

SIGNATURE VISION PLANSM

GE 20/20 • NON GROUP STANDARD EVIDENCE OF COVERAGE • CONTRACT OF BENEFITS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

GE DENTAL & VISION, a California Corporation (the "Plan"), hereby agrees that the Members and their eligible dependents are covered under and subject to all the provisions, definitions, limitations and conditions of the Evidence of Coverage – Contract of Benefits. The Plan's principal address from which it conducts its business is 30851 West Agoura Road, Agoura Hills, California, 91301. The Plan's telephone number is (800) 333-9561.

Part 1. DEFINITIONS:

BENEFITS PROGRAM means the vision services offered by Signature and available to Individual Members as set forth in the co-payments, exclusions, limitations of benefits as well as the specific obligations, duties and covenants contained within this Evidence of Coverage. They are included as Part 6 and Part 7 of this Evidence of Coverage-Contract of Benefits.

CO-PAYMENT means the amount the Member or someone on his or her behalf shall pay the Participating Doctor directly when various services listed in the Description of Benefits and Co-payments are performed by the Participating Doctor for the Member.

COVERAGE DECISION means the approval or denial of health care services by the Plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of this health care service plan contract.

ELIGIBLE DEPENDENTS means the lawful spouse of the Member (unless legally separated), a dependent parent (provided proof of dependency is furnished to the Plan by the Member at the time of enrollment), or the unmarried children (including step-children, adopted and foster children who are dependent on the Member for support and maintenance) of the Member, from and after birth, until their 19th birthday (or 23rd if a full-time student). At attainment of age 19 coverage as a dependent shall be extended if the child is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) chiefly dependent upon the Member for support and maintenance (provided proof of such incapacity and dependency is furnished to the Plan by the Member within 31 days of the child's attainment of age 19).

EMERGENCY OFFICE VISIT means any non-medical eye care delivered on an emergency basis by the assigned participating doctor which is in addition to the covered annual eye examination.

MEDICAL EMERGENCY Medical care needed on an emergency basis performed by a licensed physician

MEMBER means any eligible person and his or her eligible dependent(s) for whom the appropriate premium was paid, prior to the coverage period, for the Covered Vision Services.

OFFICE VISIT means any non-medical eye care delivered on a non-emergency basis by the assigned participating doctor which is in addition to the covered eye examination.

PARTICIPATING DOCTOR means Doctors who have contracted with the Plan to provide vision services to the Members.

PLAN means the Signature Vision Plan, a product of GE DENTAL & VISION.

PREMIUM means those amounts payable monthly or annually as set forth in the Evidence of Coverage - Contract of Benefits in consideration for the coverage provided.

SERVICES IN PROGRESS means a series of vision services provided by the Participating Doctor requiring more than one day to complete, or of such a nature that a Member would not reasonably contract to have performed the first of the services without assurance that each of the later services would be performed in sequence according to the agreed upon schedule or on dates reasonably close to the scheduled dates, and the first of which vision services has been performed on or before the date benefits terminate.

SUBSCRIBER means the individual who has purchased vision services.

Part 2. EFFECTIVE DATE OF COVERAGE: All Members who have submitted the required enrollment information to the Plan and paid or had paid on their behalf the appropriate premium by the 20th of the month, shall be eligible for benefits commencing on the 1st day of the following month and shall continue for one (1) month thereafter.

Part 3. PREPAYMENT FEES: PREPAYMENT FEES: The following prepayment fee is applicable to this Evidence of Coverage - Contract of Benefits: monthly paid premium Individuals \$3.25, Member and One (1) Dependent \$5.50, Family \$9.00; annually paid premium Individual \$39.00, Member and One (1) Dependent \$69.00, Family \$108.00. The Plan shall not increase the premium to the Member except after a period of at least thirty (30) days from and after postage paid mailing to the Member at the Member's address of record with the Plan explaining the proposed increase in premium. There may be a monthly service charge, not to exceed \$1.00 per month, for electronic payment processing. You will be notified in writing thirty (30) days prior to the imposition of any change in electronic processing charge. The prepayment fee is due and payable by the Member on or before the twentieth (20th) day of the month prior to the coverage period and such prepayment fee shall continue eligibility of benefits for one (1) month commencing on the first day of the following month.

If the Subscriber's payment for premium results in a lack of payment due to any banking issue, that is not the responsibility of the Plan, then the Plan may impose a service charge not to exceed fifteen (15) dollars.

