Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

VISION CLASSIC

LIMITED BENEFIT POLICY

Attached is the Schedule of Benefits, showing name of Policyholder, Policy number, type of Policy (individual or otherwise), premiums and the effective date.

GUARANTEED RENEWABLE CONDITIONED UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201

ARKANSAS BLUE CROSS AND BLUE SHIELD

VISION EXPENSE POLICY

OUTLINE OF COVERAGE

If, after examination of your Policy, you are not satisfied with any of its terms or conditions, you may return it to the Company within thirty (30) days of its delivery to you and receive a full refund of all premiums.

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of your Policy. The outline is not your Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

VISION EXPENSE COVERAGE - Policies of this category are designed to provide to persons insured, coverage for vision expenses. Coverage is provided for a vision examination and vision materials subject to any Copayment provisions or other limitations which may be set forth in the Policy.

BENEFITS

COPAYMENT - is the amount the Covered Person must pay for Covered Services in any Frequency Period before benefits will be paid, subject to the limitations shown on the Schedule of Benefits.

COVERED SERVICES -

Vision Exam - One exam every twelve (12) months

Spectacle Lenses - Up to two lenses provided one time every twelve (12) months

Frame - One frame provided one time every twenty-four (24) months

Contact Lens Allowance - Contact lenses benefit provided in lieu of lenses and/or frame one time every twelve (12) months.

ALLOWABLE CHARGE -

Frame - The amount the Policy will allow for frames. Any amount over the Allowable Charge is the Covered Person's responsibility.

Contact Lenses - The amount the Policy will allow for materials and services. Any amount over the Allowable Charge is the Covered Person's responsibility.

AGE LIMITATIONS - Dependent Children are covered in accordance with Policy guidelines. You are responsible for changes in coverage status (from individual to family or from family to individual).

SPECIAL LIMITATIONS

Vision Examination and Vision Materials - Fees charged by a Provider for services *other than* Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

NON-PARTICIPATING PROVIDERS - This Policy provides direct reimbursement for Vision Examinations and Materials when received from Non-Participating Providers in accordance with the following fee schedule.

Exam	Up to $45	Trifocal Lenses	Up to $65
Frame	Up to $70	Lenticular Lenses	Up to $100
Single Vision Lenses	Up to $30	Elective Contact Lenses	Up to $105
Bifocal Lenses	Up to $50	Necessary Contact Lenses	Up to $210

BENEFITS AND SERVICES NOT INCLUDED FOR:

Services or supplies collectible under Worker's Compensation or any law providing benefits for dependents of military personnel; services for conditions which treatment is provided by federal or state government or are provided without cost; experimental or investigational services; services provided by an Immediate Relative; Charges for services or supplies for which no charge is made that the Covered Person is legally obligated to pay; charges for which no charge would be made in the absence of vision coverage; charges for service by other than a Provider; charges by a Provider to complete forms for benefit determinations; fees charged by a Provider for services other than covered Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider; such fees or materials are not covered under this Policy; benefits for services of materials started prior to the date the Covered Person was eligible under this Policy; orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses; medical and/or surgical treatment of the eye, eyes, or supporting structures; any vision examination or any corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under this Policy; Plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Frequency Period when Vision Materials would next become available; specialized techniques that entail procedure and process over and above that which is normally adequate; any additional fee is the Covered Person's responsibility; all other services not specifically listed as benefits herein.

Guaranteed Renewable/Conditioned upon Residence in Arkansas

This Policy and riders are guaranteed renewable so long as you reside in Arkansas. The Company may change the established premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification.

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SCHEDULE OF BENEFITS

Effective Date: 10/01/2016
Document Creation Date: 07/15/2016

		Monthly
Identification #: XCV9000000	**Coverage Type**	**Premium**
VSP CLASSIC VISION POLICY	Vision	$7.60
Group #: BR549		
Premium Billing Frequency: Monthly		

Member Number	Name	Date of Birth	Effective Date
01	John R Doe	12/15/1968	10/01/2016

Please verify the information is correct. Claims payment determination will be based on the information noted above. If you have any questions or if the information on this document is incorrect, please call [1-800-123-4567].

Refer to this Insurance Policy for a full explanation of your benefits, the limitations on these benefits and the services that are not covered.

