



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP EYE CARE INSURANCE POLICY

The Policyholder	EVIDENT SCIENTIFIC MIS, INC.	Policy Number	10-67399
State of Delivery	Massachusetts	Plan Effective Date	January 1, 2026
		Plan Change Effective Date	January 1, 2026
Premium Due Date 1st of each month.		Renewal Date	January 1

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

This plan does not include pre-existing condition limitations or exclusions.

The Benefits for Covered Services described in this Policy are available to you regardless of your county of residence within the Commonwealth of Massachusetts. The Massachusetts Department of Insurance has determined the plan service area as Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties whereby the population of In-Network Vision providers may afford you with reasonable access to care from an In-Network Provider. However, if you live in Dukes, Franklin or Nantucket County you may experience somewhat longer travel times/distances, in order to receive Covered Services from an In-Network Vision Provider.

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

Massachusetts Notice of Inquiry and Grievance Procedures

**Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free) 402-309-2579 (FAX)**

Please read this notice carefully. This notice contains important information about how to make inquiries and/or file grievances with your insurer. Also, you always have the right to contact the Massachusetts Division of Insurance if you have a question or concern regarding your coverage under this contract. The Massachusetts Division of Insurance may be contacted through their Consumer Hotline at 1-617-521-7794.

I. Definitions

“Grievance” means any written complaint submitted to the insurer by or on behalf of an insured person concerning any aspect or action of the insurer, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services and administrative operations.

“Adverse Determination” means a determination by a carrier to deny, reduce, or modify the availability of any health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness, level of care or effectiveness.

II. Internal Grievance Process

1. Filing a Grievance

You may file a grievance by phone, in person, by mail, or by electronic means. We will provide you or your authorized representative, if any, a written resolution of a grievance within thirty (30) business days of receipt of the oral or written grievance.

2. Written Decision

In the case of a grievance which involves an adverse determination, our written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental and/or vision practice philosophy and will also include:

1. An identification of the specific information upon which the adverse determination was based;
2. Discuss the insured’s presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and
3. Reference and include applicable clinical practice guidelines and review criteria.

3. Reconsideration

We will always provide the opportunity to reconsider a final decision where relevant information was received too late to review within the thirty (30) business daytime limit or was not received but expected to become available within a reasonable time period.

We will review a reconsideration and provide our written response as soon as possible following receipt of the additional information but we agree to provide such response no later than thirty (30) business days following your request for reconsideration.

You always have the right to contact the Department of Insurance:

**Division of Insurance
One Federal Street, Suite 700
Boston, MA 02110-2012
(617) 521-7794
(877) 563-4467**

**Massachusetts Health Policy Commission – Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
(800) 436-7757**

Upon request, interpreter and translation services related to administrative procedures are available.

متوفر تحت الطلب خدمات ترجمة، كتابية وشفهية، تختص بالإجراءات الإدارية.

បើសុំបាន ឥឡូវនេះ មានសេវាបកប្រែ និងបកប្រែសំឡេង ទាក់ទងនឹងនីតិវិធីប្រតិបត្តិការ របស់អាជ្ញាធរ.

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

Sur demande, des services d'interprétation et de traduction concernant les procédures administratives sont disponibles.

Κατόπιν αίτησης διαθέτονται ερμηνευτικές και μεταφραστικές υπηρεσίες για διαχειριστικές υποθέσεις.

Sévis entépret ak tradiksyon ki ginyin rapo ak fonksyônman administrasyon an, la pou ou depi ou mande-l.

A richieste, servizi di interpretazione e traduzione riguardo a procedura amministrativi sono disponibile.

ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ຈະມີບໍລິການບາຍພາສາລະອະໂພສາໄວ້ສໍາຫລັບເລື່ອງຕ່າງໆ ທີ່ກ່ຽວຂ້ອງກັບ ກະບອບການຕ່າງ ໆ ທາງດ້ານການບໍລິຫານ.

Sob requerimento, disponibilizamos serviços de interpretação e tradução relacionados a procedimentos administrativos.

По заявкам предлагаются услуги по переводу, связанному с административными порядками.

A pedido, están disponibles servicios de interpretación y traducción relacionados a procedimientos administrativos.