Part 4. IDENTIFICATION OF MEMBER: The Plan issues each Member an I.D. card to be presented at the time services are obtained at the assigned participating vision office. The Member is not required to file any claims.

Part 5. PRINCIPAL BENEFITS AND COVERAGES: The following services are the principal benefits which Members are entitled. Only these procedures are provided for either partially or totally by the Plan. The Member may be responsible for a co-payment for these procedures. Please reference the definition of Coverage Decision, to fully understand what is meant by coverage for a given procedure. If a service is requested and provided to a Member and the procedure is not listed in this Description of Benefits and Co-payments, the Member shall pay the vision doctor his or her usual and customary fee

for the treatment received. There may be some procedures that are listed in this Evidence of Coverage that may not be available at all locations due to an individual vision doctor's scope of practice.

DESCRIPTION OF BENEFITS & CO-PAYMENTS

SERVICES

Office visits* No Charge
 Emergency office visits* No Charge

ACCESSORIES

Eyeglass adjustment No Charge
 Eyeglass case No Charge

* See Office Visit/Emergency Section, located in Part 8 Principal Exclusions and Limitations on Benefits, first section, number 5.

Part 6. OTHER CHARGES: The Member is responsible for the Co-payments for services listed in the following "Description of Benefits and Co-payments." Services not listed will be billed to the Member at the Participating Doctor's UCR [Usual, Customary and Reasonable] fee.

SERVICES

Visual analysis (eye exam, including refraction and glaucoma testing) \$20.00

Contact Lens Evaluation See Fitting / Evaluation Fee

FRAMES

Any type and size 25% Discount

PLANO SUNGLASSES 25% Discount

LENSES

PER PAIR

SINGLE VISION (glass or plastic) \$40.00

BIFOCALS (glass or plastic)

FT28, Round \$60.00
 Executive Add \$20.00

PER PAIR

FT35 Add \$20.00

TRIFOCALS (glass or plastic)

7x28 \$75.00
 7x35, 8x35 Add \$20.00
 Executive Add \$25.00

Progressives Add \$80.00

ALL OTHERS 25% Discount

LENS ADDITIONS

Polycarbonate (single vision) Add \$32.00
 Polycarbonate (Multifocal) Add \$36.00
 Hi-Index (1.57 or less, non-aspheric) Add \$42.00
 Solid Tint Add \$12.00
 Gradient Tint (single or double) Add \$ 17.00
 Scratch coating Add \$17.00
 UV coating Add \$17.00
 Anti-reflective coating Add \$56.00

Edge polish Add \$12.00
 Photochromic Glass (single vision) Add \$32.00
 Photochromic Glass (Multifocal) Add \$36.00
 Photochromic Plastic (single vision) Add \$82.00
 Photochromic Plastic (Multifocal) Add \$86.00
 All others 25% Discount

CONTACT LENSES

COST PER LENS

COST PER LENS

SOFT DAILY WEAR

Regular Soft (Clear or Tinted) \$40.00
 Toric (Clear or Tinted) \$80.00

Opaque/Colored (sph) \$70.00
 Bifocal \$110.00

SOFT EXTENDED WEAR

Regular (Clear or Tinted) \$45.00
 Toric (Clear or Tinted) \$95.00

Opaque/Colored (sph) \$75.00
 Bifocal \$125.00

RIGID

Hard Lens (P.M.M.A.) \$35.00
 RGP (DW – Sph) \$55.00
 RGP (EW – Sph) \$65.00

Toric/Bitoric \$90.00
 Bifocal \$125.00

Disposables (Spherical 1 – Day/2 – Week) 10% Disc
All Other Types of Contact Lenses 15% Disc

Planned Replacements 15% Disc
Contact Lens Solutions 15% Disc

Contact Lens Fitting/Evaluation Fee

(Includes training and starter care kit) 15% Disc

OFFICE VISIT/EMERGENCY

Members who have received an eye exam by assigned provider within the past year No Charge
Members who have not received an eye exam by an assigned provider for more than one (1) year or members who have never received an eye exam by the assigned provider20.00

NOTE #1: CONTACT LENS POWERS OVER -8.00 D SPH, +4.00 D SPH AND/OR -2.00 D CYL ARE CONSIDERED CUSTOM AND MAY BE CHARGED EXTRA.

NOTE #2: WHEN PURCHASING CONTACT LENSES, PATIENTS MUST HAVE A CONTACT LENS EVALUATION WHICH INCLUDES THE 90 DAY FOLLOW UP CARE IN ADDITION TO THE INITIAL EXAM.

