

DeltaVision® Care Policy

Underwritten by:

Ember Assurance, Inc.

6465 Greenwood Plaza Blvd. Ste 900 Centennial, Colorado 80111
(303-741-9300)

Routine Vision Benefits Administered by:

Vision Service Plan Insurance Company ("VSP")
3333 Quality Drive, Rancho Cordova, California 95670

DELTAVISION® BENEFITS CONTRACT

The parties to this DELTAVISION® BENEFITS CONTRACT (this "Contract") are the employer applicant, MARS ASSOCIATES (herein called the "Group" or "Client") and the underwriter, Ember Assurance, Inc. (herein called "Ember Assurance"). This Contract provides the terms and conditions of the DeltaVision® vision care insurance policy (herein called "DeltaVision®" or the "Policy") and consists of this cover page ("Declarations Page") and the schedules and exhibits (and any appendices or riders) attached hereto, including without limitation the Schedule of Benefits and the General Provisions. This Contract will become binding upon the parties and their respective successors and assigns on the first day of January 2025 for a two-year period and for successive one-year periods thereafter unless terminated as provided herein. This Contract is issued and delivered in the state of Colorado, is governed by the laws of Colorado, and may not be changed, altered, or terminated except in accordance with Article I (RENEWAL AND TERMINATION) of the General Provisions included with this Contract. Capitalized terms used herein have the meanings set forth where such term is first used, or as set forth in Article IX (DEFINITIONS) of the General Provisions.

DeltaVision® is underwritten by Ember Assurance, an affiliate of Delta Dental of Colorado. Claims processing, claims service and provider network access and administration for DeltaVision® are provided under contract by VSP.

This Declarations Page supersedes any contrary provision of the subsequent sections of this contract.

DECLARATIONS PAGE

Group: MARS ASSOCIATES

Type of Contract: DeltaVision® 225

Group Number: # 9001

Contract Group Effective Date: January 1, 2025

Contract Anniversary Date: January 1st

SCHEDULE OF BENEFITS SUMMARY
TO DELTAVISION® BENEFITS CONTRACT
(Who Pays What)

Table of Covered Services with VSP Preferred Providers for Enrollees and Eligible Dependents

Your Coverage With A VSP Provider			
Service/Materials	Description of Coverage	Co-Pay	Coverage Period*
WELLVISION EXAM	Focuses on your eyes and overall wellness	\$10	Every calendar year
PRESCRIPTION GLASSES		\$25	See frames and lenses
FRAMES	• \$245 featured frame brands allowance • \$225 frame allowance • 20% savings on the amount over your allowance • \$125 Costco® frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	• \$0 • \$95 - \$105 • \$150 - \$175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• \$225 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to \$60	Every calendar year
EXTRA SAVINGS	Glasses and Sunglasses Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

*Beginning with the first date of service.

Child Dependent Age Limit is to the end of the month in which the child attains age 26.

Enrollment Type: Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Contract Anniversary Date during which eligible individuals may choose to enroll themselves and/or their Eligible Dependents in the Policy, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Contract Group Effective Date and will continue until terminated as set forth in this Contract.

Where two individuals who are spouses are both eligible for coverage under this contract, they may be enrolled in the Policy together or separately, but not both. Child Dependents may only be enrolled under one parent. The term spouse includes a civil union partner or a domestic partner.

Rate Coverage

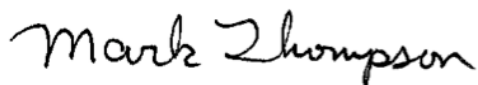
Coverage Tier	Rate Amt
SUBSCRIBER	\$ 13.94
SUBSCRIBER PLUS ONE DEPENDENT	\$ 27.19
SUBSCRIBER PLUS TWO OR MORE DEPENDENTS	\$ 43.21

These rates are contingent upon the minimum percent enrollment as stated in the original quote, in accordance with the eligibility provisions in Article I.

