Combined

Evidence of Coverage and Disclosure Form

Employer Group

(“the Group”)

Orland Unified School District

Underwritten by:

Medical Eye Services, Inc.

(“the Plan”)

Effective Date: October 1, 2019

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage and constitutes only a summary of the Plan. The Contract must be consulted to determine the exact terms and conditions of coverage.

The Contract is on file with your Employer and a copy will be furnished upon request.

Right to Review Notice

You have the right to view the Evidence of Coverage and Disclosure Form prior to enrollment. Please read this booklet carefully and completely to be sure you understand the benefits, exclusions, limitations and general provisions. Individuals with special vision care needs are encouraged to read carefully those sections that apply to them. It is your responsibility to keep informed about any changes in the Plan.

Should you the Enrollee have any questions regarding the Plan, see the Employer or contact the Plan office listed on the back cover of this booklet.

Continuation of Coverage Notice

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Important

No Enrollee has the right to receive the benefits of the Plan for Covered Services furnished following termination of coverage, except as specifically provided under the Extension of Benefits provisions in this booklet.

Benefits of the Plan are available only for Covered Services furnished during the term it is in effect and while the Enrollee claiming benefits is actually covered by the Contract.

Benefits may be modified during the term of the Plan as specifically provided under the terms of the Group Contract or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Covered Services furnished up to or after the effective date of modification. There is no vested right to receive the benefits of the Plan.

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Introduction

Medical Eye Services, Inc. (the Plan) was incorporated in California in 1992 and is licensed under the California Knox-Keene Health Care Service Plan Act.

One of the Plan's primary goals is to promote vision plans that provide quality eye care services.

This booklet describes benefits only for Covered Services from the Plan's Participating Providers and, if applicable, Non-Participating providers. The Plan's provider network includes Ophthalmologists, Opticians and Optometrists. The Plan arranges for the provision of Covered Services by contracting with Participating Providers to serve Enrollees in an organized and cost-effective manner. The Principal Benefits and Coverage and Schedule of Allowances sections show the benefits for Covered Services. The Enrollee should verify that the provider of choice is an MES Participating Provider before Covered Services are received. A directory of the Plan's Participating Providers is available to all covered Enrollees on the website (www.MES*Vision*.com), or by calling **888-859-5841 (toll-free)**, or through your Benefits Administrator. The Plan's Participating Providers agree to accept payment by the Plan plus the Enrollee's payment of any applicable Copayment/Deductible amount as payment in full for Covered Services.

Definitions

Whenever any of the following terms are capitalized in this booklet, they will have the meaning below:

Act
The California Knox-Keene Health Care Service Plan Act of 1975 as amended, as set forth in Chapter 2.2 of Division 2 of the California Health and Safety Code (beginning with Section 1340), and its implementing regulations, as set forth in Title 28 of the California Code of Regulations.

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

Calendar Year
A period beginning on January 1 of any year and ending on December 31 of the same year.

Claim Form
The form which shows amounts charged for vision care services to be submitted to the Plan for reimbursement.

Close Relative
The spouse, child, brother, sister, or parent of an Employee or Dependent.

Coated Lenses
A substance which is added to a finished lens on one or both surfaces.

COBRA (Consolidated Omnibus Budget Reconciliation Act)
COBRA is a Federal law that applies to employers and group health plans that cover 20 or more employees. It provides extended coverage under the group benefit plan in which an eligible employee or eligible dependent is currently enrolled, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

Cal-COBRA
A California Law that applies to employers and group health plans that cover 2 to 19 eligible employees. The Enrollee may keep their vision coverage insurance up to 36 months.

Contract
Includes the Contract between the Plan and the Group, this Evidence of Coverage and Disclosure Form, the Employee's enrollment Application and any addenda or amendments thereto.

Contract Month
A period beginning on the first day of any calendar month and continuing to the last day of the same calendar month.

Coordination of Benefits
Allocation of responsibility to pay for vision care between two or more group vision plans covering the same Enrollee.

Copayment or Deductible

An Enrollee's share of costs for Covered Services usually paid to the Participating Provider at the time care is rendered. This specific amount, paid by the Enrollee, applies to the various Covered Services for the benefit variation selected listed in the Schedule of Allowances.

