

# Client Vision Care Plan



Vision Care for Life

**Client Name:** LEIDOS HOLDINGS INC.  
**Client Number:** 12180678  
**Effective Date:** JANUARY 1, 2021

## 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

**Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.**

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

**This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.**

#### **ELIGIBILITY FOR COVERAGE**

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

## **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. 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. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

## **TO OBTAIN FURTHER INFORMATION**

Contact VSP at 800-877-7195 or [www.vsp.com](http://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](http://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](mailto: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.

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

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

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

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

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

## **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:

<b>ADDITIONAL BENEFIT RIDER</b>	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.
<b>ASSIGNMENT OF BENEFITS</b>	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.
<b>CLIENT</b>	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.
<b>COORDINATION OF BENEFITS</b>	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
<b>COPAYMENTS</b>	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.
<b>COVERED PERSON</b>	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.
<b>ENROLLEE</b>	An employee or member of Client who meets the criteria for eligibility established by Client.
<b>PLAN OR PLAN BENEFITS</b>	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).
<b>OPEN ACCESS PROVIDER</b>	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.
<b>PLAN ADMINISTRATOR</b>	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.
<b>POLICY</b>	The contract between VSP and Client upon which this Plan is based.
<b>SCHEDULE OF BENEFITS</b>	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.
<b>VSP PREFERRED PROVIDER</b>	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.
<b>URGENT CARE</b>	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 Choice Plan® Basic**

#### **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
- 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.

## **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\*\***

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.

## **CONTACT LENSES**

### **ELECTIVE**

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

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

### **NECESSARY**

Necessary Contact Lenses are covered 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**

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter), except as specifically allowed under the SunCare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- 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.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

**REIMBURSEMENT SCHEDULE  
OPEN ACCESS PROVIDERS**

**COPAYMENT**

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

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

**SPECTACLE LENSES**

Single Vision Up to \$ 30.00\* once every 12 months\*\*  
Bifocal Up to \$ 50.00\* once every 12 months\*\*  
Trifocal Up to \$ 65.00\* once every 12 months\*\*  
Lenticular Up to \$100.00\* once every 12 months\*\*

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

**CONTACT LENSES**

**Elective**

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

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

**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 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.

## **OPEN ACCESS PROVIDERS**

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

## **EXHIBIT A**

### **SCHEDULE OF BENEFITS 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
- 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.



## **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\*\***

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 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.

## **CONTACT LENSES**

### **ELECTIVE**

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

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

### **NECESSARY**

Necessary Contact Lenses are covered 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**

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter), except as specifically allowed under the SunCare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- 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.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

**REIMBURSEMENT SCHEDULE  
OPEN ACCESS PROVIDERS**

**COPAYMENT**

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

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

**SPECTACLE LENSES**

Single Vision Up to \$ 30.00\* once every 12 months\*\*

Bifocal Up to \$ 50.00\* once every 12 months\*\*

Trifocal Up to \$ 65.00\* once every 12 months\*\*

Lenticular Up to \$100.00\* once every 12 months\*\*

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

**CONTACT LENSES**

**Elective**

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

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

**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 VSP Preferred Provider.

### **OPEN ACCESS PROVIDERS**

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

## EXHIBIT C

### VSP VISION CARE, INC. ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

#### GENERAL

This 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 or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

#### ELIGIBILITY

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

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

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

#### PROGRAM DESCRIPTION

The Diabetic Eyecare Program ("DEP") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- "floating" spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema
- age-related macular degeneration
- glaucoma



## **PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES**

### **COVERED PERSON HAS A GROUP MEDICAL PLAN**

The DEP Plus Program 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 how to obtain plan benefits.

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

### **COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN**

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Preferred Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

## **REFERRALS**

If Covered Person's VSP Preferred Provider cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.**

**PLAN BENEFITS  
VSP PREFERRED PROVIDER**

**COVERED SERVICES**

**Eye Examination:** Covered in full after a Copayment of \$20.00.

**Special Ophthalmological Services:** Covered in Full.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

**NOT COVERED**

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

## DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, “straight ahead” central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

## EXHIBIT C

### LASER VISIONCARE<sup>SM</sup> PREFERRED PROGRAM SCHEDULE OF BENEFITS

#### VSP VISION CARE, INC.

Covered Persons who meet the eligibility requirements outlined under Eligibility herein are entitled to the following laser vision correction benefits, subject to the conditions, limitations and exclusions as stated herein.