Riders or Appendices Attached

Countersigned:

Delta Dental of Colorado



Signature

December 1, 2024

Date

Accepted:

MARS ASSOCIATES – #9001

Signature

Date

DeltaVision® Care Policy

CONTACT US

**Visit Vision Service Plan Insurance Company's "VSP" Website:
www.vsp.com**

**You can search for a Provider, download a claim form, or access
other personal account information.**

**Customer Service:
1-800-877-7195**

EXHIBIT A
SCHEDULE OF BENEFITS DETAILS
DELTAVISION® BENEFITS CONTRACT
DeltaVision® using VSP's Choice Network

1.0 GENERAL

This Schedule of Benefits is incorporated into (and forms a part of) the Contract, Policy or Evidence of Coverage to which it is attached. This Schedule of Benefits (Details) supplements the Schedule of Benefits (Summary) included with the Contract and lists the vision care services and materials to which Covered Persons under DeltaVision® Care Policy are entitled, subject to any Copayments and other conditions, limitations and/or exclusions as stated in the Contract.

As used herein, "Covered in Full" means less any applicable Copayments as specified in the Contract.

Other capitalized terms used herein but not defined herein have the meanings set forth Article IX (DEFINITIONS) of the General Provisions to this Contract.

The time periods set forth herein (e.g., "every calendar year") begin with the first date of service.

2.0 POLICY BENEFITS WITH VSP PREFERRED PROVIDERS COPAYMENT

There shall be a Copayment of \$0 - 30 for the WellVision Exam payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$0 - \$30 Copayment payable at the time the materials are ordered. The Copayments applicable to Elective Contact Lenses is set forth in Section 2.1(d) below.

2.1. COVERED SERVICES AND MATERIALS WITH VSP PREFERRED PROVIDERS

(a) WellVision Eye Examination – Covered in Full every calendar year

Comprehensive examination of visual functions and prescription of corrective eyewear.
See Schedule of Benefits Summary for applicable Copayments.

(b) Spectacle Lenses – Covered in Full every calendar year

Spectacle Lenses: Single Vision, Lined Bifocal, Lined Trifocal, and Lenticular.
Polycarbonate lenses are Covered in Full for eligible Child Dependents.
Standard progressive lenses are Covered in Full.
See Schedule of Benefits Summary for applicable Copayments.

Lens Enhancements: (When indicated, some plans will afford coverage for select lens enhancements based on added plan features to the foundational full service plan)

See Schedule of Benefits Summary for applicable Copayments.

<i>Lens Enhancement</i>	<i>Single Vision</i>	<i>Multifocal</i>
Anti-reflective coating	Covered	Covered
Polycarbonate - Children	N/A	Covered
Progressive* Photochromic	Covered	Covered

**Note: Policy may cover standard progressives only or all progressives.*

(c) Frames – Covered in Full (up to the retail allowance) once every calendar year for adults or once every calendar year for unmarried Child Dependents

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

See Schedule of Benefits Summary for retail allowance and applicable Copayments.

LightCare Enhancement: If this enhancement is purchased by the Group/Covered Person, then the frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. Lab-fabricated plan lenses are not covered.

(d) Elective Contact Lenses:

Elective Contact Lenses (materials only) are covered up to the retail allowance once every calendar year (in lieu of frame and lenses).

The Elective Contact Lens fitting and evaluation services are Covered in Full once every calendar year. See Schedule of Benefits Summary for retail allowance and applicable Copayments.

(e) Necessary Contact Lenses:

Necessary Contact Lenses are Covered in Full once every calendar year when specific benefit criteria are satisfied and when prescribed by a VSP Preferred Provider.

If provided, the Necessary Contact Lenses benefit is in lieu of the spectacle lens and frame benefits.

2.2. LOW VISION SERVICES WITH VSP PREFERRED PROVIDERS

Professional services for severe visual problems not correctable with regular lenses is Covered in Full when specific benefit criteria are satisfied and when prescribed by a VSP Preferred Provider. This includes evaluation, diagnosis and prescription of vision aids where indicated, as well as Supplemental Tests and Supplemental Aids if prescribed by a VSP Preferred Provider.

The maximum benefit for all Low Vision services and materials is \$1000 and a maximum of two (2) Supplemental Test within a 24 month period.

The Supplemental Aids benefit pays 75% of the VSP Preferred Provider's fee, up to the maximum benefit of \$1000.

2.3. VSP DIABETIC EYECARE PLUS PROGRAMSM WITH VSP PREFERRED PROVIDERS

Additional coverage for members with diabetic eye disease, glaucoma or age-related macular degeneration is available with a \$20 Copayment per visit.