Covered Services
Vision care services and materials which are specified as benefits in the Contract.

Department of Managed Health Care (the Department)
An administrative agency of the California Government responsible for regulation of health care service plans licensed under the Knox-Keene Act.

Dependent

1. An Employee's legally married spouse or registered domestic partner who is:
   a. not legally separated from the Employee; and
   b. not an Employee on active duty with the Armed Forces; or

2. An Employee's registered domestic partner who is an adult of the same sex and meets all of the requirements of California Family Code 297 as applicable.
   a. Both persons file a Declaration of Domestic Partnership with the Secretary of State;
   b. Both persons have a common residence;
   c. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
   d. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated;
   e. The two persons not related by blood in a way that would prevent them from being married to each other;
   f. Both persons are at least 18 years of age;
   g. Either of the following: both persons are members of the same sex or one or both persons are over the age of 62; and
   h. Both persons are capable of consenting to the domestic partnership.

3. An Employee's unmarried or married child (including any stepchild, children of domestic partner, or legally adopted child), not covered for benefits as an Employee, not a member on active duty with the Armed Forces, and
   a. primarily dependent upon the Employee for support and maintenance; or
   b. dependent upon the Employee for medical support pursuant to a court order; and less than 26 years of age or
   c. less than 26 years of age; or
   d. less than 26 years of age, if a full-time student and proof of student status is submitted to the Plan. Full-time student means enrolled in a college, university, vocational or technical school for a minimum of twelve (12) units as an undergraduate, or six (6) units as a graduate student; or
   e. those individuals in an Employee's immediate family who meet the criteria of the definition of a Dependent as used in the current United States Internal Revenue Code and Regulations of the United States, and who have been enrolled and accepted by the Plan as a Dependent and have maintained membership under the terms of the Plan.

Disability
An injury or illness (including a nervous or mental disorder) or a condition (including pregnancy);

however
1. all injuries sustained in any one accident will be considered one Disability;
2. all illnesses existing simultaneously which are due to the same or related causes will be considered one Disability;
3. if any illness is due to causes which are the same as or related to the causes of any prior illnesses, the succeeding illness will be considered a continuation of the previous Disability and not a separate Disability.

Elective Plan
A voluntary vision plan offered to a group which permits each eligible Employee the option to elect to enroll or not.

Employee
An individual who is defined by the Group as a full-time employee, and who receives compensation from the Group in the form of salary, wages or commissions, and whose regular work week with the Group meets the Group's required number of hours, and whose duties in such employment are performed at the Group's usual place of business except salespersons and others whose duties are of a kind and nature that require them to be performed away from such usual place of business.

Enrollee
An individual, who meets all applicable eligibility requirements, specified by the Contract, is enrolled with the Plan and for whom the required premium actually has been received and accepted by the Plan.

Experimental or Investigational
Any treatment, therapy, procedure, drug or drug usage, biological product, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which the Plan has determined in its sole discretion, not to have been demonstrated accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state government agency, prior to use and where such approval has not been granted at the time the services or materials were rendered, shall be considered Experimental or Investigational in nature. Services or materials which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials or other studies on human patients, shall be considered Experimental or Investigational in nature. "Experimental or Investigational" also includes services, materials, drugs and procedures that are determined by the Plan to be educational or the subject of a clinical trial.

The fact that a Participating Provider, or medical profession may prescribe, order, recommend, recognize or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device or materials does not in itself make the vision care service or materials non-Experimental or non-Investigational within this definition.

Group
The entity for whose Employees Covered Services are being provided.

Keratoconus

A development of dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissues in its central area.

Mentally Disabled (or Mental Disability)
Only those persons, not psychotic, who are so Mentally Disabled from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control and care for their own welfare or for the welfare of others or for the welfare of the community.

Non-Elective Plan
A vision plan variation offered to a group which does not permit each eligible Employee the option to elect to enroll or not, that is, all eligible Employees are enrolled.

Non-Participating Provider
An Ophthalmologist, Optician or Optometrist who has not contracted with the Plan to accept the terms, conditions, and compensation as set forth by the Schedule of Allowances.

Ophthalmologist
A doctor of medicine (M.D. or D.O.) who specializes in the diagnosis and treatment of defects and diseases of the eye, performing surgery when necessary or prescribing other types of treatment, including glasses or contact lenses and who is duly licensed by the applicable licensing party.

