

Group Vision Care Policy



Group Name: BANNER HEALTH - ARIZONA
Group Number: 12140277
Effective Date: JANUARY 1, 2011

CERTIFICATE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER: Banner Health
NAME OF PLAN: Banner Health Vision Plan
PRINCIPAL ADDRESS: 1441 N. 12th Street, Phoenix, AZ 85006

EMPLOYER I.D.#: 45-0233470

POLICY #: 12140277

PLAN ADMINISTRATOR: VSP
ADDRESS: 3333 Quality Drive, Rancho Cordova, CA 95670

PHONE NUMBER: (916) 851-5000 (800) 877-7195

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:
ADDRESS:

This form is a summary of the Policy provisions and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Policy itself. A specimen copy of the Policy will be furnished upon request.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER The document attached to this Certificate of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Policy.

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

BENEFIT AUTHORIZATION Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

COPAYMENTS Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

COVERED PERSON An Enrollee or eligible dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under the Policy.

ELIGIBLE DEPENDENT

- Your legally married spouse (same gender),*
- Your common-law spouse if you live in a state that recognizes such marriages. Proof is required.
- Your domestic partner. (same or opposite gender) (The domestic partner packet must be completed and turned in to the Service Center at Banner Plan Administration.)
- Your unmarried child(ren) up to age 25 who does not provide over one-half (1/2) of his/her own financial support and who is not claimed on another person's tax return including their own (whether born to you or legally adopted) or child(ren) for whom you are legally responsible to provide health coverage under a *qualified medical child support court order***. Your unmarried stepchildren and children for whom you or your spouse have legal custody/guardianship wherein each case such children are dependent on you for support, cannot be claimed as a tax dependent by any other person, and have not reached age 25. Children of an eligible dependent are excluded unless you or your spouse has legal custody/guardianship. You will need to provide a copy of any court decree or legal documentation..
- Your unmarried child(ren) who are at least age 25 who are incapable of self-support due to continuously disabling mental or physical handicap, does not provide over half of his/her own support and who is not claimed on another person's tax return including their own. You must provide proof of the disability within one year of the following, whichever is later:
 - The child's 25th birthday, or
 - The date the incapacity began if the child is over age 25.
 - If your child was covered under another employer's plan but loses coverage because of

your divorce, death of your spouse, loss of eligibility under your spouse's employer's plan, or the employer discontinues the plan, your child may be covered under the medical plan as long as your child was incapable of self-support because of a mental or physical handicap incurred before your child reaches age 25 and you notify the Plan within 31 days of when your child's coverage would end.

EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their eligible dependents.
KERATOCONUS	A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
NON-MEMBER PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Policy document maintained by your Group Administrator.
PREMIUMS	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by your Group Administrator.
RENEWAL DATE	The date on which the Policy shall renew or terminate if proper notice is given.
SCHEDULE OF BENEFITS	The document, attached as Exhibit A to the Group Policy document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Policy.
SCHEDULE OF PREMIUMS	The document, attached as Exhibit B to the Group Policy document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.
VISUALLY NECESSARY OR APPROPRIATE	Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

ELIGIBILITY FOR COVERAGE

Enrollees: To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: See Eligible Dependent above.

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

PREMIUMS

Your Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by your Group.

PROCEDURE FOR USING THE POLICY

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.
2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.
3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of your termination of coverage or the termination of the Policy. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Policy. VSP will pay the Member Doctor directly according to its agreement with the doctor.

Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Policy. When Covered Person requests services under this Policy, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Policy's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

Prior Authorization

Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

- A. **Initial Determination:** VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
- B. **Appeals:** If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an

appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Covered Person may designate any person, including the provider, as Covered Person's authorized representative.

For more information regarding VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's Customer Service Department.

BENEFITS AND COVERAGES

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP Policies. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Policy in lieu of all other lens and frame benefits described herein for the current eligibility period.

Visually Necessary contact lenses, together with necessary professional services, will be provided as indicated on the enclosed insert. Coverage for Visually Necessary contact lenses - regardless of whether they are obtained from a Member Doctor or Non-Member Provider - is subject to review and authorization from VSP's optometric consultants.