PART 7. PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS

The limitations listed below apply to your Signature Vision Plan. However, you may elect to have any treatment performed at the doctor's regular fee:

1. Any procedure not listed under Principal Benefits and Coverage or Other Charges may be available at the Participating Doctor's usual and customary fee.
2. Follow-up care for contact lenses shall be limited to a period of three (3) months. Additional visits are subject to an office visit charge which is set by the doctor's UCR [Usual, Customary and Reasonable] fee.
3. Benefits are not available if the Member receives such services from an Optometrist who is not his/her assigned Participating Doctor.
4. Lenses and frames furnished under this Plan which are lost or broken will not be replaced except at the Member's yearly examination.
5. Office visit listed at no charge co-payments is defined as any non-medical eye care appointment delivered on a non-emergency basis by the assigned participating doctor in addition to the provided annual eye examination. Examples include difficulty seeing with the new glasses or inability adjusting to the new prescription. Emergency office visit listed at no charge co-payments is defined as any non-medical eye care delivered on an emergency basis by the assigned participating doctor in addition to the provided annual eye examination. Examples include a sudden change of prescription or a lost contact lens in the eye. The following are NOT considered emergencies: broken glasses, lost contact lens, lost glasses.
6. The initial examination and one corrective device is allowed per Membership year, per Member. One corrective device is defined as one pair of glasses, one pair of yearly contact lenses, or one year's supply of disposable/planned replacement contact lenses. The Member may request an additional refraction if he/she desires, at no additional charge. Any subsequent refractions, at the Member's request in the same policy year, may result in an additional charge of \$20 for each refraction. If the Member experiences a change in his or her prescription, the Member is eligible to receive new lenses at the appropriate Plan Co-payment.
7. If the Participating Doctor determines that a referral to a specialist is appropriate and the Member has medical coverage, the Member is to be advised to seek care through his/her medical coverage. If the member has no medical coverage or the Member's medical coverage does not cover the needed treatment, then the Participating Doctor may provide a referral and the Member shall be responsible for the referred care. The Participating Doctor must make his/her records available for the specialist to review upon written request from the Member.

The following vision services and procedures are not included in this Signature Vision Plan and there is no coverage for these items. However, you may elect to have any treatment performed at the doctor's regular fee:

1. Orthoptics (process for improvement of visual perception and coordination of the two eyes for good binocular vision).
2. Visual training.
3. Contact lenses for Keratoconus and Aphakia.
4. A second pair of glasses in lieu of bifocals.
5. Replacement of lost, stolen, or destroyed lenses and frames.
6. Medical care, surgical treatment, ophthalmologic emergencies, or any hospital or medical charges are excluded. In the event that Member desires to be hospitalized for any ocular procedure, the cost will be borne by the Member.
7. Orthokeratology (a procedure for decreasing refractive error by use of contact lenses).
8. Charges for any treatment, which because of the Member's general health, or mental, emotional, behavioral, or physical limitations, cannot be performed in the assigned Participating Doctor's office.
9. Low vision care (the treatment and use of specialized devices to assist those persons who are partially sighted).
10. Prolonged occlusion tests associated with special remedial care or a diagnosis of strabismus or amblyopia.
11. The services of specialized Ophthalmologists or Optometrists are not covered benefits under the Plan. If, in the opinion of the assigned Participating Doctor, it is in the best interest of the Member to be referred to a specialist for such services, the Member shall be responsible for the fee-for-service charges for the specialty services rendered. Examples of specialty areas include the care and treatment of refractive surgery, cataract surgery, glaucoma, corneal disorders, binocular vision disorders, dyslexia, and reading disabilities.
12. Any eye examination required by an employer as a condition of employment, unless it is in conjunction with an eye examination for which the Member is otherwise entitled under the Plan.
13. This program does not provide coverage for medications other than those that are utilized by the assigned Participating Doctor at the Member's visit in the Participating Doctor's office.
14. Disease contracted or injury sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not a result of war.
15. A treatment plan which, in the opinion of the Participating Doctor, is not medically necessary, will not produce a beneficial result, or has a poor prognosis.
16. The Participating Doctor shall have the right to discontinue further treatment of a Member who continually fails to keep appointments or who fails to follow their prescribed course of treatment.