Optician
An individual who is engaged in the filling or dispensing of ocular prescriptions involving lenses, lens forms, eye glasses, optical devices, contact lenses or any ophthalmic appliances; and the services related to such filling and dispensing and who is duly licensed by the applicable licensing party.

Optometrist
A doctor of optometry (O.D.) who is specifically trained to examine the eyes and determine the presence of visual problems, and who may prescribe glasses, contact lenses and other optical aids or eye exercises in treatment of visual disturbances and who is duly licensed by the applicable licensing party.

Orthoptics
The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular lenses.

Other Plan
For the purpose of Coordination of Benefits, any plan, other than the Plan, providing benefits or services for vision care or treatment whose benefits or services are provided by:

1. any group, blanket or franchise insurance coverage;
2. service plan contracts, group practice, individual practice and other prepayment coverage;
3. any coverage under labor-management trustee plans, union welfare plans, or employee benefit organization plans;
4. any coverage under governmental programs (including Medicare);

5. any coverage required or provided by any statute;
6. any group coverage sponsored by or provided through a school or educational institution; and
7. any self-funded Employee welfare benefit plan or any other coverage on a group basis.

Oversized Lenses
Lenses to fit frames with an eye size of 61mm or more.

Participating Provider
An Ophthalmologist, Optician or Optometrist who has contracted with the Plan to accept the terms, conditions, and compensation as set forth by the Schedule of Allowances.

Photochromic Lenses
Lenses which change color with intensity of sunlight.

Physical Handicap
A physical or mental impairment that results in anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months in duration.

Physician
A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)

Plan
Medical Eye Services, Inc., a California corporation. The mailing address is P.O. Box 25209, Santa Ana, California 92799-5209. The telephone number is **888-859-5841 (toll-free)**.

Polycarbonate
An impact resistant material. For safety purposes, it is sometimes recommended for children younger than 18 or whenever greater impact resistance is required. The material is thin, light-weight and has built in UV protection.

Professional Service
Routine vision examination, eyewear materials selection, fitting of eyeglasses or contact lenses, related adjustments, etc.

Progressive Lenses
Multifocals which do not have a visible dividing line.

Schedule of Allowances
The allowed amounts for Covered Services rendered by Participating Providers.

Service Area
That certain geographic area which the Plan has been licensed to arrange for the provision of Covered Services to Enrollees and within which each Employee must either work or reside to be eligible for coverage under the Plan.

Service Intervals

The specific period of time in which Covered Services are provided as shown in the Schedule of Allowances.

Standard Lenses
Plastic lenses that fit any frame with an eye size less than 61 mm.

Subnormal or Low Vision Aids
Devices (optical and non-optical) to assist those persons who are partially sighted.

Tinted Lenses
Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

Total Disability (Or Totally Disabled)
1. with respect to an Employee otherwise eligible for coverage as an Employee, a Disability which prevents the Employee from working with reasonable continuity in the Employee's customary employment or in any other employment in which the Employee reasonably might be expected to engage, in view of the Employee's station in life and physical and mental capacity;
2. with respect to a Dependent, a Disability which prevents the Dependent from engaging with normal or reasonable continuity in the Dependent's customary activities or in those in which the Dependent otherwise reasonably might be expected to engage, in view of the Dependent's station in life and physical and mental capacity.

Eligibility Requirements

Before you or your Dependents can obtain benefits under the Plan, you must be enrolled. Here are the eligibility requirements for both you and your Dependents.

If you are a regular, full-time Employee, you are eligible for coverage as an Enrollee on the day following the date you complete the waiting period (the number of days of continuous employment required by your Employer) for coverage.

Your spouse and all your Dependents are eligible at the same time as you. Newborn infants of the Employee will be eligible immediately after birth. Adopted children will be eligible immediately upon placement in the physical custody of the Employee.

For Dependents of Employees who enroll during the initial open enrollment period, the Dependent's date of eligibility is the latest of the following:

1. The effective date of any part of this Contract providing Dependent benefits;
2. The date of eligibility of the Employee;
3. The date of birth for any newborn infant of the Employee;
4. The date of placement in the physical custody of the Employee for any adopted children or;
5. The date the Employee acquires a new Dependent (other than a newborn or newly adopted child) after the Employee's date of eligibility.