3.0 POLICY BENEFITS WITH OPEN ACCESS PROVIDERS

There shall be a Copayment of \$0 - \$30 for the WellVision Exam payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$0 - \$30 Copayment payable at the time the materials are ordered. There is no Copayments applicable to Elective Contact Lenses. In addition, the following terms apply to all Open Access Provider services:

- (a)** The exclusions and limitations of benefits as described above for VSP Preferred Providers also apply to services rendered by Open Access Providers.
- (b)** Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- (c)** There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- (d)** Ember Assurance and VSP are unable to require Open Access Providers to adhere to VSP's quality standards.

3.1. COVERED SERVICES AND MATERIALS WITH OPEN ACCESS PROVIDERS

- (a) WellVision Eye Examination – Covered in Full (up to \$45) once every calendar year**

Comprehensive examination of visual functions and prescription of corrective eyewear.

- (b) Spectacle Lenses – Covered in Full (up to specified limits) once every calendar year**

Spectacle Lenses: (i) Single Vision up to \$30, (ii) Lined Bifocal up to \$50, (iii) Lined Trifocal up to \$65, and (iv) Lenticular up to \$100.

Polycarbonate lenses are Covered in Full for eligible Child Dependents.

Standard progressive lenses are Covered in Full.

- (c) Frames – Covered in Full (up to \$70) once every calendar year for adults or once every calendar year for unmarried Child Dependents**
- (d) Elective Contact Lenses – Covered in Full (up to \$105) every calendar year**

The specified allowance applies to both the doctor's fitting and evaluation fees and to materials. Elective Contact Lenses are in lieu of frame and lenses.

(e) Necessary Contact Lenses – Covered in Full (up to \$210) every calendar year:

The Necessary Contact Lenses benefit is available when specific benefit criteria are satisfied and when prescribed by a Covered Person's Open Access Provider.

If provided, the Necessary Contact Lenses benefit is in lieu of the spectacle lens and frame benefits.

3.2. LOW VISION SERVICES WITH OPEN ACCESS PROVIDERS

Professional services for severe visual problems not correctable with regular lenses is Covered in Full (up to \$125) when specific benefit criteria are satisfied and when prescribed by a Covered Person's Open Access Provider. This includes evaluation, diagnosis and prescription of vision aids where indicated, as well as Supplemental Tests and Supplemental Aids if prescribed by a VSP Preferred Provider.

The maximum benefit for all Low Vision services and materials is \$1000 and a maximum of two (2) Supplemental Test within a 24 month period.

The Supplemental Aids benefit pays 75% of the VSP Preferred Provider's fee, up to the maximum benefit of \$1000.

4.0 EXCLUSIONS AND LIMITATIONS OF BENEFITS

4.1. Limitations on Frames: Some brands of spectacle frames may be unavailable for purchase as Policy Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Preferred Provider or by calling (800) 237-6060.

4.2. Services and Materials Not Covered: Any services and/or materials not specifically included herein are not covered by the Policy. Without limiting the generality of the foregoing, the following are not covered by the Policy:

- (a)** Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter) are not covered by the Policy, except as specifically allowed under the LightCare Enhancement, if purchased by the Covered Person.
- (b)** Two pair of glasses instead of bifocals.
- (c)** Replacement of lenses, frames and/or contact lenses furnished under this Policy that are lost or damaged, except at the normal intervals when Policy benefits are otherwise available.
- (d)** Orthoptics or vision training and any associated supplemental testing.
- (e)** Medical or surgical treatment of the eyes.
- (f)** Contact lens insurance policies or service agreements.
- (g)** Refitting of contact lenses after the initial (90-day) fitting period.

- (h)** Contact lens modification, polishing or cleaning.
- (i)** Local, state and/or federal taxes, except where required by applicable law.
- (j)** Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

EXHIBIT B
GENERAL PROVISIONS
TO DELTAVISION® BENEFITS CONTRACT
DeltaVision® using VSP's Choice Network

These General Provisions are incorporated into (and forms a part of) the Contract, Policy or Evidence of Coverage to which it is attached. Capitalized terms used herein but not defined herein have the meanings set forth elsewhere in the Contract.

