



January 15, 2007

PAM MACLEOD
FARM CREDIT FOUNDATIONS PLAN
SPONSOR COMMITTEE,
375 JACKSON
SAINT PAUL, MN 55101

**RE: FARM CREDIT FOUNDATIONS PLAN SPONSOR COMMITTEE, GROUP
#12301177
JANUARY 1, 2007 DOCUMENTS**

Attention Pam Macleod:

Enclosed are your JANUARY 1, 2007 documents.

This new document supersedes any existing document you have with VSP. If you have any questions, or need additional information, please do not hesitate to contact us at 866-213-2249, and a VSP representative will assist you.

Enclosures



VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE POLICY

Group Name **FARM CREDIT FOUNDATIONS PLAN SPONSOR
COMMITTEE**

Policy Number **12301177**

State of Delivery **MINNESOTA**

Effective Date **JANUARY 1, 2007**

Policy Term **TWENTY-FOUR (24) MONTHS**

Premium Due Date **FIRST DAY OF MONTH**

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("the Company") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Policy.

Gary Brooks, Senior Vice President, Operations

**VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY
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**VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY**

**SECTION I.
DEFINITIONS**

Key terms used in this Policy are defined and shall have the meaning set forth as follows, unless the context of a term's usage clearly requires otherwise:

1.01. ADMINISTRATIVE SERVICES PROGRAM: A group vision care plan whereby Group pays the Company for the Plan Benefits in addition to a monthly administrative fee.

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

1.03. BENEFIT AUTHORIZATION: Authorization issued by the Company identifying the individual named as Insureds of the Company, and identifying those Policy Benefits to which Insured is entitled.

1.04. CONFIDENTIAL MATTER: All confidential or personal information concerning the medical, personal, financial or business affairs of Insured acquired in the course of providing Plan Benefits hereunder.

1.05. COPAYMENTS: Those amounts required to be paid by or on behalf of Insured for Plan Benefits which are not fully covered.

1.06. ELIGIBLE DEPENDENT: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by the Company in Section VI. of this Policy under which such Enrollee is covered.

1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Insured to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

1.08. **ENROLLEE**: An employee or member of Group who meets the criteria for eligibility specified under Section VI. Eligibility For Coverage.

1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by the Company.

1.10. **GROUP**: An employer or other entity which contracts with the Company for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

1.11. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Insureds of the Company.

1.12. **GROUP VISION CARE POLICY (also, "The Policy")**: The Policy issued by the Company in favor of a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Insureds of the Company and receive Plan Benefits in accordance with the terms of such Policy.

1.13. **INSURED**: An Enrollee or Eligible Dependent who meets Insured's eligibility criteria and on whose behalf Premiums have been paid to the Company, and who is covered under this Policy.

1.14. **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.

1.15. **MEMBER DOCTOR**: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Insureds of the Company.

1.16. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Company to provide vision care services and/or vision care materials to Insureds of the Company.

1.17. **PLAN ADMINISTRATOR**: The person specifically so designated on the application, or if an administrator is not so designated, the Group. The Plan Administrator shall have authority to control and manage the operation and administration of the Policy on behalf of the Group.

1.18. **PREMIUMS**: The payments made to the Company by Group on behalf of Insured to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached hereto as Exhibit B.

1.19. **RENEWAL DATE**: The date on which the Policy shall renew, or expire if proper notice is given.

1.20. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A, that lists the vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy.

1.21. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to the Company by or on behalf of Insured to entitle him/her to Plan Benefits.

1.22. **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.

SECTION II.
TERM, TERMINATION, AND RENEWAL

2.01. Plan Term: This Policy shall become effective on the date first above stated, and shall remain in effect for the Policy Term. At the expiration of the Policy Term, the Policy shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term, that such party is unwilling to renew the Policy. If such notice is given, the Policy shall expire at 12:00 midnight on the last day of the Policy Term unless the parties reach mutual agreement on its renewal.