If you acquire a new Dependent (other than a newborn or newly adopted child), you must submit an application for coverage within thirty-one (31) calendar days from the date of acquisition of

the Dependent. An application is required at all times. If you contribute toward the cost of your premiums, you may enroll any eligible Dependent who was eligible only at the time of your annual enrollment.

Enrolled dependent children who would normally lose their eligibility under the Plan solely because of age, but who are physically handicapped or mentally disabled, may have their eligibility extended under the following conditions:

(a) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition
(b) the child must be chiefly dependent upon the Employee for support and maintenance. For continuation of benefits for this dependent, a Physician's written certification of Mental Disability or physical handicap must be submitted no later than 30 days prior to reaching the maximum age limit (60 days after receiving the 90-day notification from the Plan.)

Upon receiving your request for continued coverage of a mentally disabled dependent and proof of the criteria in (a) and (b) above, the Plan will make a determination as to whether the dependent child is entitled to continue coverage before the child reaches the limiting age. If the Plan fails to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to physical or mental disability, injury, illness or condition.

Proof of continuing Disability and dependency must be submitted twenty-four (24) months after the initial certification and annually thereafter. Based on the requirements described under Extension of Benefits provisions in this booklet, an Employee and his or her Dependents may continue group coverage under the Plan when coverage would otherwise cease.

An Employee requesting reinstatement of their dependent benefits after they have been discontinued due to voluntary cancellation while they remained eligible will require approval by the Plan in order to be considered for coverage hereunder. Such benefits shall become effective on the first day of the month following the date of approval by the Plan.

Notwithstanding any other provision of law, an employer or the Plan shall not deny enrollment of a child under the Plan's coverage of a child's parent on any of the following grounds:

1. The child was born out of wedlock.
2. The child is not claimed as a dependent on the parent's federal income tax return.
3. The child does not reside with the parent or within the Plan's Service Area.

Notwithstanding any other provision of law, in any case in which a parent is required by a court or administrative order to provide health insurance coverage for a child and the parent is eligible for the Plan's coverage through an employer, the employer or the Plan shall do all of the following, as applicable.

1. Permit the parent to enroll any child who is otherwise eligible to enroll for coverage, without regard to any enrollment period restrictions.

2. If the parent is enrolled in the Plan but fails to apply to obtain coverage for the child, enroll that child in the Plan upon presentation of the court order or request by the district attorney, the other parent or person having custody of the child, or the Medi-Cal program.

3. The employer or the Plan shall not disenroll or eliminate coverage of a child unless either of the following applies:

    a. The employer has eliminated coverage for all Employees or eliminated Dependent coverage.
    b. The employer or the Plan is provided with satisfactory written evidence that either of the following apply:

        i. The court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.
        ii. The child is or will be enrolled in a comparable vision plan through another insurer that will take effect not later than the effective date of the child's disenrollment.

In any case in which health insurance coverage is provided for a child pursuant to a court or administrative order, the Plan shall do all of the following:

1. Provide any information, including, but not limited to, the child's membership in the Plan, the evidence of coverage and disclosure form, and any other information provided to the covered parent about the child's coverage to the non-covered parent having custody of the child or any other person having custody of the child and to the district attorney when requested by the district attorney.

2. Permit the non-covered parent or person having custody of the child, or a provider with the approval of the non-covered parent or person having custody, to submit claims for Covered Services without the approval of the covered parent.

3. Make payment on claims submitted in accordance with subparagraph (2) directly to the non-covered parent or person having custody (if Non-Participating Provider benefits available), to the Participating Provider on behalf of the non-covered parent, or to the Medi-Cal program. Payment on claims for services provided to the child shall be made to the covered parent for claims submitted or paid by the covered parent.