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ARTICLE I. TERM, RENEWAL AND TERMINATION

1.01. Term and Renewal: This Policy shall commence on the Effective Date noted on the Declarations Page of this Policy, and shall remain in effect for the Policy Term. Except as otherwise provided herein, this Contract will automatically renew for additional one-year terms.

1.02. Termination:

- (a) Either party may terminate the Policy without cause at the end of any Contract Year by giving the other party written notice at least 30 days prior to the end of the then-current Contract Year.
- (b) Either party may terminate this Policy upon the other party's material breach of the terms and conditions set forth in the Contract. The non-breaching party must provide the breaching party with written notice of the breach, which specify the nature of the breach in reasonable detail. The breaching party will be afforded 30 days from their receipt of such notice to cure the breach. If the breach is not cured within such 30-day period, the Policy will terminate without further action on the last day of the 30-day period. If the breach is for non-payment of premiums, Ember Assurance's notice will include the specific date of termination. Client must give its Enrollees written notice of termination for non-payment within 15 days after receipt of Ember Assurance's notice of termination.
- (c) Except as otherwise provided in this Policy, an Enrollee's coverage will end immediately:
 - (1) On the date the Policy terminates;
 - (2) When the Enrollee ceases to be eligible for coverage;
 - (3) For any Enrollee enrolled as a Dependent, when the Enrollee's coverage ends; and
 - (4) On the premium due date if premiums are not paid by that date. Except as provided herein, if Client does not make a premium payment in full when due, the Client shall have a thirty-one (31) day grace period ("Grace Period"), during which coverage shall remain in effect unless Client has given written notice of termination in accordance with this Section 1.02. Enrollees will not receive Plan Benefits during the Grace Period unless all past due premiums are paid within the Grace Period. There is no Grace Period if the first month's premium is past due.

ARTICLE II. OBLIGATIONS OF EMBER ASSURANCE

2.01. Coverage of Covered Person: Ember Assurance will enroll for coverage, as directed by Client, each eligible Enrollee and his/her Eligible Dependents (if dependent coverage is provided), all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Ember Assurance may require Client to complete, sign and forward to Ember Assurance a Client Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. Following the enrollment of the Covered Persons, Ember Assurance will provide Client with an Evidence of Coverage

for distribution to Covered Persons by Client. Such Evidence of Coverage and Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

2.02. Administration of Plan Benefits: Routine vision benefits are administered by Vision Service Plan Insurance Company ("VSP") and VSP Network Providers (or through other licensed vision care providers where a Covered Person chooses to receive Plan Benefits from an Open Access Provider). Ember Assurance shall provide Covered Persons such Plan Benefits as listed in the Schedule of Benefits (Exhibit A to the Contract and, when purchased by Client, the Additional Benefit Rider) attached hereto, subject to any limitations, exclusions, or member responsibilities (e.g. Copayments) stated therein. VSP Network Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials. Notwithstanding any other provision in the Contract, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits and, when purchased by Client, the Additional Benefit Rider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Network Provider for information describing vision care services and vision care materials offered. A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from a VSP Network Provider. When a Covered Person seeks Plan Benefits from a VSP Network Provider, the Covered Person must schedule an appointment and identify himself/herself as a DeltaVision® Covered Person so the VSP Network Provider can obtain a Benefit Authorization. A "Benefit Authorization" will be issued to the VSP Network Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires. Benefit Authorizations are issued in accordance with the latest eligibility information furnished by Client and the Covered Person's past service utilization, if any. Any Benefit Authorization shall constitute a certification to the VSP Network Provider that payment will be made to the VSP Preferred Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date. VSP, as the administrator, shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days by providing notice to the claimant of the reasons for the extension. VSP may not request a refund or offset against a claim paid to a vision care provider more than twelve (12) months after it has paid a claim except in cases where the original claim was submitted fraudulently, or the provider was already paid for the services, or the services were not delivered by the provider.

2.03. Open Access Provider Services: When Covered Persons elect to utilize the services of an Open Access Provider, benefit payments for services from such Open Access Provider will be determined according to the Policy's Open Access Provider benefit fee schedule if Open Access Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Open Access Provider may bill Covered Persons for that provider's standard rates, regardless of the amount of Plan Benefits. If Covered Person obtains Plan Benefits from an Open Access Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed in accordance with the Open Access Provider reimbursement schedule shown on the Schedule of Benefits (Exhibit A to the Contract and, if purchased by Client, the Additional Benefit Rider, in each case less any applicable Copayments.