17. In the event the Member has other vision coverage, benefits will be coordinated as follows: A. If the other coverage is a group or non-group pre-paid program the Member may obtain covered services from a Participating Doctor of either program and be subject to the appropriate Co-payment. B. If the other coverage is group or non-group insurance the Participating Doctor will provide covered services to the Member at the Co-payment specified in the Description of Benefits and Co-payments. The Participating Doctor may not collect more, from the insurance payment and Member payment combined, than the Co-payment specified in the Description of Benefits and Co-payments.
18. Care or treatment which is obtained from, or for which payment is made by, any federal, state, county, municipal, or other governmental agency, including any foreign government.
19. Any corrective treatment required as a result of services performed by a non-participating doctor while this coverage is in effect, and any services started by a non-participating doctor will not be the responsibility of the Participating Doctor's office or the Plan for completion or compensation.
20. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the standard vision care community.

Part 8. GRIEVANCE PROCEDURES/ARBITRATION: A Member who alleges that his enrollment has been canceled or not renewed because of the Member's health status or requirements for health care services may request a review of cancellation by the Department of Managed Health Care. If a Member is dissatisfied with the provision or lack of provision of services under this agreement, he or she may file either an oral or written complaint with the Plan. This can be done by calling or writing the Administrator of the Plan. Grievances should be directed to GE DENTAL & VISION, 30851 WEST AGOURA ROAD, SUITE 300, AGOURA HILLS, CALIFORNIA 91301, (800) 333-9561. The Plan shall whenever possible resolve all grievances within thirty (30) days and provide the Member with a written, clear and concise explanation or statement concerning the disposition or pending status of the grievance within thirty (30) days of the Plan's receipt of the grievance.

Should any dispute, grievance or controversy of any kind or nature arise between the parties to this agreement or any of its terms or conditions which is not resolved through the procedure described above, the dispute, grievance or controversy thereof, shall be settled by arbitration in accordance with the rules and regulations then in force and effect of the American Arbitration Association; and judgment upon the award rendered by the arbitrator may be duly entered in any court in the State of California having jurisdiction thereof. The prevailing party shall be entitled to costs and reasonable attorney's fees. It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. All parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

The Plan shall assume all or a portion of a Member's share of the fees and expenses of the arbitration in cases of extreme financial hardship (pursuant to California Health & Safety Code § 1373.20(c)). The Plan will provide the Member, upon request to GE DENTAL & VISION, Grievances - Arbitration, 30851 West Agoura Road, Suite 300, Agoura Hills, California 91301, (800) 333-9561, with an application for relief of the Member's portion of the arbitration costs. Nothing in the Plan's Grievance Procedure precludes any Member from securing representation by an attorney or from seeking intervention by an appropriate State or Federal agency or department.

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired to receive complaints regarding health plans. The Department's Internet website <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at (1-800-333-9561) and use the plan's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The plan's grievance process and Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Part 9. CHOICE OF DOCTORS AND PROVIDERS: Each Member and eligible dependent must select a participating vision office from the current "list of participating vision offices" with a maximum of one (1) provider office per family, (one (1) provider per Member), and inform the Plan of the selection(s). The Member and all of his or her covered dependents may obtain his or her covered services only from his or her designated participating vision office. The Member and his or her covered dependents may elect to change vision offices. Request for such a change must be received by the Plan, in writing, at least thirty (30) days prior to the effective date of change.

Part 10. LIABILITY OF SUBSCRIBER AND MEMBER FOR PAYMENT: By statute, every contract between the Plan and a provider must provide that, in the event the Plan fails to pay the provider any sums which the Plan owes to the provider, the Member will not be liable to the provider for payment of any such amount. If the Plan fails to pay a non-contracting provider, the Member may be liable to the non-contracting provider for the cost of services received by that Member.

Part 11. EMERGENCY SERVICES AND REIMBURSEMENT PROVISIONS: A Member requiring emergency vision service while more than fifty (50) miles from the participating vision office to which assigned, may have such emergency service rendered by any licensed doctor in the area where such emergency occurs. Emergency vision services are defined as those services provided in response to an acute or urgent need for such care and in a situation where both return to the assigned participating vision office and delay of vision treatment would impose unreasonable hardships on the Member and would not be medically advisable. The Plan shall pay up to \$20.00 for all emergency care rendered during a contract year to the Member. The Member shall notify the Plan of such emergency care within a reasonable length of time after it was rendered, and provide bona fide documentation thereof.

Part 12. RENEWAL PROVISIONS: The Subscriber may renew coverage at the prevailing rate and for the benefits available at the time the Evidence of Coverage - Contract of Benefits expires. Notice of rates and benefits available will be mailed to the Member thirty (30) days prior to the expiration of the Evidence of Coverage - Contract of Benefits.