IF THE ENROLLEE IS SUBJECT TO THE CALIFORNIA FAMILY RIGHTS ACT OF 1991 AND/OR THE FEDERAL FAMILY & MEDICAL LEAVE ACT OF 1993, AND THE APPROVED LEAVE OF ABSENCE IS FOR FAMILY LEAVE UNDER THE TERMS OF SUCH ACT(S), THE ENROLLEE'S PAYMENT OF PREMIUMS WILL KEEP THEIR COVERAGE IN FORCE FOR SUCH PERIOD OF TIME AS SPECIFIED IN SUCH ACT(S). THE ENROLLEE'S EMPLOYER IS SOLELY RESPONSIBLE FOR NOTIFYING YOU OF THE AVAILABILITY AND DURATION OF FAMILY LEAVES.

Effective Date of Coverage

Benefits of this Vision Plan become effective at 12:01 A.M. Pacific Time on the eligibility date established by your Employer. When your Employer pays the full amount of the premiums for you, your coverage becomes effective automatically. If you contribute toward the cost of your

premiums, you are required to submit a completed enrollment form to the Plan prior to or within thirty-one (31) calendar days of the date you become eligible in order to have coverage commence on your eligibility date.

Coverage for your Dependents is never automatic. Enrollment is your responsibility. If you submit an enrollment form for Dependent coverage prior to or within thirty-one (31) calendar days of the date you become eligible, their coverage will be effective on the same date as yours.

Coverage for a newborn child will become effective on the date of birth. Coverage for a newly adopted child will become effective on the date the child is placed in the physical custody of the Employee for adoption. In order to have coverage continue beyond the first thirty-one (31) calendar days without a lapse, a written application must be submitted to the Plan within thirty-one (31) calendar days of the date of birth or adoption for your Dependent.

Coverage under the Plan may be affected based on the following circumstances:

1. If you are absent from work because of illness or injury when your coverage would normally be effective, your coverage will take effect on the date of your return to active full-time work.

2. If a Dependent, other than a newborn or newly adopted child is receiving inpatient hospital care because of illness or injury at a time when coverage would otherwise be effective, the Dependent will be entitled to benefits on the first day following discharge from the hospital.

Extension of Benefits

If an Enrollee becomes Totally Disabled while validly covered under the Plan and continues to be Totally Disabled on the date coverage terminates, the Plan will extend benefits of the Contract, subject to all exclusions and limitations herein, for Covered Services directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following:

1. 12:01 A.M. on the day following a period of twelve (12) months from the date coverage terminates;
2. the end of the period of Total Disability;
3. the date on which the Enrollee’s applicable maximum benefits are reached,
4. the date on which a replacement carrier provides coverage to the Enrollee without limitation as to the Totally Disabling condition provided that:

No extension will be granted unless the Plan receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) within thirty (30) calendar days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Plan.

Individual Continuation of Benefits

The Enrollee should examine their options carefully before declining this coverage. The Enrollee should be aware that companies selling individual health insurance typically require a review of the Enrollee’s medical history that could result in a higher premium or the Enrollee could be denied coverage entirely.

Applicable to Enrollee's when the Group is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (groups of 20 or more eligible employees) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA) (groups of 2 to 19 eligible employees). The Group should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), an Enrollee will be entitled to elect to continue group coverage under this Contract if the Enrollee would otherwise lose coverage because of a Qualifying Event that occurs while the Group is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Enrollee if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Enrollee will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Enrollee is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any Pre-existing condition. Under COBRA, an Enrollee will not be entitled to benefits if at the time of the qualifying event such Enrollee is entitled to Medicare.

A. Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the subscriber:

    a. the termination of employment (other than by reason of gross misconduct); or

    b. the reduction of hours of employment to less than the number of hours required for eligibility.

2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the subscriber, or subscriber's Dependent spouse or Domestic Partner, during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Group is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

    a. the death of the subscriber; or
    b. the termination of the subscriber's employment (other than by reason of such subscriber's gross misconduct); or
    c. the reduction of the subscriber's hours of employment to less than the number of hours required for eligibility; or
    d. the divorce or legal separation of the subscriber from the Dependent spouse or termination of the domestic partnership; or
    e. the subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
    f. a Dependent child's loss of Dependent status under the Contract.