Vision Coverage Information

Classic Plan

Benefit Frequency	Frequency Period Once every -
Eye Examination	12 months
Spectacle Lenses	12 months
Frame	24 months
Contacts *(in lieu of glasses)*	12 months

Copayments	In-Network Coverage
Exam	$10.00
Materials *(frames and lenses)*	$20.00

In-Network Allowances	
Frame	Included up to $125.00
Elective Contact Lenses	Included up to $125.00
Covered Lens Options	Polycarbonate for Children, Scratch Coat Tint, Kids Care

ARTICLE I. STATEMENT OF COVERAGE

A. This Policy contains the insurance benefits provided by Arkansas Blue Cross and Blue Shield, (the Company) to you and is subject to its terms. Payment for vision services will be made in accordance with this Policy; however, only services specifically listed herein for the individuals listed on the Schedule of Benefits are covered.

B. This coverage is most effective and advantageous when the services of Participating Providers are used.

C. Participating Providers are paid directly by the Company. You are responsible for any charges beyond the Policy payment. The determination of whether a Provider is Participating Provider or Non-Participating Provider is the responsibility of the Company. The Company can provide a list of Participating Providers, or you may also access our web site at WWW.ARKANSASBLUECROSS.COM. You should always ask your chosen Provider if he/she participates. We also recommend that you take this Policy with you to your Provider's office.

D. The decision about whether to use a Participating Provider is the sole responsibility of the Covered Person. Participating Providers are not employees or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

E. The effective date of your coverage is indicated in the Schedule of Benefits.

F. Continuance of coverage under this Policy shall be contingent upon receipt of premiums remitted in advance by the Policyholder.

G. Under this Policy, notice is effectively delivered when it is mailed to your most recent address as recorded in our records.

H. The Company reserves the right to amend the premiums required for this Policy. If we do so, we will give thirty (30) days written notice to the Policyholder and the change will go into effect on the date indicated the notice.

I. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this document. Any change or amendment must be in writing and signed by an Officer of the Company.

ARTICLE II. DEFINITIONS

A. Allowable Charge, when used in connection with Vision Examinations and Vision Materials covered in this Policy, will be the amount deemed by the Company to be reasonable. An amount equaling the lesser of the charge billed by the Provider or the Arkansas Blue Cross and Blue Shield allowance is the basic charge. However, this charge may vary, given the facts of the case and the opinion of the Company's Vision Advisor.

B. Child means the Policyholder's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Policyholder for adoption. "Child" also means a Child for whom the Policyholder must provide medical support under a qualified medical Child support order or for whom the Policyholder has been appointed the legal guardian.

C. Company means Arkansas Blue Cross and Blue Shield.

D. Copayment means the amount required to be paid to a Provider by or on behalf of a Covered Person in connection with Covered Services. Copayments are listed in the Schedule of Benefits.

E. Covered Person means the Policyholder upon whom premiums have been paid and his Eligible Dependents, if any, for whom premiums have been paid.

F. Covered Services mean a service or supply specified in this Policy or specifically approved by the Company for which the Company will reimburse charges.

G. Date of Service is the date that treatment is completed.

H. Discount means the percentage in which a Participating Provider has agreed to reduce the charge for the requested service, material or procedure. Discounts are available at most Participating Provider locations.

I. Eligible Dependents are the Policyholder's:

1. Spouse;
2. Child less than 26 years of age;
3. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided 1.) such Child is or was under the limiting age of dependency stated in Subsection 2. above at the time of application for coverage under the Policy or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage.

   The Company shall have the right to require satisfactory proof of mental or physical incapacity with the right to examine your child at the Company's expense, but not more than once bi-annually. Upon failure to submit such required proof or to permit such an examination, or when your child ceases to be so incapacitated, coverage with respect to that child shall cease.

   Note: Domestic partners are not eligible for coverage as Dependents under this Policy.

J. Frequency Period means the time period during which you are eligible for the Vision Examination and Vision Materials as stated in the Schedule of Benefits. This time period is measured from the date of your last Vision Examination or the date you received Vision Materials.

K. Immediate Relative means a person who ordinarily resides in the Covered Person's home, including self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law.