- 2.04. Information to Covered Persons:** Upon request, Ember Assurance shall make available to Covered Persons necessary information describing Plan Benefits and instructions for use. A copy of this Policy shall be provided to Client and will be made available at the offices of Ember Assurance for any Covered Persons. Covered Persons may obtain a list of the names and locations of all VSP's Preferred Providers at <https://www.vsp.com>, by calling the Customer Care toll-free number (800) 877-7195, or by sending a written request to Ember Assurance or VSP. If Client supplies email addresses of Covered Persons to Ember Assurance or VSP, Ember Assurance and VSP may use the email addresses to communicate information to Covered Persons about their Plan Benefits.
- 2.05. Preservation of Confidentiality:** Ember Assurance shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, VSP Preferred Providers, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is permitted or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law.
- 2.06. Urgent Vision Care:** When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider.
- 2.07. Medical Vision Care:** Services for conditions of a medical nature are covered only under supplemental eyecare plans. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. If Client has not purchased one of these plans, Covered Persons are not covered by Ember Assurance for such services and should contact a physician under Covered Persons' medical insurance plan for care.
- 2.08. Non-Medical Services:** For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person should call the Customer Care toll-free number (800) 877-7195 for assistance. Reimbursement and eligibility are subject to the terms of this Policy.
- 2.09. Coordination of Benefits:** Unless otherwise agreed to by Client and Ember Assurance, the following rules governing Coordination of Benefits shall apply. When Ember Assurance is the primary insurer, it will pay Plan Benefits according to the terms of this Policy, subject to any applicable state or federal codes, statutes or regulations. When Ember Assurance is the secondary insurer, it will coordinate those vision care services and materials that were considered by the primary insurer as allowable expenses. Ember Assurance will pay the lesser of:
- (a) The normal Plan Benefit, in absence of other coverage, or
 - (b) The remaining balance up to Covered Person's Plan Benefits, not to exceed the billed amount.

ARTICLE III. OBLIGATIONS OF CLIENT

- 3.01. Identification of Eligible Enrollees:** An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified by the Client and in accordance with applicable state and federal law. Client shall provide Ember Assurance with required eligibility information, in a mutually agreed upon timeframe, format and medium, to identify all Enrollees who are eligible for coverage under this Policy. If the age of a person has been misstated, Ember Assurance will make any necessary equitable adjustments in premiums, if applicable, and in accordance with the timeframe set forth in Section 3.02.
- 3.02. Retroactive Eligibility Terminations:** Retroactive eligibility changes are limited to the month in which notification is received by Ember Assurance, plus two prior months. Ember Assurance may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.
- 3.03. Change of Client Composition:** Client's percentage of Enrollees covered under the Policy as well as Client's contribution and eligibility requirements are factors used to determine rates and are considered material to Ember Assurance's obligations under this Policy. During the term of this Policy, Client must provide Ember Assurance with written notification of any changes that will significantly impact utilization of the Plan Benefits and such changes must be agreed upon by Ember Assurance. Nothing in this section shall limit Client's ability to add Enrollees or Eligible Dependents under the terms of this Policy. For purposes of this paragraph, Client may not reduce membership by more than ten percent (10%) over a twenty-four (24) month period without Ember Assurance's written consent.
- 3.04. Audits:** Upon reasonable advance written notice, Client will permit Ember Assurance's auditors or other representatives to review Client's eligibility, enrollment and related records, at a place and time that is agreeable to both parties. The purpose of the review is to verify that only eligible individuals are enrolled.
- 3.05. Payment of Premiums:** Upon receipt of a billing statement from Ember Assurance, Client shall remit to Ember Assurance the premiums. Such premiums shall remain in effect for the Policy Term unless the Client requests a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Client), or there is a material change in Policy terms or conditions pursuant to Section 9.02, provided any such change is agreed to in writing by Ember Assurance. Client premium payments are due upon receipt of Ember Assurance's billing statements and shall become delinquent thirty-one (31) days after the date set forth on the billing statement. Client shall be responsible for any legal fees and/or costs of collection incurred by Ember Assurance to collect amounts due under this Policy.
- 3.06. Distribution of Required Materials:** Client shall provide to Enrollees any materials required by any regulatory authority within the timeframe required under applicable law.
- 3.07. Communication Materials:** Communication materials created by Client which relate to this Policy may be submitted to Ember Assurance for review and approval. Ember Assurance's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Client's materials meet any applicable legal or regulatory requirements including, but not limited to, ERISA requirements. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