***Note:** Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the subscriber elects to enroll.

or

***Note:** Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

3. For COBRA only, with respect to a subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Group's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

B. Notification of A Qualifying Event

1. With respect to COBRA enrollees:
   The enrollee must notify the Group, in writing, of all qualifying events (divorce, legal separation, termination of a domestic partner or a child's loss of Dependent status) within 60 days of the date of the qualifying event. If the Enrollee fails to make the notification to the Group within the required 60 days, the Enrollee will be disqualified from receiving continuation coverage. The Enrollee must elect continuation coverage within the 60 days of either (1) the date that the Enrollee's coverage under the Contract terminated or will terminate by reason of a qualifying event, or (2) the date the Enrollee was sent the notice of the required benefit information, premium information, enrollment forms, and disclosures to allow the qualified beneficiary to formally elect continuation coverage, whichever is later.

   The Group is responsible for notifying its COBRA administrator (or Plan administrator if the Group does not have a COBRA administrator) of the enrollee's death, termination, or reduction of hours of employment, the subscriber's Medicare entitlement or the Group's filing for reorganization under Title XI, United States Code.

   When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Enrollee by first class mail of his or her right to continue group coverage under this Contract. The Enrollee must then notify the COBRA administrator within 60 days of the later of: (1) the date of the notice of the Enrollee's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

   If the Enrollee does not notify the COBRA administrator within 60 days, the Enrollee's coverage will terminate on the date the Enrollee would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA Enrollees:
   The Enrollee is responsible for notifying the Plan in writing of the Employee's/subscribers death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a child's loss of Dependent status under this Contract. Such notice must

be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Contract because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Enrollee from receiving continuation coverage under Cal-COBRA.

The Group is responsible for notifying the Plan in writing of termination or reduction of hours of employment within 30 days of the Qualifying Event.

When the Plan is notified that a Qualifying Event has occurred, the Plan will, within 14 days, provide written notice to the Enrollee by first class mail of his or her right to continue group coverage under this Contract. The Enrollee must then give the Plan notice in writing of the Enrollee's election of continuation coverage within 60 days of the later of: (1) the date of the notice of the Enrollee's right to continue group coverage, and (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to the Plan by first-class mail or other reliable means.

If the Enrollee does not notify the Plan within 60 days, the Enrollee's coverage will terminate on the date the Enrollee would have lost coverage because of the Qualifying Event.

If this Contract replaces a previous group plan that was in effect with the Group's, and the Enrollee had elected Cal-COBRA continuation coverage under the previous plan, the Enrollee may choose to continue to be covered by this Contract for the balance of the period that the Enrollee could have continued to be covered under the previous plan, provided that the Enrollee notify the Plan within 30 days of receiving notice of the termination of the previous group plan.

C. Duration and Extension of Continuation of Group Coverage

Cal-COBRA Enrollees will be eligible to continue coverage under this Contract for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA Enrollees will be eligible to continue coverage under this Contract for 18, 29, or 36 months depending on the type of Qualifying Event. Contact your group for more information.

COBRA Enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Enrollee's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA or Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Enrollee to continue group coverage under this Contract.

D. Notification Requirements of Cal-COBRA Extension

The Group or its COBRA administrator is responsible for notifying COBRA Enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA Enrollee should contact the Plan for more information about continuing coverage. If the Enrollee elects to apply for continuation of coverage under Cal-COBRA, the Enrollee must notify the Plan at least 30 days before COBRA termination.

E. Payment of Premiums

Premiums for the Enrollee continuing coverage shall be 102 percent of the applicable group premium rate if the Enrollee is a COBRA Enrollee, or 110 percent of the applicable group premiums rate if the Enrollee is a Cal-COBRA Enrollee, except for the Enrollee who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 shall be 150 percent of the applicable group premium rate.

Note: For COBRA Enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, premiums for Cal-COBRA coverage shall be 110 percent of the applicable group premiums rate for months 30 through 36.

If the Enrollee is enrolled in COBRA and is contributing to the cost of coverage, the Group shall be responsible for collecting and submitting all premium contributions to the Plan in the manner and for the period established under this Contract.

Cal-COBRA Enrollees must submit premiums directly to the Plan. The initial premiums must be paid within 45 days of the date the Enrollee provided written notification to the Plan of the election to continue coverage and be sent to the Plan through the MESVision website at (www.MES*Vision*.com) or by first-class mail or other reliable means. The premiums payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Enrollee from continuation coverage.

F. Effective Date of The Continuation of Coverage

The continuation of coverage will begin on the date the Enrollee's coverage under this Contract would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as premiums are timely paid.