L. Member means the Policyholder. See ARTICLE VII.

M. Necessary Contact Lenses are contact lenses provided when functional vision correction cannot be achieved with prescription eyeglasses but can be achieved with contact lens wear. Conditions that may justify Necessary Contact Lenses include Keratoconus, Anisometropia, Aniseikonia, Astigmatism, Pathological Myopia, Post-traumatic Disorders, Aphakia, Aniridia, certain corneal conditions and instances in which visual acuity is not correctable with conventional spectacles. The Provider makes the clinical determination whether or not a patient is eligible for Necessary contact lenses during a comprehensive eye examination. If a Provider feels that a patient needs necessary contact lenses for a condition that is not on the list and can clinically justify the need, then that request is evaluated by a clinical specialist. Necessary Contact Lenses will be covered-in-full when supplied by a Participating

Provider; however, **Prior Verification** is necessary.

The Utilization Review Committee reviews and determines whether treatment, procedures and services are medically necessary. The Committee conducts prior approval, concurrent and respective reviews and issues determinations in accordance with regulatory and accreditation standards and timeframes. The Utilization Review Committee establishes criteria for monitoring utilization and tracks and trends utilization.

N. Non-Participating Provider means a Provider who does not have a contract with the Company, directly or indirectly, to provide Covered Services.

O. Participating Provider means a Provider who has signed a contract with the Company, directly or indirectly, to provide Covered Services. The Company will pay a Participating Provider directly.

P. Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.

Q. Policy means this document, your Schedule of Benefits, the application and any amendments or endorsements signed by an Officer of the Company.

R. Policyholder means the person with whom the Company has agreed to provide benefits and whose name appears on the Schedule of Benefits.

S. Prior Verification means the process by which a Provider determines in advance of the Covered Person obtaining Necessary Contact Lenses or laser vision correction meets coverage requirements. Note that Prior Verification does not mean that the Necessary Contact Lenses or the laser vision correction will be covered regardless of other terms, conditions or limitations outlined in this Policy, but means only that coverage will not be denied for failing to meet necessity requirements if complete and accurate information has been furnished to the Company when Prior Verification is given. Without limiting the application of other coverage limitations or exclusions, for example, Prior Verification shall not be interpreted to waive eligibility requirements such as dependent status or timely premium payment, nor shall Prior Verification be deemed to waive network benefit limits or any other specific Policy condition, exclusion or limit, such as a Frequency Period maximum or policy limit.

T. Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

U. Spouse means an individual who is the husband or wife of a Member as a result of a marriage that is legally recognized in a jurisdiction within the United States of America.

V. Stepchild means a natural or adopted Child of the Spouse of the Policyholder.

W. The masculine gender when used herein shall include the feminine gender.

X. Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT). Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation

of non-medical diagnostic and non-medical treatment programs.

Y. Vision Materials means corrective lenses and/or frames or contact lenses.

Z. We, Our and Us means the Company, Arkansas Blue Cross and Blue Shield.

AA. You and Your means a Covered Person.

ARTICLE III. SPECIFIC BENEFITS AND LIMITATIONS OF THE PLAN

A. **Coverage for Vision Examination and Vision Materials.** Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in this Policy, coverage for Vision Examinations and Vision Materials begins on the Covered Person's effective date and is limited to the Frequency Period stated in the Schedule of Benefits. When Vision Examinations and/or Vision Materials are received from a Participating Provider, You are responsible for:

1. The Copayment, if a cash payment is due at the time services are rendered; or
2. The difference between the Allowable Charge plus any negotiated Discount and the scheduled fee; the Company will pay the dollar amount of the Allowable Charge or the actual charge, whichever is less; or
3. the difference between any negotiated Discount and the scheduled fee.

NOTE: In-network allowance for wholesale frames are included up to $70.00.

B. **Non-Participating Provider Benefits.** Benefits for services or materials received from a Non-Participating Provider are shown in terms of the dollar amount We will reimburse You for that service or material, not the total amount for which You are responsible. If You use a Non-Participating Provider, Your total responsibility is the difference between the reimbursement and the total amount charged by the Non-Participating Provider; We will pay the dollar amount of the reimbursement for that service or material or the actual charge, whichever is less. Reimbursement will be made according to the following fee schedule.

