Refractive Surgery: Like LASIK, PRK utilizes the excimer laser to reshape the curvature of the eye and treats nearsightedness, farsightedness and astigmatism. PRK differs from LASIK as it is performed on the surface of the eye and no flap is created during the procedure. Most patients will benefit from Custom PRK, which provides your surgeon an additional level of data about your vision requirements using customized wavefront technology.

All-laser LASIK: An advanced form of LASIK eye surgery that uses two separate lasers — a femtosecond laser for the first step of the procedure (creating the corneal flap) and an excimer laser to reshape the underlying corneal tissue and improve vision.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

1. Services not specifically included in this Rider as covered Plan Benefits.
2. Prescription drugs or other medications
3. Laser vision correction procedures other than PRK, Custom PRK, PRK, Custom LASIK, Conventional LASIK or All Laser LASIK.,
4. Surgical or pathological treatment of the eye, except as specified under Plan Benefits.
5. Inpatient hospital and anesthesia costs for Covered Services not able to be provided on an outpatient basis.
6. Frames, spectacle lenses, contact lenses or other materials of any kind.
7. Plano Lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power).
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **LEIDOS HOLDINGS INC.**
Group ID: **12180678**
Effective Date: **JANUARY 1, 2026**

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

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $70.00 SV Lenses reimbursed up to $30.00 Bi-Focal Lenses reimbursed up to $50.00 Tri-Focal Lenses reimbursed up to $65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees	$20.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first day of the Benefit Period.

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