2.02. Early Termination Provision: The premium rate(s) payable by Group under this Agreement is based on an assumption that the Company will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If this Agreement is terminated by Group before the end of the Policy Term or any subsequent renewal terms, for any reason other than material breach by the Company, Group shall be liable for the lesser of any deficit incurred by the Company or the remaining payments which Group would have paid for the full Term of the Agreement. A deficit incurred by the Company will be calculated by subtracting the cost of incurred and outstanding claims from the premiums received by the Company from Group. Group agrees to pay the Company within thirty-one (31) days of notification of the amount due.

SECTION III.
OBLIGATIONS OF THE COMPANY

3.01. Coverage of Insureds: The Company will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Insureds." To institute coverage, Group may be required by the Company to complete and sign a Group Application and forward such application to the Company, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Insured, the Company will make available to all Insureds a Vision Care Brochure. Such Brochure will summarize the terms and conditions set forth in this Policy.

3.02. Provision of Plan Benefits: Through its Member Doctors (or through other licensed vision care providers where the Insured chooses to receive Plan Benefits from a Non-Member Provider), the Company shall provide Insureds such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), as may be Visually Necessary or Appropriate, subject to any limitations, exclusions, or Copayments therein stated. When the Insured desires to receive Plan Benefits from a Member Doctor, the Insured shall contact the Company or the Member Doctor. The Company shall provide Benefit Authorization to the Member Doctor or to the eligible Insured for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by the Company in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by the Company shall constitute a certification to the Member Doctor that payment will be made. The Company shall not be held liable to Group for any Benefit Authorizations so issued in error. Insureds are

required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Insured obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details).

The Company shall pay or deny claims for Plan Benefits provided to Insureds, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after the Company has received a completed claim, unless special circumstances require additional time. In such cases, the Company may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. Determination of Visual Necessity: Plan Benefits are covered only when and to the extent that they are deemed Visually Necessary or Appropriate for the proper treatment of the Insured's condition. Questions involving necessity or appropriateness of treatment shall be decided by the Member Doctor (or Non-Member Provider) responsible for the Insured's care and are subject to review by the Company. Any objections of Insured relating to such decisions may be made to the Company at the address given herein.

3.04. Provision of Information to Insureds: The Company shall make available to the Insured necessary information describing Plan Benefits and the appropriate method for using them. A copy of this Policy shall be placed with Group and also will be made available at the offices of the Company for any Insureds who wish to inspect or copy it. The Company shall provide to Insureds an updated list of Member Doctors' names, addresses, and telephone numbers.

3.05. Preservation of Confidentiality: The Company shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Policy,

including but not limited to, sharing information with medical information bureaus, or as may otherwise be required by law.

3.06. Emergency Vision Care: When vision care is necessary for Emergency Conditions, Insureds may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from the Company is required for Insured to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Insureds are not covered by the Company for medical services and should contact a physician under Insureds' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Insured should contact the Company's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

SECTION IV.
OBLIGATIONS OF THE GROUP

4.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified in Section 6.01(a) and/or as mutually agreed to by the Company and Group. By the Effective Date of this Policy, Group shall provide the Company with a listing, in a form approved by the Company, of all of its Enrollees who are eligible for coverage under this Policy as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to the Company on or before the last day of each month, in a form approved by the Company, a listing of all Enrollees with a designation of family status who will be added to or deleted from the Company's coverage rosters for the succeeding month.

4.02. Payment of Premiums: On or before the first day of each month, Group shall remit to the Company the Premiums payable for the next month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy for each succeeding month. The amount of such Premiums for each Insured shall be provided as a Schedule of Premiums incorporated in this Policy as Exhibit B. Only Insureds for whom Premiums are actually received by the Company shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Insured is not received by the time specified above, the Company reserves the right to terminate all rights of such Insured, and such rights may be reinstated with acceptance of a payment by Group; however, such reinstatement shall not cover the costs of vision services incurred during the period of ten (10) days after date of such acceptance.