Exam	up to $45	Trifocal Lenses	up to $65
Frame	up to $70	Lenticular Lenses	up to $100
Single Vision Lenses	up to $30	Elective Contact Lenses	up to $105
Bifocal Lenses	up to $50	Necessary Contact Lenses	up to $210

C. **Vision Examination Benefit.** A Vision Examination includes but is not limited to, case history (eye and vision history and medical history); entrance distance acuities; external ocular evaluation including slit lamp examination; internal ocular examination; tonometry; distance refraction (objective and subjective); binocular coordination and ocular motility evaluation; evaluation of papillary function; biomicroscopy; gross visual fields; assessment and planning; vision care counseling; form completion; and Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases when professionally indicated).

D. **Vision Materials Benefit.** If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be covered, subject to the following limitations:

1. Spectacle Lenses - up to two lenses provided one time in each Frequency Period;
2. Frames - one frame provided one time in each Frequency Period;

3. Contact Lenses - contact lens benefit provided in lieu of frames and/or lenses no more than one time in each Frequency Period. Participating Providers will apply the Allowable Charge towards a contacts supply.

E. **Necessary Contact Lenses**. Necessary Contact Lenses are subject to Prior Verification and are limited to one pair of lenses per Frequency Period unless a subsequent Vision Examination shows a prescription change that qualifies for another lens or lenses due to necessity. You or your attending Provider must send a completed request to the Company for Necessary Contact Lenses *before* the lenses are dispensed initially or due to a change in prescription. Any amount due over the Allowable Charge for such lenses is Your responsibility. If You do not obtain Prior Verification for Necessary Contact Lenses initially or due to a prescription change, the entire charge is Your responsibility.

F. **Low Vision Coverage.** Subject to Prior Verification, coverage is provided for low-vision services and optical devices as described below.

1. Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision. Services from a Non-Participating Provider are only covered up to $125.00.
2. Maximum low-vision aids as Visually Necessary or Appropriate are covered at 75% of the cost up to maximum of $1,000 every two years for items such as high power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

G. **Laser Vision Correction Discounts.** A Covered Person is entitled to savings of up to 10% - 20% off the Provider's charge, or a 5% Discount on any advertised special through Our network of physicians and refractive surgery centers (some centers provide a flat fee equating to these Discount levels).

H. **Ancillary Product Discount.** Most Participating Providers provide a twenty percent (20%) courtesy Discount for items not covered by this Policy, e.g. second pair of glasses, sunglasses, etc.

I. **Kids Care Benefits.** The Kids Care benefit meets the eye care and eyewear demands of active and growing children by providing two comprehensive eye exams and one pair of glasses every year, plus other important benefits. All benefits described below are subject to the copayments and allowances listed in the Schedule of Benefits.

Kids Care benefits are subject to a 12-month Frequency Period for exam, lens, frame (Child) and contact lenses.

1. Exam Services. Two comprehensive eye exams are covered-in-full, subject to an exam copayment, which test for eye health and vision issues that can begin during childhood, like nearsightedness, amblyopia (lazy eye), and strabismus.
2. Lenses are covered-in-full, less the lens copayment, including child-friendly, impact-resistant polycarbonate lenses. There is an option to cover photochromic adaptive lenses, a great choice for kids that offers UV protection

and the versatility of one pair of glasses for all environments. All lens enhancements are covered after the copayment. Additional lenses covered-in-full when a minimum of .50 diopter change has occurred between Frequency Periods.

3. Frames are covered-in-full up to the allowance specified with a twenty percent (20%) discount on any amount above the retail allowance.

ARTICLE IV. SERVICES NOT INCLUDED

Except as specifically provided in this Policy, no coverage will be provided for:

A. Services or supplies collectible under Worker's Compensation or any law providing benefits for dependents of military personnel; services for conditions which treatment is provided by federal or state government or are provided without cost;

B. experimental or investigational services;

C. services provided by an Immediate Relative;

D. Charges for services or supplies for which no charge is made that the Covered Person is legally obligated to pay; charges for which no charge would be made in the absence of vision coverage;

E. charges for service by other than a Provider;

F. charges by a Provider to complete forms for benefit determinations;

G. fees charged by a Provider for services other than covered Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider;

H. benefits for services of materials started prior to the date the Covered Person was eligible under this Policy;

I. orthoptic or vision training, subnormal vision aids and any associated supplemental testing and aniseikonic lenses;

J. medical and/or surgical treatment of the eye, eyes or supporting structures;

K. any vision examination or any corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under this Policy;

L. Plano (non-prescription) lenses or non-prescription sunglasses;

M. two pair of glasses in lieu of bifocals;

N. lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Frequency Period when Vision Materials would next become available;