IMPORTANT INFORMATION

The following provides summary information regarding your rights as well as summary descriptions of the practices of Ameritas Life Insurance Corp. with regard to your dental and/or eye care coverage's provided to you under an Ameritas Life Insurance Corp. certificate of coverage.

CONSUMER RIGHTS

- ✓ **Termination of Individual Coverage.** Coverage is provided to you as a member of a group contract based on the eligibility requirements established by the group policyholder. As long as you maintain your eligibility, your coverage may only be canceled, or its renewal refused, in the following circumstances:
 - (1) Non-renewal or cancellation of the group contract through which the insured receives coverage;
 - (2) Failure by the insured or other responsible party to make payments required under the contract;
 - (3) Misrepresentation or fraud on the part of the insured; or
 - (4) Commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the mental or physical condition of the insured.

The involuntary termination rate for Massachusetts's insureds during the previous calendar year was 0%. "Involuntary disenrollment" means those insureds whose coverage was terminated as a result of conditions (3) or (4) listed above.

The voluntary termination rate for Massachusetts's insureds during the previous calendar year was 8%. "Voluntary disenrollment" means that an insureds whose coverage was terminated as a result of conditions (1) or (2) above.

- ✓ **Grievance Process.** You have the right to make inquiries and/or file a complaint with your insurer. Please review the attached notice entitled "Notice of Inquiry and Grievance Procedures" so that you understand your rights and the responsibilities of your carrier in handling your specific inquiry and/or complaint.
- ✓ **Interpreter/Translation Services.** Upon request, interpreter and translation services related to administrative procedures are available. This service is provided through AT&T Language Line, which supports 140 languages.

OUR PRACTICES

- ✓ **Communication.** As a group contract, the coverages under the group plan renew annually. Notices of any modifications or changes to the plan design will be provided to the policyholder 60 days prior to the effective date of the change. In addition to any coverage changes, notice will also be provided of a material change in clinical review criteria and a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes. If changes are material, notice of the change will be provided to at least one adult insured in each household. This notice may be in the form of a rider, amendment or endorsement to the certificate of coverage.
- ✓ **Quality.** Depending upon the benefit plan the policyholder has selected, you may have the option to seek services from a participating provider. Please refer to your certificate of coverage for benefit plan information.
Whether your plan provides for a participating provider option ("PPO") or not, you have the freedom of choice to seek services from any provider and benefits will be paid for all services which are considered covered expenses as defined within your certificate.

For PPO network plans we have established a Quality Management Program with policies and procedures to ensure that minimum standards are met and that proper evaluations are conducted in order to provide insureds with access to quality care.

The Quality Management Program addresses the following standards:

- < Provider and Member Services
- < Provider Credentialing
- < The Patient Record/File
- < Sterilization and Infection Control
- < Medical Emergency Preparedness
- < Environmental and Radiology Safety
- < Professional Standards
- < Utilization Review Program
- < Accessibility of Services
- < Member and Provider Satisfaction

The Quality Management Program has been developed in conjunction with individual practitioners and individual practitioners actively within the program to ensure the program's overall effectiveness.

- ✓ **Utilization Review Program.** Generally, utilization review means a set of formal criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a dental care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with actively practicing providers in all specialty areas of expertise and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

In order for a submitted procedure to be covered, the procedure must be included on the List of Covered Procedures contained within your certificate. If a procedure is not a covered procedure, then the claim for that procedure will be denied in accordance with the terms of your certificate and the group policy. Frequency, age, effective dates of coverage, etc may also limit coverage of certain covered procedures, these limitations are stated within your certificate.

There are also a limited number of listed procedures which are only considered a covered expense if the patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed practitioner that the procedure that was performed was not determined to be medically necessary in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.

All claims will be processed within at most 30 working days of obtaining all the necessary information. Our standard turn-around times are generally below 10 working days for claim review. For all claims submissions, you and your provider will receive an explanation of benefits which details how each submitted procedure was reimbursed and/or the reason for denial.

When a claim has been denied or partially denied based on medical necessity, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed health professionals and only after receiving any relevant clinical information necessary to make the decision.

For any questions you have regarding how a claim was paid, please feel free to contact us at the following:

Ameritas Life Insurance Corp.
Attention: Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657

877-897-4328 (Toll-Free)

NOTICE

- 1) You can access your specific evidence of coverage and any amendments by visiting our on-line portal¹ located at ameritas.com

Information that can be accessed at this location includes:

Benefit Summary – A highlight of the benefit information for the plan you've purchased.