The Company may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. The Company may

change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Policy are changed. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy. No change will be made more than once during any 12-month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy.

Notwithstanding the above, the Company reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to Premiums the Company receives from Group.

4.03. Grace Period: Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of Premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Insureds covered hereunder.

If Group fails to make any payment of premiums due by the end of any grace period, the Company may notify Group that the payment of Premiums has not been made, that coverage is canceled and that Group is responsible for payment of all Plan Benefits provided to Insureds after the last period for which Premiums were fully paid, including the grace period.

4.04. Other Information to be Provided: Group shall furnish to the Company monthly, during the effective period of this Policy, such information as may reasonably be required by the Company for the purposes of this Policy, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form specified by the Company. In addition, Group shall, when requested, make available for inspection by the Company such records as may have bearing on the coverage of Insureds under this Policy.

4.05. Distribution of Required Documents: Group shall distribute to Enrollees any disclosure forms, Policy summaries or other material required to be given to Policy subscribers by any regulatory authority. Such materials shall be distributed by Group no later than thirty (30) days after the receipt thereof.

4.06. Risk-to-ASP Conversion Provision: Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services program.

SECTION V.
OBLIGATIONS OF INSUREDS UNDER THE POLICY

5.01. General: By this Policy, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Policy may be amended or terminated by agreement between the Company and Group without consent or concurrence of the Insureds. This Policy, and all Exhibits, Riders and attachments hereto, shall constitute the Company's sole and entire undertaking to Insureds covered under this Policy.

All persons covered as Insureds under this Policy shall have the following obligations as a condition of their coverage.

5.02. Copayments for Services Received: Where, as indicated on the Schedule of Benefits, Exhibit A hereto, Copayments are required for certain Plan Benefits, these Copayments shall be the personal responsibility of the Insured receiving the care and must be paid to the Member Doctor on the date the services are rendered.

5.03. Complaints and Grievances: Time of Action: Insureds shall report any complaints and/or grievances to the Company at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to the Company verbally or in writing. Insured may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in the Company's review. The Company 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 not later than one hundred twenty (120) days after the Company's receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, the Company

will notify the Insured of the expected resolution date. Upon final resolution, the Company will notify the Insured of the outcome in writing.

5.04. Insurance Fraud: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria:** Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees:** To be eligible for coverage, a person must:

(1) currently be an employee or member of Group; and

(2) meet the coverage criteria mutually agreed upon by Group and the Company.

(b) **Eligible Dependents:** If dependent coverage is provided, the persons eligible for dependent coverage as dependents shall include:

(1) the legal spouse of any Enrollee; and

(2) any unmarried child of an Enrollee, including any natural child from the moment of birth, any dependent child who does not reside with the Enrollee, legally adopted child, or other child for whom a court holds the Enrollee responsible; and

(A) for whose support the Enrollee is legally responsible and who has not yet attained the age of 19 years; or

(B) unmarried child who has not yet attained the age of 26 years and is currently enrolled as a full-time student in good standing actively pursuing a degree or certificate at a recognized educational institution.

(C) any student who, by reason of illness, injury, or physical or mental disability, as documented by a physician, is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load.

(3) as further defined by Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he/she remains a dependent and the Enrollee's coverage remains in force; provided however, that satisfactory proof of the dependent's incapacity can be furnished to the Company within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated or at such other times as the Company may request proof, but not more frequently than annually.

6.02. Documentation of Eligibility: Persons satisfying the requirements for coverage under either of the above classes shall be eligible if:

(a) in the case of an Enrollee, the individual's name and Social Security Number have been reported by Group to the Company in the manner provided hereunder; and

(b) in the case of changes to a Dependent's status, the change has been reported by the Group to the Company in the manner provided herein.

As indicated in Section 4.04. herein, the Company may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents and to allow for any clerical errors. Subject to the provisions outlined in Section 4.03. above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage to which the Insured is entitled under the Policy.