O. specialized techniques that entail procedure and process over and above that which is normally adequate - any additional fee is the Covered Person's responsibility;

P. all other services not specifically listed as benefits herein.

Q. Contact Lens Replacement.

ARTICLE V. SUBROGATION

If a Covered Person is injured by a third party, the Company is subrogated to all rights the Covered Person may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided. The Covered Person must cooperate fully with the Company in its efforts to collect

from the third party, and if the Covered Person fails to do so, the Company shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments or credits due under this Policy. The Company may assert its subrogation rights independently of the Covered Person. In addition to the above-referenced subrogation rights, the Company also has reimbursement rights should the Covered Person, or the legal representative, estate or heirs of the Covered Person recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Covered Person shall promptly reimburse the Plan any monetary recovery made by the Covered Person and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source**.**

ARTICLE VI. COORDINATION OF BENEFITS AGAINST OTHER VISION COVERAGE

A. **Definitions:**

1. **Allowable Expense** is a necessary, reasonable, and customary item of expense for vision care; when the item of expense is covered at least in part by one or more plans covering the insured for whom the claim is made.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.
2. **Claim Determination Period** is the Frequency Period. However, it does not include any part of a year during which a Covered Person has no coverage under this Policy.
3. **Other Vision Plan** is any form of coverage which is separate from this Policy with which coordination is allowed. Other Vision Plans shall be any of the following which provides vision benefits or services:
   a. Group insurance or group-type coverage, whether insured or uninsured, including prepayment groups. It does not include school accident type coverage (grammar, high school and college student coverages, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis") or group or group type hospital indemnity benefits of $100 or less per day.
   b. Individually underwritten vision plan with a coordination of benefits provision.
   c. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

      Each contract or other arrangement for coverage under a., b. or c. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
4. **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits. In other words, a plan that does not have a COB provision is always the Primary Plan.

5. **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

   When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

6. **This Plan** is this Individual Policy.

B. **Applicability**

If either a Policyholder or Eligible Dependent are covered by any other vision benefits plan and receive services covered by both This Plan and the other plan, benefits will be coordinated. This means that one plan will be primary, while the other plan will be secondary. Each plan will provide only that portion of its benefit that is required to cover expenses. Coordination of Benefits prevents duplicate payments and overpayments.

C. **Order of Benefit Determination Rules**

1. General

   When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless;

   a. The other plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

2. Rules

   This Plan determines its order of benefits using the first of the following rules which applies:

   a. Non-Dependent/Dependent - The benefits of the plan which covers the Covered Person as an employee, member or subscriber are determined before those of the plan which covers the Covered Person as a dependent; except that: if the Covered Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

      (i) Secondary to the plan covering the Covered Person as a dependent and

      (ii) Primary to the plan covering the Covered Person as other than a dependent then the benefits of the plan covering the Covered Person as a dependent are determined before those of the plan covering that Covered Person as other than a dependent.

   b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph c. below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:

      (i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before whose of the plan of the parent whose birthday falls later in that year; but

      (ii) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of

the plan which covered the other parent for a shorter period of time.

(iii) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

However, if the other plan does not have the rule described in (i) immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced - If two or more plans cover an Covered Person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) First, the plan of the parent with custody of the child;

(ii) Then, the plan of the spouse of the parent with custody;

(iii) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. Continuation Coverage - If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(i) First, the benefits of a plan covering the Covered Person as an employee, member or subscriber (or as that Covered Person's dependent);

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rules described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the plan which covered a, member or subscriber longer are determined before those of the Plan which covered that Covered Person for the shorter term.

D. **Effect on the Benefits of This Plan:**

1. <u>When This Section Applies</u>

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision; whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

ARTICLE VII. OTHER PROVISIONS

A. Entire Policy.

This Policy, any amendments thereto, and the Application, Change Request Form and the Schedule of Benefits constitute the entire agreement between the parties. No part of this Policy shall be changed or waived in any way except by written amendment signed by the President of the Company. No Agent has the authority to change any of its terms.