Certificate of Coverage – A document that can be viewed or printed showing all parameters of your plans benefit information.

ID Card – This item may be presented at the provider's office to identify you as an Ameritas member

Provider Lookup – The Member may access our provider directory to access an in-network provider.

Resource Center – Access valuable information such as the glossary of terms, frequently asked questions and how to nominate a dentist or specialist.

- 2) You have the right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time.
- 3) For questions regarding your plan, or to request a paper copy of your Policy at no charge to you, please call 1-800-487-5553.
- 4) You can access the following information by visiting vsp.com
Provider Lookup – To access a list of providers, please visit vsp.com
Claims Information – Shows action taken on submitted claims including paper and electronic Explanation of Benefits (EOB) and the amount of remaining benefits your plan has for the current benefit period

¹Creation of a user name and password required.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of pharmacy prescriptions and eye wear. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

If you are traveling outside the United States and require emergency care for a service that would be covered under this Policy, you may contact AXA Assistance USA, Inc. for an appointment with a qualified provider. Such services would be considered as an out-of-network claim.

Pharmacy prescriptions are subject to a discount at CVS, Walgreens, Rite Aid and Walmart pharmacies. Access your prescription discount ID card by logging into your secure member account.

Hearing

Hearing aid device discounts are available through the Tuned hearing savings program. Refer to your Ameritas ID savings card when ordering online or call us for more information.

Up to 50% off MSRP on all available styles of hearing aid devices.

TABLE OF CONTENTS

Name of Provision	Page Number
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Premiums	9050
Definitions	
Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Contribution Requirement	
Effective Date	
Termination Date	
Eye Care Expense Benefits	9270
Coordination of Benefits	9300
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
General Provisions Continued	9323
Participation Requirements	
Termination of Policy	
Grace Period	

SCHEDULE OF BENEFITS **OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class

Class Description

Class 1

Eligible Employee Electing VSP Vision

Class 2

Eligible Employee Electing EyeMed Vision

Class Number 1

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:

Exams, Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period \$0

Contact Lenses - Each Benefit Period

Contact Lens Fitting and Evaluation - Each Benefit Period \$60

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 2

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount \$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,02

Eye Care Insurance	\$6.00 per Insured Person
	\$5.99 Spouse Only
	\$9.60 Child(ren) Only
	\$13.20 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserve the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or
3. We are required by either the federal government or by any state or local government or by any agency thereof to change benefits as a result of regulatory change or pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to an enrollee, covered person, Insured, member, policy holder or subscriber of a Dental Carrier.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child refers to the child of the Insured, a child of the Insured's spouse or a child of the Insured's Domestic Partner, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 2

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.
- c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial

two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

USUAL and CUSTOMARY ("U&C")

Usual and Customary ("U&C") describes those vision charges that we have determined to be the usual and customary charge for a given benefit within a particular area. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee.

BENEFIT PERIOD

Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

BENEFIT LEVEL

Health benefits provided through a Preferred Provider Health Plan to Covered Persons, as opposed to the payments made to the provider, by the Health Benefit Plan.

COMMISSIONER

The Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

COVERED SERVICES

Health Care Services that an insurer is obligated to pay for or provide under either a Health Benefit Plan or a workers' compensation insurance policy.

EVIDENCE OF COVERAGE

Any policy, certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the Insured is entitled.

FINDING OF NEGLECT

A determination by the Commissioner that an Organization offering a Preferred Provider Health Plan has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers in the form and within the time required.

HEALTH BENEFIT PLAN

The health insurance policy, subscriber agreement, plan, certificate, agreement, or contract between the Covered Person or Health Care Purchaser and an Organization, which defines the Covered Services, and Benefit Levels available.

HEALTH CARE PROVIDER

A provider of Health Care Services licensed or registered pursuant to M.G.L. c. 111 or c. 112.

HEALTH CARE PURCHASER

A person, partnership, association, or corporation that provides health care coverage to its employees or members and their dependents by reimbursing the Covered Persons directly for covered Health Care Services or by contracting with an Organization to provide, arrange for the provision of, reimburse and/or pay for covered Health Care Services.