G. Termination of Continuation of Group Coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this Group Vision Plan Contract (if the Group continues to provide any group vision plan for subscribers, the Enrollee may be able to continue coverage with the other plan);
2. failure to timely and fully pay the amount of required premiums as applicable. Coverage will end as of the end of the period for which premiums were paid;
3. the Enrollee becomes entitled to Medicare;
4. the Enrollee no longer resides in California;
5. the Enrollee commits fraud or deception in the use of the benefits of this Contract.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

H. Notification Requirements

The Plan must notify a qualified beneficiary during the 180 days prior to the expiration of continuation coverage of (1) the date continuation coverage will terminate and (2) the availability of any conversion coverage that is available.

Reimbursement Provision

How to Use the Plan

Please determine whether your Ophthalmologist, Optician or Optometrist is a Participating Provider by visiting www.MES*Vision*.com or referring to a current MES Provider Directory. Make an appointment with the Participating Provider of your choice and inform them of your vision coverage. Participating Providers will have claim forms available. Although Enrollees are not required to provide a claim form, the form can be downloaded from the Plan's website at www.MES*Vision*.com. Participating Providers will submit a Claim Form to the Plan and are reimbursed directly. Participating Providers will accept payment by the Plan for Covered Services as payment in Full, except as noted in Schedule of Allowances, Exclusions, and Limitations.

It is the Enrollee's responsibility to identify him/herself as having an MES vision plan. The Participating Provider is required to refund the amount the Enrollee paid, less any Copayments/Deductibles or payments for non-Covered Services, if the Enrollee later (after the date of service) identifies him/herself as an Enrollee of the Plan.

If services are rendered by a Non-Participating Provider, the claim(s) shall be submitted to the Plan by the Enrollee and payment will be made directly to the Enrollee in accordance with Non-Participating Provider Schedule of Allowances.

All claims for reimbursements must be submitted to the Plan within six (6) months after the date of service.

Claims Review

The Plan reserves the right to review all claims to determine whether any exclusions or limitations apply.

The Plan may use the services of physician consultants, peer review committees of professional societies and other consultants to evaluate claims.

Payments to Providers

The Plan payments are set forth in the Schedule of Allowances found in this booklet for Covered Services rendered by Participating Providers. All payments for Covered Services will be made by the Plan. Participating Providers (Ophthalmologists, Opticians and Optometrists) under agreement with the Plan are reimbursed directly by the Plan, and will accept payment by the

Plan as payment in full.

Upon termination of any Participating Provider, the Plan shall be liable for payment of Covered Services rendered by such provider (other than any Copayment/Deductible) to an Enrollee who retains eligibility under the Plan or by operation of law, who is under the care of such provider at the time of such termination, until the Covered Services being rendered to the Enrollee by such provider are completed unless the Plan makes reasonable and appropriate provision for the assumption of such services by another Participating Provider.

If a Participating Provider terminates participation in the Plan, you may select a Participating Provider of your own choice from the provider directory. You should contact the Plan to verify the new provider's participation prior to receiving any services under the Plan.

Non-Assignability

Coverage or any benefits of this Vision Plan may not be assigned.

Plan Interpretation

The Plan shall have the power and discretionary authority to construe and interpret the provisions of the Contract. The Plan shall exercise this authority for the benefit of all Enrollees entitled to receive benefits under the Plan.

Principal Benefits and Coverage

The Plan will pay the allowed amount in the Participating Provider Schedule of Allowances for the Covered Services rendered the Participating Providers less any Copayments/Deductibles. If Covered Services are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid on the basis of the Non-Participating Schedule of Allowances less any Copayments/Deductibles.

Examination

1. One comprehensive eye examination in a 12 consecutive month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. 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 examination, gross visual fields and basic sensorimotor examination. It often includes as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

Lenses

2. One pair of Standard Lenses in a 12 consecutive month period. "Standard Lenses" (plastic) fit any frame with an eye size less than 61mm; or

3. One pair of contact lenses for cosmetic reasons or for convenience when provided in lieu of other eyewear once in a 12 consecutive month period, or at a 12-month interval if the

examination indicates a Prescription Change every other Calendar Year or every Calendar Year if the examination indicates a Prescription Change; or

The contact lenses are in lieu of other eyewear benefits. The Plan will pay up to the amount shown in the Schedule of Allowances toward the contact lens evaluation, fitting costs and materials, except when the Enrollee has a separate fitting benefit.