#### DEFINITIONS

**Primary Eye Care Doctor:** A VSP participating doctor who performs consultation, preoperative examinations and postoperative examinations. Laser Vision Correction Primary Eye Care Doctors are doctors with special training in the co-management of laser vision correction patients.

**Laser In Situ Keratomileusis (LASIK):** A procedure performed with a laser light beam during which a small, thin flap is made on the cornea allowing the laser to reshape the exposed corneal tissue.

**Participating Laser Vision Correction (LVC) Facilities:** Facilities that have contracted with VSP to provide Laser Vision Correction services to Covered Persons in coordination with Participating Surgeons.

**Participating Surgeon:** A VSP participating provider who is licensed as a doctor of Ophthalmology in the State in which he/she practices and who is contracted with VSP to perform surgical and advanced eye care, including Laser Vision Correction services.

**Photorefractive Keratectomy (PRK) Laser Refractive Surgery:** A procedure to correct nearsightedness which is performed with an excimer laser using a laser light beam to reshape the surface of the cornea.

**Laser Vision Correction Surgery:** The surgical procedures used to correct vision problems (such as nearsightedness, farsightedness, and astigmatism) covered under this Plan and provided by a coordinated network of Primary Eye Care Doctors, Participating Surgeons and Participating LVC Facilities.

**Custom LASIK:** A type of technology used in LASIK surgery, also called wavefront-guided LASIK. This wavefront technology measures the eye from front to back to create a three-dimensional corneal map. This measurement then guides the laser to reshape the cornea.

#### ELIGIBILITY

Benefits are available to Employees and their Eligible Dependents. Only one Laser Vision Correction Surgery per eye per lifetime is covered.

#### COVERED SERVICES

Laser Vision Correction Surgery is used to correct vision problems such as nearsightedness, farsightedness, and astigmatism. Covered Persons are entitled to the following Laser Vision Correction benefits when obtained from VSP Primary Eye Care Doctors, Participating Surgeons and Participating LVC Facilities, subject to the payment responsibility of Covered Persons as noted in the second column:

##### Covered Service

Initial consultation

Preoperative Exams

##### Covered Person Benefit

No cost

No cost\*

PRK, LASIK, or Custom LASIK Surgery	\$100.00 per-eye allowance**
Postoperative examinations	No cost (included in surgery fee)
Enhancement surgery	No cost

(Only covered if needed and if performed within the time period specified by the Participating Laser Vision Correction Facility)

\* If a Covered Person obtains initial consultation services and/or preoperative exams, but surgery is not indicated or performed, this Plan will cover the costs of one such round of preoperative services. Such costs will not count towards a Covered Person's benefit allowance for laser vision correction surgery, which may be obtained at a later date.

\*\* This plan provides an allowance of \$100.00 per eye (up to a \$200 lifetime maximum) to be paid towards the above Laser Vision Correction Surgery services. VSP has contracted with the Participating Laser Vision Correction Facilities to provide discounts to VSP members. The discounted price will not exceed \$1800 per eye for LASIK, \$1500 per eye for PRK, and \$2300 per eye for Custom LASIK. In the event that a Covered Person receives Laser Vision Correction services on one eye only, any remaining balance may not be applied towards the cost of surgery in the second eye.

## HOW DOES THE PLAN WORK?

STEP ONE: Call VSP's Customer Service Department at (800) 877-7195 to locate a Primary Eye Care Doctor and identify yourself as a Covered Person. Your VSP participating doctor may be a Laser Vision Correction Primary Eye Care Doctor. When you call Customer Service, you may verify your doctor's participation.

STEP TWO: Call a Laser Vision Correction Primary Eye Care Doctor and identify yourself as a Covered Person. Tell the doctor that you are using the Laser VisionCare benefit. The doctor will need your identification number (usually Social Security Number) and your group name.

STEP THREE: The doctor will perform an examination to determine if you are a candidate for Laser Vision Correction Surgery and discuss the benefits, risks and alternatives to surgery. If you wear contact lenses, you may need to see the Co-Manager several times before you are ready for surgery, to ensure your vision is stable. If you are a candidate for Laser Vision Correction Surgery, the Co-Manager will refer you to a Participating LVC Surgeon/Facility.