ARTICLE IV. OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

- 4.01. General:** This Policy provides coverage for Client's Enrollees. If Client offers dependent coverage, this Policy will also cover Enrollees' Eligible Dependents. This Policy may be amended or terminated by written agreement between VSP and Client without the consent or concurrence of Covered Persons. This Contract, together with any and all Schedules, Exhibits and/or attachments hereto, constitutes the entire obligation of VSP to Covered Persons.
- 4.02. Copayments for Services Received:** Any Copayments required under this Policy shall be the personal responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed Policy allowances, annual maximum benefits or any other stated Policy limitations are not considered Copayments but are also the responsibility of the Covered Person.
- 4.03. Obtaining Services from VSP Preferred Providers:** To utilize Plan Benefits, Covered Persons must select a VSP Preferred Provider, schedule an appointment and inform the doctor's office that they are a Covered Persons under the Policy. The VSP Preferred Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from a VSP Preferred Provider without a Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Open Access Provider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Preferred Providers for information regarding the vision care services and vision care materials they offer.
- 4.04. Open Access Provider Benefits:** If required by state law, or if purchased by Client, this Policy provides Plan Benefits for services and materials received from Open Access Providers. Covered Persons may submit requests for reimbursement to VSP and VSP will pay available Plan Benefits to Covered Persons. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided.
- 4.05. Complaints and Grievances:** Complaints and Grievances may be submitted by Covered Persons to VSP in writing, by telephone, online or through Covered Persons' VSP Network Providers, as explained in the Evidence of Coverage for this Policy. VSP will resolve all Complaints and Grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, VSP will resolve all Complaints and Grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the final resolution of all Complaints and Grievances.
- 4.06. Claim Denial Appeals:** If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

- (a) **Initial Appeal:** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.
- (b) **Second Level Appeal:** If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. VSP's communication to the Covered Person shall include the specific reasons for the determination.

Appeal Address:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

ARTICLE V. CONTINUATION OF COVERAGE

- 5.01. **COBRA:** If, and only to the extent, that COBRA applies to the parties to this Policy, Ember Assurance shall make the required COBRA continuation coverage available to Covered Persons in accordance with the provisions of COBRA.
- 5.02. **Continuation of Insurance for Enrollees:** If an Enrollee's coverage under this Policy ceases because of the termination of the Enrollee's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits, Enrollee may continue his or her present coverage under this Policy for a period of twelve (12) months immediately following the date of the termination of the person's eligibility, without evidence of insurability. (This is not available if Client is required by federal law to provide continuation of coverage pursuant to COBRA.) The following requirements apply:
 - (a) The application and payment for the extended coverage is made to Client within 31 days after issuance of written notice, but in no event beyond the 60-day period following the date of the termination of Enrollee's eligibility;
 - (b) Each premium for such extended coverage is timely paid to the Client on a monthly basis during the 12-month period;

- (c) The premium for continuing the Group coverage shall be at Ember Assurance current rate applicable to the Group policy plus any applicable administrative fee not to exceed two percent of the current rate; and
- (d) Continuation shall only be available to a member who has been continuously insured under the Group policy during the entire three months' period immediately preceding termination of eligibility.
- (e) The Client shall provide each employee or other Enrollee under such a policy written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation or conversion of the Group policy. Such notice shall be provided within 14 days of Client's knowledge of the employee's or other Enrollee's loss of eligibility under the policy.

ARTICLE VI. DISPUTE RESOLUTION

- 6.01. Dispute Resolution:** No lawsuit, action, mediation request or other request for relief under the Contract may be brought until the claimant has first exhausted all administrative remedies under the Contract. Under no circumstances may any such action be brought more than three years after the cause of action first arose. Any period during which a dispute is in mediation will toll this three-year limit.
- 6.02. Choice of Law:** The laws of Arapahoe County, Colorado govern this Policy in all respects, except in circumstances in which federal law preempts state law.
- 6.03. Damage Limitation:** Notwithstanding anything herein to the contrary, in no event shall either party to this Agreement be liable to the other party for indirect, incidental, special, punitive or consequential damages of any type whatsoever, including lost profits, arising out of or relating to this Agreement, even if such party has been advised of the possibility of such damages. In no event shall damages under this Agreement exceed the amount of fees paid by Client to Ember Assurance during the six (6) months immediately preceding the action which gives rise to the claim, cause of action or other request for relief.