HEALTH CARE SERVICES

Services rendered or products sold by a Health Care Provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

INSURED HEALTH BENEFIT PLAN

A Health Benefit Plan in which the Organization assumes financial risk arising out of the contractual liability to pay for or reimburse Covered Persons for Covered Services. The term does not include a Health Benefit Plan in which an Organization functions solely as a third-party administrator.

ORGANIZATION

An entity authorized by the Commissioner to bear risk, including, but not limited to companies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L. c. 175. "Organization" shall also include an authorized insurer, self-insurer, or self-insurance group as defined in M.G.L. c. 152 §§ 1, 25A and 25E.

POLICY

Any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides insurance benefits whether as a service or on an indemnity reimbursement or prepaid basis.

SICKNESS

A sickness or disease of an insured that first manifests itself after the effective date of insurance and while the insurance is in force.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she complete the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing VSP vision working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing VSP vision working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before they can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing EyeMed vision working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing EyeMed vision working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on January 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before they can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

All Classes

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

Class Number 1

INSURED. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

NOTICE REQUIREMENTS. If an Insured's coverage terminates due to non-payment of premiums, then each Insured will be provided a notice of such termination. The notice will be mailed to the last known address of the Insured. Any claims for services will be paid in accordance with the terms of the contract for any health care service received by the Insured prior to the date of notification.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

An employee or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections below explain when and how insurance may be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Thirty-One Day Continuation of Coverage in accordance with M.G.L. c.175, s. 110D

If an employee leaves his/her job for any reason (quit, terminated, laid off, plant closing, etc.) or if a child ceases to be a dependent under this policy, group coverages provided under this policy will be extended for 31 days in accordance with Massachusetts Law, chapter 175, section 110D. The employer/employee contributions will remain the same for the 31-day period as during employment. The 31-day continuation period begins the date the employee actually terminates employment or the date the child ceases to be considered a dependent under the policy.

This continuation of coverage is in addition to any other continuation periods applicable under Massachusetts law as defined below. This benefit does not extinguish eligibility for benefits available under the Federal Consolidated Omnibus budget Reconciliation Act. (COBRA).

Federally Required Continuation
For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.
2. certain church plans.

When a person is eligible for both state benefits and federal COBRA benefits, certain state and federal benefits overlap and run concurrently. Please note the election of continued coverage under certain state laws may extinguish eligibility for benefits under federal law.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Leave of Absence
For Employees Only

If membership is because of employment and an Insured's active service terminates because of a leave of absence, the insurance will stay in force for two months only if the Policyholder pays his or her premiums and does not cancel the insurance.

If the Policyholder is subject to COBRA, the rules applicable to COBRA will supersede the continuation due to a leave of absence.

Separation or Divorce
For Dependents Only

The Insured's spouse may continue coverage without additional premium (unless the divorce or separation judgment specifies otherwise) if the Insured and the spouse:

- a. become legally separated; or
- b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation.

For purposes of this continuation provision such spouse is called "former spouse."

The former spouse may also continue to insure his or her dependent children.

Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits

This continuation applies to all benefits provided under this policy covering the former spouse.

Termination

Such insurance will stop on the earliest of:

1. the last day of the period for which the premium is paid;
2. the date coverage would normally stop under the terms of the policy;
3. the date specified in the judgment of separation or dissolution;
4. the date either party remarries*;
5. the date insurance terminates for the Insured;
6. the date the policy terminates.

*In the event of the remarriage of the Insured, the former spouse shall have the right, if so provided in said judgment, to continue to be covered as a member of the group.

We will send notice of termination of continuation coverage, and any right to reinstate coverage to the former spouse at the last known address.

Premium

We may charge the full premium, i.e., the employee and employer's portion, during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed. Any part of the premium to be paid by the former spouse should be paid to the employer. The employer may stop coverage if any premium is not received within 30 days following the due date.

Claims

Claims incurred by the former spouse will be paid to the former spouse or the provider. Claims incurred by dependent children not living with the Insured will be paid to the provider or the parent with custody.

Notice

We are required to send notice of name, address and policy numbers of persons electing this continuation to the Massachusetts Department of Public Welfare. We must send the notice within 30 days of the date continuation coverage starts.

EYE CARE EXPENSE BENEFITS

Class Number 1

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

AMOUNT PAYABLE

The Amount Payable for out of network-benefits are based on a percentage of the provider's fee, up to a Usual and Customary Charge.