You hereby expressly acknowledge your understanding that this Policy constitutes a contract solely between you and Arkansas Blue Cross and Blue Shield, that Arkansas Blue Cross and Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Arkansas Blue Cross and Blue Shield to the use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that Arkansas Blue Cross and Blue Shield is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Contract based upon representations by any person other than Arkansas Blue Cross and Blue Shield and that no person, entity, or organization other than Arkansas Blue Cross and Blue Shield shall be held accountable or liable to you for any of the obligations created under this Policy.

B. Time Limit on Certain Defenses.

1. Except for fraudulent misstatements made by you in the application for this Policy, no misstatement shall be used to void any of its terms after three (3) years.

2. Incontestable. Except for a disease or physical condition excluded from coverage by name or description no claim for loss occurring after twelve (12) months from the effective date of this Policy shall be denied.

C. Termination of a Covered Person’s Coverage for Cause:

1. The Company may terminate coverage under this Policy upon thirty (30) days’ written notice for:

a. intentional misrepresentation of material fact or fraud in obtaining coverage; or

b. intentional misrepresentation of material fact or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

2. For purposes of this termination for cause provision, intentional misrepresentation of material fact occurs if (i) information is withheld or if incorrect information is provided and (ii) the Company would not have issued this Policy, would have charged a higher premium, would have required the Policy to be amended, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented.

3. Termination for cause shall be effective upon the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the date stated in the termination notice letter to Policyholder.

4. A Covered Person may appeal a termination for cause action. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the termination effective date stated in the termination notice letter to Policyholder.

D. Notice and Proof of Claim.

1. You must submit written proof of any services, supplies or treatment and the Charges to the Company within one hundred eighty (180) days after such services, supplies or treatment were received from a Provider. To submit a claim from a Non-Participating Provider, send written proof to VSP, P.O. Box 997105, Sacramento, CA 95889-7105.

2. The Company, upon receipt of such notice, will furnish to you such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Company receives such notice, you shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

3. Subject to all applicable statutory provisions and rules and regulations of the Arkansas Insurance Department, all benefits payable under this Policy will be payable immediately upon receipt of written proof of loss.

E. Legal Actions. No Court suit shall be brought to recover on this Policy before sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No legal action shall be brought after the expiration of three (3) years from the time written proof of loss is required to be furnished.

F. This Policy shall be in effect until terminated by its terms.

G. Unless you change residence from Arkansas, this Policy and any amendments or riders to it are guaranteed renewable. The initial premium you pay for this Policy will not increase during the first twelve (12) months this Policy is in force. After twelve (12) months, your premium rate will be subject to any changes in premium resulting from

your age increasing over one of the premium rate age-bands or the Company changing the established premium rate for all policies and riders of the same form number and premium classification as this Policy.

H. A grace period of thirty-one (31) days will be granted for the payment of premiums becoming payable after the first such payment, during which grace period the Policy shall continue in force. If premiums are not paid within thirty-one (31) days after they become due and payable this Policy is terminated as of the date on which the premiums were due and payable.

I. Reinstatement: If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the Company or by any agent authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated Policy shall cover only loss as may begin more than ten (10) days after such date. In all other respects, the Covered Person and Company shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

J. This Policy shall terminate upon the death of the Policyholder. In such event, the Company shall return all unearned premiums to your estate or other appropriate party.

K. Before any benefits can be paid, you agree, as a condition of coverage under this Policy, and authorize and direct any Provider of vision services or supplies to furnish Arkansas Blue Cross and Blue Shield, its agents, or any of its subsidiaries, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you authorize the release of such records to any third party review person or entity, for purposes of coverage determination and payment. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any Provider so respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Company, or failure to cooperate fully to obtain information requested by the Company from your Provider shall be, by itself, grounds for denial of benefits under this Policy.

L. Change of Residence. Upon a Policyholder moving permanently to another state, this Policy shall be void at the end of the period for which premiums have been paid. Upon application to the Company, membership shall be transferred to the Company in the area of your new residence. Upon transfer, rates and benefits may be substantially different.

M. Assignment. No assignment of benefits under this Policy shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Policyholder.

N. Upon termination of this Policy all benefits, except charges incurred prior to termination, shall cease.

O. Clean Claims. If the Company is able to process your claim without requesting additional information, it will notify you of its claim determination within 30 days of the Company's receipt of the claim. The Company will forward any payment resulting from the claim determination within 45 days (30 days if the claim is submitted electronically) of the Company's receipt of the claim.