The Plan is prohibited from decreasing in any manner the benefits referred to in this Evidence of Coverage – Contract of Benefits except after a period of at least thirty (30) days from and after the postage paid mailing to the Subscriber at the Subscriber’s address of record with the Plan of written notice of any proposed change in benefits.

Part 13. FACILITIES: Participating Doctors are available for non-emergency care during their regular office hours. Emergency care is available on a twenty-four (24) hour basis. Names and locations of the Plan’s participating vision offices are located on the “List of Participating Doctors.”

Part 14. TERMINATION OF BENEFITS/DISENROLLMENT After the date on which termination becomes effective, the Participating Doctor will complete any "services in progress" as defined in Part I. Benefits shall cease when the following occurs.

a) The date of expiration of the Evidence of Coverage - Contract of Benefits, if not renewed.
b) The date of expiration of the period for which the last premium was paid, subject to compliance with notice requirements. The premium is due on the 20th day of the month for coverage during the following month, and is delinquent if not paid on the due date. If the premium is delinquent, Plan may give written notice to the Member that said premium is past due. Fifteen (15) days after the delinquency date, if the premium has not been paid, the Plan may, at its option, terminate the Member’s Evidence of Coverage - Contract of Benefits by giving written notice of termination to the Member. Said termination becomes effective on the fifteenth (15th) day following receipt of postage paid mailing to the Member.

c) The Plan reserves the right to terminate the Membership contract of a Member if the Plan is unable, after a reasonable effort, to establish and maintain a satisfactory doctor-patient relationship between a Participating Doctor and that Member. Notice of such termination must be in writing by the Plan and coverage shall cease fifteen (15) days after receipt of postage paid mailing of such notice. Following termination, the Plan will refund any premium received by it on behalf of such Member during the period of one month prior to such termination.

d) On the last day of the month for which a premium payment was made by or on behalf of a Member who is no longer eligible for benefits.

e) Upon a dependent’s attaining the age of 19 (or 23 if a full-time student), marriage, or otherwise becoming ineligible as defined in Part I.

f) A thirty (30) day written notice by the Subscriber to the Plan requesting a voluntary cancellation effective on the 30th day of such a notice. In the event of cancellation, the Member will be returned a pro-rata portion of the prepayment fee paid with the pro-rata portion return computed from the end of the thirty (30) day notice of cancellation period. Enrollment fees are non-refundable.

g) In the event the proper premium amount is paid after cancellation of the Member, the Plan shall reinstate the Member without requiring a new application unless the Plan shall, within twenty (20) business days: 1) refund the payment made or 2) issue to the other party (Member) a new contract accompanied by written notice stating the differences between the new contract and the terminated contract with regards to benefits, coverage, or otherwise.

h) Cancellation by the Plan pursuant to a "notice of cancellation" for good cause other than failure to pay premium will become effective fifteen (15) days from the date which said notice of cancellation is mailed.

i) Upon termination or notice of termination, the Member may request that the cancellation be reviewed by the Commissioner of the Department of Managed Health Care.

j) If coverage lapses from non-renewal, while a Member is hospitalized or undergoing treatment for an ongoing condition, the Plan has a thirty (30) day grace period for full reinstatement of coverage without a lapse in coverage.

Part 15. PUBLIC POLICY COMMITTEE: The Plan encourages participation by Members in the Plan’s Public Policy Committee. The Public Policy Committee meets quarterly and appoints selected Members to serve for a period for two (2) years.

The Public Policy Committee establishes Public Policy issues with the Plan, evaluates Plan performance as it relates to the membership and reviews Plan materials. Interested Members are requested to contact the Plan’s administrative office for further information.

Part 16. VISION RECORDS: The vision records of a Member concerning services performed hereunder shall remain the property of the Participating Doctor, and shall be available to the Plan and the Department of Managed Health Care for inspection.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Part 17. SECOND OPINIONS: Members are entitled to a second vision opinion pursuant to the policy the Plan has filed with the Department of Managed Health Care. If a Member desires a second opinion (to request additional treatment or limit treatment currently recommended) from the Member’s Participating Doctor or Specialist, he or she may file either an oral or written request for a second opinion with the Plan. This can be done by calling or writing the Plan as follows: Signature Vision Plan, Grievances - Second Opinion, 30851 West Agoura Road, Agoura Hills, California, 91301, (800) 333-9561. If the Plan believes a second opinion is needed, the Plan will arrange for the second opinion and the Member will be responsible for the applicable co-payment, if any. If a second opinion is not believed to be necessary by the Plan, the Member can obtain a second opinion from a Plan provider for a specified co-payment or can obtain a second opinion from any non-participating provider at the Member’s sole expense. The Member may appeal the denial for a second opinion utilizing the grievance procedure described herein. The appeal will be reviewed through the Plan’s grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available vision records and the input of the referring Participating Doctor or Specialist. All appeals for the necessity of a second opinion are reviewed by a doctor having appropriate clinical background, as determined by the Vision Director.