If you select contact lenses for other than Visually Necessary circumstances, they will be considered Elective contact lenses. When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown on the enclosed insert. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Policy includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. **THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS.** Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.
6. Additional Discount: Each Covered Person shall be entitled to receive a discount of twenty percent (20%)* toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.**

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of glasses only.

- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Note: For Plan B patients (12/12/24), the 20% discount applies to the frame on the off year.

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

7. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Policy maintained by your Group Administrator.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There is no benefit under this plan for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
- Services/materials not indicated as covered Plan Benefits on the enclosed insert.

LIABILITY IN EVENT OF NON-PAYMENT

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION PLAN OTHER THAN THOSE NOT COVERED BY THE POLICY.

COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

**VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195**

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

TERMINATION OF BENEFITS

Terms and cancellation conditions of your vision care policy are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this Policy whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to you as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: BANNER HEALTH - ARIZONA

Plan Number: 12140277

Effective Date: JANUARY 1, 2009

Plan Term: FORTY-EIGHT (48) MONTHS

VISION CARE PLAN DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

BANNER PLAN ADMINISTRATION

(NAME)

525 W BROWN ROAD

(ADDRESS)

MESA, AZ 85201

(CITY, STATE, ZIP)

MONTHLY PREMIUM:

YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

ELIGIBILITY:

ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 25. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:

ENHANCED PLAN B (VALUE PLAN)

EXAMINATION: ONCE EVERY 12 MONTHS

LENSES: ONCE EVERY 12 MONTHS

FRAMES: ONCE EVERY 24 MONTHS

TERM, TERMINATION AND RENEWAL:

AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

TYPE OF ADMINISTRATION:

BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

PLAN BENEFITS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>35.00*</i>
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VISION CARE MATERIALS

Lenses

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>25.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>40.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>50.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>100.00*</i>

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$</i>	<i>45.00*</i>
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

CONTACT LENSES

<i>Visually Necessary Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>250.00*</i>
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<i>Elective Professional Fees** and Materials</i>	<i>Up to \$ 100.00</i>	<i>Up to \$</i>	<i>100.00</i>
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When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

LENS OPTIONS

<i>Blended lenses</i>	<i>Covered in Full</i>	<i>Up to \$</i>	<i>40.00</i>
<i>Progressive lenses</i>	<i>Covered in Full</i>	<i>Up to \$</i>	<i>50.00</i>

****Subject to Copayment, if any.***

*****Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.***

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.

LOW VISION

Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

Supplemental Testing Covered in Full Up to \$125.00
(includes evaluation, diagnosis and prescription of vision aids where indicated)

Supplemental Aids 75% of cost 75% of cost

Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) years.

ADDITIONAL DISCOUNT

Each Covered Person shall be entitled to receive a discount of twenty percent (20%)* toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.**

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Note: For Plan B patients (12/12/24), the 20% discount applies to the frame on the off year.

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: BANNER HEALTH - ARIZONA

Plan Number: 12140277

Effective Date: JANUARY 1, 2010

Plan Term: FORTY-EIGHT (48) MONTHS

VISION CARE PLAN DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

BANNER PLAN ADMINISTRATION

(NAME)

525 W BROWN ROAD

(ADDRESS)

MESA, AZ 85201

(CITY, STATE, ZIP)

MONTHLY PREMIUM:

YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

ELIGIBILITY:

ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 25. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:

EXAM PLUS (DISCOUNT PLAN)

EXAMINATION:

ONCE EVERY 12 MONTHS

TERM, TERMINATION AND RENEWAL:

AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

TYPE OF ADMINISTRATION:

BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

PLAN BENEFITS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

VISION CARE SERVICES

Vision Examination

*Covered in Full**

*Up to \$ 35.00**

ADDITIONAL DISCOUNT

*Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.**

*Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- *Discounts do not apply to vision care benefits obtained from Non-Member Providers.*
- *20% discount applies to complete pairs of glasses only.*
- *Discounts do not apply if prohibited by the manufacturer.*
- *Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.*