P. How To Appeal A Claim

1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your physician. You or your representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

Q. Despite our best efforts, we may make a claim payment which is not for a benefit provided under this Policy, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. The Company will have the right to offset future payments made to you or your Provider if prompt refund of such payment is not received.

ARTICLE VIII. POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING

A. Membership

By virtue of ownership of this Policy, the Policyholder is a member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings or assets of the Company.

B. Annual Meeting

An annual meeting of the Members shall be held each and every calendar year in the State of Arkansas for the purpose of electing directors, receiving and considering reports as to the business and affairs of the Company and transacting such other business as may properly come before the meeting. The meeting shall be held between January 1 and April 1 of each year at such place, date and time as shall be

fixed by the Board of Directors or the Chief Executive Officer. The Board of Directors may, from time to time, provide that the place, date and time of the annual meeting shall be set forth in the Policy of Members as set out in Section D. below.

> "THE ANNUAL MEETING OF THE MEMBERS SHALL BE HELD EACH YEAR AT THE HOME OFFICE, LOCATED AT 601 GAINES STREET, LITTLE ROCK, ARKANSAS, ON THE THIRD MONDAY IN MARCH AT 1:00 P.M. (PROVIDED, IF SUCH DAY SHALL BE A LEGAL HOLIDAY, THEN AT THE SAME TIME AND PLACE ON THE NEXT SUCCEEDING DATE WHICH IS NOT A LEGAL HOLIDAY)."

C. Special Meetings

A special meeting of Members for any purpose may be called by the Board of Directors or Chief Executive Officer, and shall be called by the Chief Executive Officer of the Secretary at the request of Members holding one-third (1/3) of the voting power entitled to vote thereat. Such request shall state the purpose or purposes of the meeting, and no other business outside the scope of the state purpose or purposes shall be transacted. Unless ordered by the Board of Directors, the time and place of each special meeting of Members shall be determined by the Chief Executive Officer.

D. Notice of Meetings

So long as each insurance Policy issued by the Company sets forth the place, date and hour of the annual meeting of Members, no notice of any annual meeting shall be required to be given to any Member, regardless of the number or nature of proposals to be considered and voted upon at the annual meeting. If notice of the annual meeting is not set forth in each insurance Policy, written or printed notice of the annual meeting and every special meeting of the Members, stating the place, date, time and the purpose or purposes of such meeting shall be given to the Members entitled to vote at such meeting not less than ten (10), nor more than sixty (60), days before the date of the meeting. All such notices shall be given, either personally or by the mail, by or at the direction of the Chief Executive Officer or Secretary unless ordered by the Board of Directors. Notices which shall be mailed shall be deemed to be "given" when deposited in the United States Mail addressed to the Member at the Member's address as it appears on the records of the Company, with postage prepaid [first class mail], if the notice is mailed thirty (30) days or less before the date of the meeting], and any notice transmitted other than by mail shall be deemed to have been "given" when delivered to the Member.

E. Quorum

Except as otherwise provided by applicable law, a majority of the Members of the Company (present in person or by proxy) shall be necessary to constitute a quorum for the transaction of business at any annual or special meeting of the Members of the Company.

F. Voting Rights

Each Member shall be entitled to one vote for each policy held by him upon each matter coming to a vote at meetings of Members. Such vote may be exercised in person or by written proxy.

G. Vote Required

A majority of the voting power represented at any meeting of Members shall be necessary and sufficient to approve any given matter. There shall be no cumulative voting.

H. Proxy

By accepting this Policy the Policyholder appoints the Board of Directors ("Board") of the Company to act on the Policyholder's behalf at all meetings of Members of the Company. This appointment shall include such persons at the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. This proxy, unless revoked, shall remain in effect during the term of this Policy. The Policyholder may revoke this proxy in writing by advising the Company of such revocation at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.

[P. Mark White, President]

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
LITTLE ROCK, ARKANSAS 72201

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2072 or Toll Free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages,

exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;

- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $500,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $500,000 limit, the Association will not pay more than $500,000 in health insurance benefits, $500,000 in present value of annuity benefits, $500,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.