ARTICLE VII. NOTICES

- 7.01. Notices:** Any notices required under this Policy to either Client or Ember Assurance shall be in writing. Notices to the Client shall be sent to the address or email address shown on the Client's Application unless otherwise directed by Client in writing. Notices to Ember Assurance shall be sent to the address shown on the Declarations Page. Notices will be effective (a) three days after being sent by registered or certified mail, return receipt requested, postage prepaid; or (b) upon confirmation of delivery by the recipient if sent by email. Either party may change its address for purposes of notice hereunder or designate an agent to receive notice on its behalf) by giving notice to the other party pursuant to this Section 6.01. Notwithstanding the above, any notices may be hand-delivered to an appropriate representative of the other party, however the party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

ARTICLE VIII. STANDARD PROVISIONS

8.01. Entire Agreement: This Contract (including the Declarations Page and all Exhibits, Schedules and attachments thereto), the Client Application, and the Evidence of Coverage constitute the entire agreement of the parties and supersede any prior understandings and agreements between them, either written or oral. Communication materials prepared by Client for distribution to Enrollees do not constitute a part of this Contract or the Policy.

8.02. Amendment or Modification: Except as otherwise provided herein, any change or amendment to this Contract must be mutually agreed upon by both Ember Assurance and Client and evidenced by a mutually executed amendment. No other person or entity has the authority to change this Policy or waive any of its terms or conditions.

If there is a change in premiums for any renewal period of this Policy, Ember Assurance will provide Client or its delegated representative with written notification thereof at least thirty-one (31) days before the new premiums go into effect. If the change in premium for any period is greater than thirty-five percent (35%), Ember Assurance will provide Client with written notification thereof at least sixty (60) days before the new premiums go into effect.

In addition, but subject to the above notification requirements with respect to premiums, Ember Assurance may change the Policy's terms, conditions, and premiums on the effective date specified in a written notice from Ember Assurance to Client if:

- (a) Federal, state or local law, statute, regulation, or ordinance changes Ember Assurance duties or obligations under the Policy; or
- (b) Taxes or fees due to the federal, state or local government or governmental body change. This provision applies only if the taxes or fees are calculated on the basis of amounts paid or payable under the Policy. Continued payment of premiums by Client following such notice from Ember Assurance constitutes Client's acceptance of any new terms, conditions and/or premiums as stated therein.

Continued payment of premiums by Client following such notice from Ember Assurance constitutes Client's acceptance of any new terms, conditions and/or premiums as stated therein.

8.03. Indemnity: To the extent permitted by law and subject to the limitations set forth in Section 6.03, each party hereto shall indemnify, hold harmless, and defend the other party, including its respective affiliates, employees, officers, directors, and agents from and against all claims, liabilities, losses, damages, costs, or expenses of any kind, including reasonable attorneys' fees and other costs of litigation, incurred by the other party by reason of the indemnifying party's negligence, fraud, willful misconduct, or violation of law. Except as provided herein, neither party assumes any of the contractual claims, obligations, liabilities or debts of the other party, and neither party shall, by virtue of its performance hereunder, assume or become liable for any such obligations, liabilities, or debts of the other party. Neither party shall indemnify or hold the other party harmless from claims, liabilities, losses, damages, or expenses incurred by the other party as a result of its own negligence, fraud, willful misconduct, or violation of law. Without prejudice to any rights of indemnification under this subsection,

each party shall cooperate with and assist the other party, at the other party's expense, in the defense of such claims as may be made by third parties against the other party arising out of the provision of services under this Agreement or the performance of this Agreement.