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.*

COPAYMENT

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: BANNER HEALTH - ARIZONA

Plan Number: 12140277

Effective Date: JANUARY 1, 2010

Plan Term: FORTY-EIGHT (48) MONTHS

VISION CARE PLAN DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

BANNER PLAN ADMINISTRATION

(NAME)

525 W BROWN ROAD

(ADDRESS)

MESA, AZ 85201

(CITY, STATE, ZIP)

MONTHLY PREMIUM:

YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

ELIGIBILITY:

ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 25. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:

PLAN C (PREMIER PLAN)

EXAMINATION: ONCE EVERY PLAN YEAR*

LENSES: ONCE EVERY PLAN YEAR*

FRAMES: ONCE EVERY PLAN YEAR*

*PLAN YEAR BEGINS JANUARY 1ST

TERM, TERMINATION AND RENEWAL:

AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

TYPE OF ADMINISTRATION:

BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

PLAN BENEFITS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>35.00*</i>
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VISION CARE MATERIALS

Lenses

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>25.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>40.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>50.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>80.00*</i>

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$</i>	<i>45.00*</i>
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

CONTACT LENSES

<i>Visually Necessary Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>210.00*</i>
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<i>Elective Professional Fees** and Materials</i>	<i>Up to \$ 150.00</i>	<i>Up to \$</i>	<i>100.00</i>
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LENS OPTIONS

<i>Blended lenses</i>	<i>Covered in Full</i>	<i>Up to \$</i>	<i>40.00</i>
<i>Polycarbonate lenses</i>	<i>Covered in Full</i>	<i>Not covered</i>	
<i>Progressive lenses</i>	<i>Covered in Full</i>	<i>Up to \$</i>	<i>50.00</i>
<i>Tinted/Photochromic</i>	<i>Covered in Full</i>	<i>Up to \$</i>	<i>5.00</i>

***Subject to Copayment, if any.**

****Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.**

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.

LOW VISION

Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

Supplemental Testing Covered in Full Up to \$125.00
(includes evaluation, diagnosis and prescription of vision aids where indicated)

Supplemental Aids 75% of cost 75% of cost

Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) years.

ADDITIONAL DISCOUNT

Each Covered Person shall be entitled to receive a discount of twenty percent (20%)* toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.**

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Note: For Plan B patients (12/12/24), the 20% discount applies to the frame on the off year.

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

ADDENDUM

LASER VISIONCARESM PROGRAM SCHEDULE OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

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

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

ELIGIBILITY

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

COVERED SERVICES

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

<u>Covered Service</u>	<u>Covered Person Benefit</u>
Initial consultation	No cost
Preoperative Exams	No cost*
PRK, LASIK, or Custom LASIK Surgery	\$500.00 per-eye allowance**
Postoperative examinations	No cost (included in surgery fee)
Enhancement surgery (Only covered if needed and if performed within the time period specified by the Participating Laser Vision Correction Facility)	No cost

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

**This plan provides an allowance of \$500.00 per eye to be paid toward the above Laser Vision Correction Surgery services. VSP has contracted with the Participating Laser Vision Correction Facilities to provide discounts to VSP members. The discounted price will not exceed \$1800.00 per eye for LASIK, \$1500.00 per eye for PRK, and \$2300.00 per eye for Custom LASIK. In the event that a Covered Person receives Laser Vision Correction services on one eye only, any remaining balance may not be applied towards the cost of surgery in the second eye.

HOW DOES THE PLAN WORK?

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

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

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

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

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

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

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

WHAT IF I USE A NON-PARTICIPATING DOCTOR?

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

You may obtain Laser Vision Correction Surgery services from Non-Member Providers and will receive an allowance of \$500.00 per eye towards the surgery and any associated pre and post operative services.

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

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

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

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

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7100

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

EXCLUSIONS AND LIMITATIONS

Limitations:

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

Exclusions:

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

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