STEP FOUR: Make an appointment with the VSP Participating LVC Surgeon/Facility. Your doctor may schedule this appointment for you. This appointment is usually at a Participating LVC Facility. The Participating Surgeon will:

- Discuss the procedure and answer any questions
- Have you review and sign the informed consent documentation?
- Perform the surgery

Prior to the surgery, the Participating LVC Facility will collect your share of the surgery fee.

STEP FIVE: Post-surgical care will be coordinated by your Primary Eye Care Doctor and Participating Surgeon. You will likely visit the doctor several times after the surgery to ensure your eyes heal properly.

### **WHAT IF I USE A NON-PARTICIPATING DOCTOR?**

VSP's Participating Primary Eye Care Doctors, Surgeons and LVC Facilities provide Covered Persons with quality laser vision correction services at competitive fees. By using participating doctors, you can be assured you are receiving the highest quality care.

You may obtain Laser Vision Correction Surgery services from Non-Member Providers and will receive an allowance of \$100.00 per eye towards the surgery and any associated pre-and post-operative services.

THERE IS NO ASSURANCE THAT THE NON-MEMBER PROVIDER ALLOWANCE WILL BE SUFFICIENT TO PAY FOR THE ENTIRE COST OF SERVICES. FEES FOR LASER VISION CORRECTION SERVICES RECEIVED FROM NON-MEMBER PROVIDERS ARE NOT SUBJECT TO A NEGOTIATED DISCOUNT. ANY COSTS ABOVE THE NON-MEMBER PROVIDER ALLOWANCE ARE NOT NEGOTIATED BY VSP AND ARE THE RESPONSIBILITY OF THE MEMBER.

The Covered Person should pay the Non-Member Provider's full fee and request a copy of the bill and surgery report. Send a copy of the itemized bill(s) to VSP. Include the following information:

- Name and mailing address
- Identification number (typically Social Security number)
- Your Employer
- Please write "PRK", "LASIK", or "Custom LASIK" on all receipts.

The above information should be submitted to VSP along with a CMS-1500 form or any generic insurance claim form that may be available from the Non-Member Provider. Mail the information to:

Vision Service Plan  
P.O. Box 997105  
Sacramento, CA 95899-7105

VSP will reimburse the Covered Person up to the Non-Member Provider Allowance amount for services received. Laser Vision Correction Surgery benefits obtained from a Non-Member Provider are subject to the same limitations as described below.

## EXCLUSIONS AND LIMITATIONS

### Limitations:

Covered Laser Vision Correction Surgery benefits are available to Covered Persons, once per eye per lifetime. Covered Persons are financially responsible for the costs of any additional professional and/or facility services received.

### Exclusions:

The following services and/or supplies are not covered under your Laser Vision Correction benefits:

1. Forms of laser vision correction surgery other than PRK, LASIK, and Custom LASIK, including but not limited to Radial Keratotomy.
2. Prescription drugs.
3. Orthoptics or vision training and any associated supplemental testing.
4. Prescription glasses or contact lenses are not covered under this plan. Covered Persons may be eligible for routine vision materials under another VSP vision plan.
5. Pathological treatment.
6. Inpatient hospital and anesthesia costs for covered services not able to be provided on an outpatient basis.
7. Services provided by providers who are not contracted Primary Eye Care Doctors, Participating Surgeons or Participating LVC Facilities, except as provided above.
8. Services not indicated as covered Plan Benefits on this Summary of Benefits.



## ADDENDUM

### VSP VISION CARE, INC. PERFORMANCE STANDARDS

VSP guarantees the performance standards outlined herein by offering to pay a financial penalty of 1% of quarterly administrative revenue per unmet standard, up to a total annual maximum of \$100,000 and a minimum annual threshold of \$250. VSP's company-wide quarterly performance results shall be used in determining whether any or all of the performance standards have been met. Any penalties owed shall be accrued quarterly and paid on an annual basis, as long as the cumulative total for the four quarters exceeds \$250. Cumulative annual penalties less than \$250 will not be carried over into the following calendar year for purposes of determining financial penalties. Payment of penalties shall be conditioned on VSP's receipt of all premiums due to VSP within established due dates.