COVERED EXPENSES

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services. In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Participating Providers.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED

An expense is incurred at the time a service is rendered or a supply item furnished.

PROOF OF LOSS

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS

This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits and outside of the coverage periods listed,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		Participating Provider	Non-Participating Provider*
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to \$ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to \$ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to \$ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to \$100.00
Frames			
Single Frame	Once every 12 months	Up to \$150.00	Up to \$ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to \$150.00	Up to \$120.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to \$210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider)
Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

EYE CARE EXPENSE BENEFITS

Class Number 2

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of:

- A. the provider's charge, or
- B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES

Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Participating Providers.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

SERVICE AREA.

Members can receive services from any Eye Care provider. Participating Provider access is available in all Massachusetts counties with the exception of Franklin, Dukes and Nantucket.

REQUEST FOR SERVICES

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured.

EXTENSION OF BENEFITS

We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS

This plan has the following limitations.

- 1) This plan does not cover more than one Eye Exam in any 12-month period.
- 2) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.
- 3) This plan does not cover more than one set of Frames in any 12-month period.
- 4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lens benefit.
- 5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.
 - a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
 - b. Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
 - c. Anisometropia of 3D or more.
 - d. High Ametropia exceeding -10D or +10D in meridian powers.
- 6) This plan does not cover Orthoptics or vision training and any associated testing.
- 7) This plan does not cover Plano Lenses.
- 8) This plan does not cover non-prescribed Lenses or sunglasses.
- 9) This plan does not cover two pairs of glasses in lieu of Bifocals.
- 10) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
- 11) This plan does not cover medical or surgical treatment of the eyes or supporting structures.
- 12) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- 13) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

SERVICE	PLAN MAXIMUM COVERED EXPENSE	
	<i>Participating Provider</i>	<i>Non-Participating Provider¹</i>
Eye Exam	Covered in Full	Up to \$ 52.00
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered in Full	Up to \$ 68.00
Lined Bifocal Lenses	Covered in Full	Up to \$ 96.00
Lined Trifocal Lenses	Covered in Full	Up to \$129.00
Frame	Up to \$150.00	Up to \$120.00
Contact Lenses		
Elective	Up to \$150.00	Up to \$120.00
Medically Necessary	Covered in Full	Up to \$200.00

¹Plan Maximum Covered Expense is based on a Usual and Customary Fee.

COORDINATION OF BENEFITS

This section applies if an Insured person has eye care coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for eye care services or supplies:
 - a. Any group or blanket insurance policy.
 - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
 - c. Any labor/management, trustee plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.
 - d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
2. "Plan" does **not** include the following:
 - a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.
 - b. Coverages for school type accidents only, including athletic injuries.
3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

- a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.
- b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - i. the parents are married;
 - ii. the parents are not separated (whether or not they ever have been married); or
 - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Eye Care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

- c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
 - i. the Plan of the Custodial Parent;
 - ii. the Plan of the spouse of the Custodial Parent;
 - iii. the Plan of the non-Custodial Parent; and then
 - iv. the Plan of the spouse of the non-Custodial Parent.

However, if the specific terms of a court decree establish a parent's responsibility for the child's Eye Care expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

- d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and
2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 45 days of receipt, we will notify you within that 45-day period providing you with a list of information necessary for us to pay the claim. If payment is not made within the required time frame, we will pay interest at the rate of eighteen percent per year on benefits for valid claims. Interest will begin to accrue 45 days after we receive notice of the claim and will accrue until the claim is settled.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org). This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

- i. necessary to calculate premiums;
- ii. necessary to determine a person's effective date or termination date of insurance;
- iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

- a. a certain percentage of all Members qualified for insurance must be insured at all times; and
- b. a certain number of Members must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	161

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.
2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

**CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Eye Care Claims:
EyeMed Vision Care
4000 Luxottica Place
Mason, Ohio 45040-8114

Eye Care Claims:
Vision Service Plan
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: EVIDENT SCIENTIFIC MIS, INC.

whose main office address is: 48 WOERD AVE
WALTHAM, MA 02453-3826

for Group Policy No. 10-67399

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

EVIDENT SCIENTIFIC MIS, INC.

(Full or Corporate Name of Applicant)

Dated at _____

By _____
(Signature and Title)

On _____, 20__

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to remain Attached to the Policy