- 8.04. Provision of Care:** Ember Assurance arranges for the provision of vision care services and materials through agreements with VSP Preferred Providers. VSP Preferred Providers are independent contractors and are responsible for exercising independent judgment. Ember Assurance does not itself directly furnish vision care services or supply materials. Under no circumstances shall Ember Assurance or Client be liable to each other for the negligence, wrongful acts or omissions of any provider (including doctors and their staff), non-VSP owned laboratory, or any other person, entity or organization performing services or supplying materials in connection with this Policy.
- 8.05. Assignment:** Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto, except as expressly authorized herein.
- 8.06. Severability:** Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.
- 8.07. Governing Law:** This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in conformance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulation, now or hereafter existing.
- 8.08. 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.
- 8.09. Equal Opportunity:** Ember Assurance is an Equal Opportunity and Affirmative Action employer.
- 8.10. Incontestability:** The validity of this Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from date of issue.

ARTICLE IX. DEFINITIONS

The key terms in this Policy are defined as follows:

- 9.01. ADDITIONAL BENEFIT RIDER:** The document, attached to this Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under Exhibit A.
- 9.02. ASSIGNMENT OF BENEFITS:** A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing Ember Assurance or VSP to pay Plan Benefits, if available, to a named Open Access Provider.

- 9.03. BENEFIT AUTHORIZATION:** A process used to confirm eligibility of an individual named as a Covered Person of Ember Assurance and identifying those Plan Benefits to which the Covered Person is entitled.
- 9.04. CHILD DEPENDENT:** Any unmarried child of an Enrollee (up to the end of the month in which such child attains age 26), including any (i) natural child from the date of birth, (ii) legally adopted child from the date of placement for adoption with the Enrollee, or (iii) other child for whom a court or administrative agency holds the Enrollee responsible. Child Dependents over age 26 who are incapable of self-sustaining employment because of intellectual disability or physical handicap, and chiefly dependent upon Enrollee for support and maintenance.
- 9.05. CLIENT or GROUP:** An employer or other entity which contracts with Ember Assurance to provide coverage under this Policy for its Enrollees and their Eligible Dependents.
- 9.06. CLIENT APPLICATION:** The form signed by an authorized representative of the Client to apply for Enrollee coverage under this Policy.
- 9.07. COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985.
- 9.08. COMPLAINTS AND GRIEVANCES:** Disagreements regarding access to care, quality of care, treatment or service under the Policy.
- 9.09. CONFIDENTIAL MATTER:** All confidential information concerning the medical, personal, financial or business affairs of Covered Persons acquired by VSP or Ember Assurance in the course of providing Plan Benefits hereunder.
- 9.10. CONTRACT YEAR:** (a) Initially, the year beginning on the Contract Group Effective Date and ending on the day before the first Contract Anniversary Date, and (b) each subsequent year beginning on a Contract Anniversary Date and ending on the day before the next Contract Anniversary Date.
- 9.11. COORDINATION OF BENEFITS:** A procedure which allows more than one insurance plan to consider a Covered Person's vision care claims for payment or reimbursement.
- 9.12. COPAYMENTS:** Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
- 9.13. COVERED PERSON:** An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to Ember Assurance, and who is covered under this Policy.
- 9.14. ELIGIBLE DEPENDENT:** Any dependent of an Enrollee who meets the criteria for eligibility established by Client.
- 9.15. ENROLLEE:** An employee or member of Client who meets the criteria for eligibility established by Client.
- 9.16. ERISA:** Employment Retirement Income Security Act of 1974.

- 9.17. EVIDENCE OF COVERAGE:** A summary of the provisions of this Policy, prepared by Ember Assurance and provided to Client for distribution to Enrollees by Client.
- 9.18. OPEN ACCESS PROVIDER:** Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of Ember Assurance.
- 9.19. PLAN BENEFITS:** The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.
- 9.20. POLICY:** The Policy issued by Ember Assurance to a Client, under which the Client's Enrollees or members, and their Eligible Dependents, are entitled to become Covered Persons of Ember Assurance and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.
- 9.21. POLICY TERM:** The length of time this Policy is in effect.
- 9.22. SCHEDULE OF BENEFITS:** The document, attached as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.
- 9.23. SCHEDULE OF PREMIUMS:** Which defines the payments a Client is obligated to pay to Ember Assurance on behalf of a Covered Person to entitle him/her to Plan Benefits.
- 9.24. URGENT CONDITION:** A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.
- 9.25. VSP PREFERRED PROVIDER:** An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons of Ember Assurance.
- 9.26. VSP'S CHOICE NETWORK:**