6.03. Change of Participation Requirements, Contribution of Fees, and Eligibility
Rules: Composition of the Group, percentage of Enrollees covered under the Policy, and eligibility requirements are material to the Company's obligations under this Policy. During the

term of this Policy, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects the Company's obligations hereunder unless the Company consents to such change in writing. The Company may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Policy.

6.04. Change in Family Status: In the event of any change in the Insured's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to the Company is to be given to the Company by the Insured, or by someone else acting on the Insured's behalf, within thirty-one (31) days of such change. If such notice is given, the change in the Insured's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Insured. A newborn or adopted child will be covered during the thirty-one (31) day period after birth or adoption.

SECTION VII.
CONTINUATION OF COVERAGE

7.01. **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 that COBRA applies, the Company shall make the statutorily-required COBRA continuation coverage available for purchase in accordance with COBRA.

7.02. **Continuation of Coverage for Insureds**: Benefits shall not be terminated, suspended, or otherwise restricted to a survivor of a deceased Enrollee until the earlier of the following dates:

- (a) in which the surviving spouse becomes covered under another group health plan; or
- (b) coverage under the Plan would have normally terminated had the Enrollee lived.

The survivor may be required to make payment to Group for the continuation of plan coverage on a monthly basis. In no event shall the amount of premium exceed 102% of the cost for the plan of other similarly situated spouses and dependents who are not survivors of a deceased Enrollee.

Failure of survivor to pay the premium within ninety (90) days of notification of the requirement to do so shall be basis for termination of coverage. Written notice of cancellation shall be mailed to the survivor's last known address at least thirty (30) days prior to said cancellation.

7.03. Disability of Enrollee: Benefits shall not be terminated, suspended, or otherwise restricted to any Enrollee who becomes totally disabled while employed by the Group solely on account of absence caused by such total disability.

If Enrollee is required to pay all or part of the premium for the extension of plan coverage, payment will be made to Group.

7.04. Termination of Employment: Every eligible Enrollee who is terminated or laid off from employment for reasons other than the discontinuance of the business, bankruptcy, or the Enrollee's disability or retirement shall have the option to continue coverage for themselves and their dependents so long as the policy remains in effect for active employees of the Group. Group shall inform the Enrollee within ten (10) days after termination or layoff of:

- (a) the right to elect to continue coverage;
- (b) the amount the Enrollee must pay to Group to retain the coverage;
- (c) the manner in which and the office of the Group to which the payment to Group must be made; and
- (d) the time by which the payments to the Group must be made to retain coverage.

Notice may be in writing and sent by first class mail to the Enrollee's last known address. If Group fails to notify the Enrollee who is properly enrolled in the plan, the Enrollee shall have sixty (60) days within which to elect coverage. The sixty (60) day period shall begin to run on the date coverage would otherwise terminate or upon the date which notice of the right to coverage is received, whichever is later.

Every eligible former Enrollee electing to continue coverage shall pay the Group, on a monthly basis, the cost of the continued coverage. If, after timely receipt of monthly payment by

eligible Enrollee, the Group fails to make the payment to Company, resulting in the termination of eligible Enrollee's coverage, Group shall become liable for the eligible Enrollee's coverage to the same extent as Company.

The Enrollee may continue the coverage until reemployed and eligible for health care coverage under another group plan, a plan sponsored by another employer, or for a period of eighteen (18) months after the termination from employment, whichever is shorter. If the Enrollee becomes covered under another group plan, and the new group plan contains any preexisting condition limitations, the Enrollee may, subject to the eighteen (18) month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied.

An Enrollee shall be eligible to continue coverage if, in the period preceding the termination or layoff from employment, the Enrollee and dependents were covered through employment by a group insurance policy, subscribers contract, or health care plan.

7.05. Election to Continue Coverage: Spouses and dependents of Enrollees may elect to continue coverage under the following circumstances:

(a) If Enrollee becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); or

(b) When dependent children cease to be dependent under the eligibility requirements of the plan.