VSP's performance hereunder is subject to interruption and delay due to causes beyond VSP's reasonable control such as acts of God, act of any government, war or other hostility, the elements, fire, explosion, power failure, equipment failure, industrial or labor dispute. In the event of any such interruption or delay, any period of performance shall be extended for a period of time equal to the interruption or delay.

#### CLAIMS PROCESSING

##### Claims financial accuracy

Performance Standard = 99% processed without financial error

Performance Penalty = 1%

Claims financial accuracy is calculated much like that of claims processing accuracy. The same random sampling of claims audited for processing accuracy is also audited for financial accuracy. Any error found that results in a financial impact is recorded as a financial error. At the end of the month, financial errors are totaled and taken as a percentage of the total dollar paid for all claims audited during the given month.

##### Claims processing accuracy

Performance Standard = 99% processed without error

Performance Penalty = 1%

Claims processing accuracy is calculated on a monthly basis based upon daily audit results. The term "processing error" encompasses all errors found in the audit regardless of whether the error caused a financial impact. At month's end, all processing errors for the month are totaled and taken as a percentage of the total number of claims audited for the month.

##### Claims timeliness

###### Performance Standard:

VSP preferred provider claims = 95% processed within 5 business days

###### Performance Penalty = 1%

All other provider claims = 95% processed within 5 business days

###### Performance Penalty = 1%

All other provider claims = 99% processed within 15 business days

**Performance Penalty = 1%**

**Claims timeliness, or turnaround time, is measured on a monthly basis. Each claim audited in the daily audit is audited for timeliness. Timeliness is measured by calculating the number of business days elapsing between the received date and the pricing date. When additional information is needed to process a claim, the timeliness date is calculated from the date the information needed to process the claim was received to the pricing date.**

#### **CALL CENTER MANAGEMENT**

##### **Abandoned call rate**

**Performance Standard = Less than or equal to 3%**

**Performance Penalty = 1%**

**The Call Center telephone abandon rate is calculated monthly by taking the total number of abandoned calls before and after sixty (60) seconds, divided by the total number of calls accepted by the Call Center, which includes calls answered via the Interactive Voice Response and Automated Call Distribution systems.**

**Average speed of answer**

**Performance Standard = Less than or equal to 25 Seconds**

**Performance Penalty = 1%**

The average speed of answer (the amount of time a caller is waiting while on hold) is calculated by dividing the total time all calls are on hold (in seconds) by the total number of calls received.

**Average call blockage rate**

**Performance Standard = Less than or equal to 2%**

**Performance Penalty = 1%**

VSP call blockage is defined as any call blocked by VSP. A blocked call results in the caller receiving a "busy" signal, and is considered unsuccessful. VSP call blockage does not include calls blocked by the long distance carrier due to circumstances beyond VSP's control. VSP call blockage standard is 2% or less of total calls attempted to VSP. The formula for this standard is: number of blocked calls divided by (blocked calls plus accepted calls) as reported by the long distance carrier.

**Call resolution (same day response)**

**Performance Standard = 98%**

**Performance Penalty = 1%**

Measurement based on internal VSP system-driven statistics. The percentage of telephone inquiries handled within the same day is obtained by taking the number of research inquiries entered into our system and dividing by the number of calls answered in the Call Center, and subtracting the result from 1.00.

**Complaint acknowledgement within 5 business days**

**Performance Standard = 96%**

**Performance Penalty = 1%**

"Telephone complaints" not resolved by the end of the following business day must be acknowledged in writing within 5 by business days. "Written complaints" not resolved within 5 business days will be acknowledged in writing on the 5th business day from receipt. Complaint acknowledgement compliancy is calculated monthly. The method for calculating the percentage is: total number of complaints meeting the 5 business day goal divided by total number of complaints.

**Complaint resolution within 30 calendar days**

**Performance Standard = 99%**

**Performance Penalty = 1%**

When a complaint is received, in writing or via phone, the person receiving it documents it in our online Research Inquiry system. The Complaint and Grievance unit monitors this workflow to assure all complaints have been resolved by the 30<sup>th</sup> calendar day.

**Average response to e-mail inquiries within 2 business days**

**Performance Standard = 100%**

**Performance Penalty = 1%**

The average time required to send the first manual reply to an email, in the specified time period.