Part 18. NOTICE OF PROVIDER STATUS: The Plan shall provide written notice, within a reasonable amount of time to the Member in the event the Participating Doctor 1) is terminated, 2) has breached the provider contract with the Plan or 3) is unable to perform as provider.

Part 19. GOVERNING LAW: The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code, and of Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provision required to be in this Evidence of Coverage by either of the above shall bind the Plan whether or not said provision is included in this Evidence of Coverage.

Part 20. TERMINATION OF PROVIDER: The Plan shall provide in its contracts with participating providers that in the event the provider is terminated from participation in the health care Plan, the provider will complete any "service in progress," whether or not the completion of said service in progress carries beyond the effective date of termination. Additionally, the Plan will make adequate arrangements to reassign the Member to another participating vision office to insure continuity of care and continuity of coverage.

Part 21. SPECIALTY CARE: The services of ophthalmologists other than those services performed by an ophthalmologist who is acting as an assigned Participating Doctor who renders only the services that a licensed optometrist would provide under the laws in the State of California, or specialist optometrists are not covered benefits under the Plan. Therefore there are no authorization requirements for referral to a specialist. If, in the opinion of the Participating Doctor, it is in the best interest of the Member to be referred to an ophthalmologist or specialist for such services, Member will be responsible for the fee-for-service charges for services rendered by ophthalmologists or specialist optometrists. The Member is advised to refer to his/her medical coverage to evaluate if coverage exists for the treatment that may be required.

Part 22. CONTINUITY OF CARE: If a Member is in a course of treatment for an acute condition or serious chronic condition, he or she may be entitled to stay with his or her current provider up to ninety (90) days, and conditioned upon the provider agreeing to the same contract conditions prior to his termination from the program. The provider is not obligated to agree to continue the delivery of care under the terms of the terminated contract. Please call the Plan at (800) 333-9561 to see if you are eligible for this benefit.

Part 23. PROVIDER INCENTIVE: The Plan compensates its Participating General Doctor's through a capitation agreement by which they are paid a fixed amount of money each month based upon the number of Members that select their office. The Doctor's also receive compensation from Members who pay a defined "co-payment" for specific vision services. In addition, there may be occasions when a program may provide supplemental payments for specific vision procedures. These are the only forms of compensation the Participating General Doctor receives. The schedule of co-payments is located in this Evidence of Coverage. If you would like more information regarding the Plan's provider incentive programs, please contact the Plan's Professional Network Service Department at (800) 333-9561.

Part 24. AUTHORIZATION OF HEALTH CARE SERVICES: The Plan will provide those vision services described in Part 5 and Part 6 of this Evidence of Coverage to Members through its Participating Doctors. Such services shall be provided only by participating vision offices. When services are rendered by a Participating Doctor to a Member, the Member is responsible for the co-payment to the Participating Doctor in the amount as specified in the Description of Benefits and Co-payments. If the services rendered are not listed in the Description of Benefits and Co-payments, the Member shall pay the doctor his or her usual and customary fee. The Plan shall not discriminate against any Member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, genetic characteristics or age.

If the Plan determines that it is unable to establish a working relationship with a Member, the Plan may elect to terminate this contract between the Plan and the Member. Depending upon the circumstances of the termination of the Group Contract, the Plan will provide the Member with a complete or partial refund of all premiums paid to the Plan for the current policy year.

The Plan determines if the Member is eligible for health care services by verifying enrollment requirements, that the Member is seeking care at a participating office and if the premiums were paid for the given period of time in which services are to be delivered. If there is a question as to the scope of coverage, the Plan reviews the procedure codes of the proposed treatment and the list of Exclusions and Limitations of the given program to see what effect they may have upon the proposed treatment with respect to coverage. The Plan then informs the Member and the provider of its findings.

Part 25. LOSS-RATIO NOTICE FOR INDIVIDUALS OR GROUPS OF TWENTY-FIVE (25) OR LESS: This is to advise you that the health care costs for this benefit program for the fiscal year ended December 31, 2002 were 45%.