The coverage described above may be continued until the earlier of the following dates:

(a) The date coverage would ordinarily terminate under the plan; or

(b) Thirty-six (36) months after continuation by the spouse or dependent was elected; or

(c) The spouse or dependent child becomes covered under another group health plan.

Any required premium contribution shall be paid on a monthly basis by the Enrollee to Group. In no event shall the amount of premium exceed 102% of the cost to the plan for such period of coverage for other similarly situated spouse and dependent children to whom the coverage described above is not applicable, without regard to whether such cost is paid by Group or Enrollee.

7.06. Dissolution of Marriage: Continuation of coverage shall be provided for Enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage. The Enrollee is to provide continued coverage for those persons.

The coverage may be continued until the earlier of the following dates:

- (a) the date the Enrollee's former spouse becomes covered under any other group health plan; or
- (b) the date coverage would otherwise terminate under the Group's policy.

SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

8.01. Claims Denial Appeals: If, under the terms of this Policy, a claim is denied in whole or in part, a request may be submitted to the Company by Insured or Insured's authorized representative for a full review of the denial. Insured may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Insured" include Insured's authorized representative, where applicable.

a) **Initial Appeal:** The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Insured for whom the claim was denied, including the Company Enrollee's name, the Company Enrollee's Member Identification Number, the Insured's name and date of birth, the provider of services and the claim number. The Insured may review, during normal working hours, any documents held by the Company pertinent to the denial. The Insured may also submit written comments or supporting documentation concerning the claim to assist in the Company's review. The Company's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Insured as follows:

1. **Prior Authorization for Visually Necessary or Appropriate Services:** within thirty (30) calendar days after receipt of a request for an appeal from the Insured;

2. **Denied Claims for Services Rendered:** within thirty (30) calendar days after receipt of a request for an appeal from the Insured.

b) **Second Level Appeal:** If the Insured disagrees with the response to the initial appeal of the claim, the Insured has a right to a second level appeal. Within sixty (60)

calendar days after receipt of the Company's response to the initial appeal, the Insured may submit a second appeal to the Company along with any pertinent documentation. The Company shall communicate its final determination to the Insured in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

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

SECTION IX.
NOTICES

9.01. **Notice:** Any notices required to be given under this Policy to either Group or the Company shall be in writing and delivered by United States First Class Mail. Notices sent to Group will be mailed to the address shown on the Group Application. Notices sent to the Company shall be sent to the address shown on this Policy. Any notices may be hand-delivered by either party to an appropriate representative of the party, with the burden being on the party effecting such hand-delivery, to prove, if questioned, that such delivery was made.

SECTION X.
MISCELLANEOUS

10.01. Entire Policy: This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, addenda and attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of the Company and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions.

10.02. Indemnity: The Company agrees to indemnify, defend and hold harmless Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of the Company, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless the Company, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Group, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

10.03. Liability: Under no circumstances shall the Company or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

10.04. Right to Reject Claims: The Company reserves the right to reject any and all claims for services or benefits that are filed with it more than one hundred eighty (180) days after completion of services.

10.05. Assignment: Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred, except as may be expressly authorized and provided herein, without the prior written consent of both parties hereto.

10.06. Severability: Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

10.07. Choice of Law: If there are any matters arising in connection with this Policy that become the subject of legal process, the applicable law shall be that of the state of delivery of this Policy.

10.08. Gender: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.09. Replacement of Coverage: Replacement coverage of vision benefits provided within a period of sixty (60) days from the date of discontinuance of a prior policy providing vision benefits shall immediately cover all Enrollees and Eligible Dependents validly covered under the previous plan at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding carrier's plan, regardless of any limitations or exclusions relating to active employment or non-confinement.

10.10. Communication Materials: All communication materials created by Group that relate to this vision care Policy must be approved by the Company in advance of mailing to Enrollees.