## SATISFACTION

### **Patient satisfaction (satisfied with level of coverage)**

**Performance Standard = 96% overall satisfaction with VSP**

**Performance Penalty = 1%**

**Performance Standard = 96% overall experience with VSP preferred provider**

**Performance Penalty = 1%**

VSP conducts patient satisfaction surveys on a quarterly basis. A random sample of claims from the prior three months is chosen that is statistically representative of all claims.

While VSP makes recommendations to all prospective Groups on which plan we feel best suits the group's employees, the ultimate decision for selection of a plan rests with the Group. As such, our performance standard is based on patients who are satisfied with the level of coverage provided by their plan. Satisfied patients includes patients who rated their overall level of coverage as "Excellent," "Very Good" and "Good". Dissatisfied patients include patients who rated their overall level of coverage as "Fair" or "Poor".

**VSP preferred provider retention rate (based on voluntary turnover)**

**Performance Standard = 98%**

**Performance Penalty = 1%**

VSP preferred provider satisfaction is based on changes in the VSP preferred provider network. On a quarterly basis, the voluntary retention rate of providers (those choosing to stay on the VSP panel) is measured as a percentage of the total number of providers in the network. The annual preferred provider retention rate is equal to the total number of providers on the panel on December 31 divided by the total number of providers on the panel January 1 of that same year.

## ACCOUNT ADMINISTRATION

### **Electronic eligibility online within 24 hours**

**Performance Standard = 98%**

**Performance Penalty = 1%**

Percentage reported based on a measurement against all maintenance files\* loaded within that quarter. VSP records both the received and loaded dates for all membership files. The data is compiled into a monthly report, which is used to calculate the quarterly statistical average.

\*All files measured for this standard must meet the following criteria:

- Identifiable Media: Eligibility file must be labeled properly.
- Proper Format: No change in format from the previously loaded eligibility file.
- Clean File:
  - 1) Physical Media must be undamaged.
  - 2) Electronic Media must have clean and complete data transmission. We must be able to successfully unzip/decrypt the incoming data.
  - 3) All media must contain proper/complete records for members and dependents.

Exclusions to this performance standard are as follows:

- 1) Membership files for open enrollment loaded prior to effective date.
- 2) Group/division restructures for existing groups (1st eligibility load based on the restructure will be excluded from the performance standard measurement).
- 3) Incorrect/Incomplete individual records for members and dependents.
- 4) If instructed to wait for group approval to load the file.

#### ONLINE REPORTS AVAILABLE BY THE 25<sup>TH</sup> OF THE MONTH

Performance Standard = 100%

Performance Penalty = 1%

All eligible online reports will be available on VSP's Resource Center by the 25th of each month.

#### **Web portal availability**

Performance Standard = 99%

Performance Penalty = 1%

**Based on a 7 x 24 schedule.**

#### **Electronic Eligibility Online within 24 Hours:**

- Identifiable Media: Eligibility file must be labeled properly.
- Proper Format: No change in format from the previously loaded eligibility file.
- Clean File:
  - (1) Physical Media must be undamaged.
  - (2) Electronic Media must have clean and complete data transmission. We must be able to successfully unzip/decrypt the incoming data.
  - (3) All media must contain proper/complete records for members and dependents.
- Exclusions to this performance standard are as follows:
  - (1) Membership files for open enrollment loaded prior to effective date.
  - (2) Group/division restructures for existing groups. (1st eligibility load based on the restructure will be excluded from the performance standard measurement.)
  - (3) Incorrect/Incomplete individual records for members and dependents.
  - (4) If instructed to wait for client approval to load the file.

#### **Patient Satisfaction:**

##### **Emails can be obtained from either the member or client**

- **Member** can go online and register, via "vsp.com."
- **Client** can provide emails on their membership load file:
  - **Must be either ANSI form 834 or VSP form 208.**

**Disclaimer:** In order for the results to be **statistically valid VSP must receive a minimum of 30 responses. Any Client with a Client-specific patient satisfaction performance guarantee (PG) that has a penalty associated with the PG must receive a minimum of 30 responses** in order for their report to be statistically valid. The Client has the choice to receive the results of the survey as a Client-specific report, but may not charge VSP a penalty.

**Summary of Benefits and Coverage**  
**VSP Choice Plan**

**Prepared for:** LEIDOS HOLDINGS INC.  
**Group ID:** 12180678  
**Effective Date:** JANUARY 1, 2021

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.