Disposable Contact Lenses should be purchased up to the maximum allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement; or

4. One pair of non-elective (medically necessary) contact lenses every 12 consecutive month period, when required following cataract surgery; or for certain conditions of Myopia, Hyperopia, or Astigmatism; or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus, or 20/60 for certain conditions of Anisometropia, or for other various corneal findings and disorders. A completed "Non-Elective (Medically Necessary) Contact Lenses Approval Request Form" along with the patient's history from the provider and approval from the Plan is required. This form can be obtained from the MES*Vision* website at www.MES*Vision*.com. If prior approval is requested, a determination will be made within five (5) business days. If the services have already been rendered, a determination will be made within thirty (30) calendar days.

Frame

5. One standard frame in a 24 consecutive month period up to the allowed amount shown in the Schedule of Allowances.

   The difference between the allowed amount and the charges for more expensive frames or unusual lenses, such as oversize, will be the responsibility of the Enrollee. Participating Providers allow a selection from frames that retail up to $125.00 with an eye size less than 61 millimeters. If a more expensive frame is selected, the Enrollee is responsible for the additional cost above the $125.00. If the lenses are 61 millimeters or over, any difference between the allowance and the provider's charge is the responsibility of the Enrollee.

Limitations

If specifically covered, benefits with respect to the following services are paid up to the applicable Schedule of Allowances.

1. Contact lenses, except as specifically covered;
2. Contact lens fitting, except as specifically covered;
3. Rigid gas permeable scleral and hybrid contact lenses may be partially covered for patients who meet the Non-Elective Contact Lens Criteria and when other contact lens approaches have been demonstrated to be unsuccessful. Ocular surface diseases and treatment of underlying ocular pathologies are generally covered under the patient's medical plan.
4. Eyewear when there is no prescription change, except when benefits are otherwise available;
5. Charges for non-standard lenses or lens options including, but not limited to, Polycarbonate, Premium Progressive Lenses, Photochromic Lenses, polarized lenses, hi-index, occupational lenses, beveled, faceted, coated (i.e., anti-reflective, scratch, mirrored, and

UV), oversized exceeding the Schedule of Allowances; or other custom lens options will only be covered to the extent there is a dollar value on the schedule and the Plan will only pay up to the amount listed. Any amount for these items above that limit shall be the responsibility of the Enrollee.
6. Tints, other than pink or rose #1 or #2, except as specifically covered;
7. Two pair of glasses in lieu of bifocals, unless prescribed;
8. New patient intermediate (follow-up) examinations: When an Enrollee elects to have comprehensive examination and is only eligible for an intermediate (follow-up) examination or selects a different provider to perform the intermediate (follow-up) examination; the Enrollee will be responsible for the difference between the intermediate (follow-up) examination allowance and the comprehensive examination allowance. To maximize benefits, the patient should return to the original provider;
9. Non-prescription (Plano) eyewear, except when specifically covered;
10. Subnormal/low vision testing and low vision aids, when specifically covered; and
11. Any promotions and/or discounts that are combined with Covered Services under the Policy.

Exclusions

The Plan does not provide benefits with respect to the following services ("non-covered services"):

1. Any eye examination required by the employer as a condition of employment;
2. Conditions covered by Workers' Compensation;
3. Contact lens insurance or care kits; or frame cases;
4. Covered Services which began prior to the Enrollee's effective date or after benefits have been terminated;
5. Charges for which the Enrollee is not legally obligated to pay;
6. Covered Services required by any government agency or program federal, state or subdivision thereof;
7. Orthoptics, vision training;
8. Services that are Experimental or Investigational in nature;
9. In connection with war or any act of war, whether declared or undeclared, a condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
10. Procedures or expenses that are not included in the Schedule of Allowances;
11. Medical or Surgical treatment of the eyes, including treatment of any suspected pathology or injury that may be uncovered during the course of a covered vision examination and that may be payable under the medical benefits of the Enrollee's health plan. In the event that the provider determines that additional diagnostic procedures or treatment plans are indicated to confirm the suspected pathology or injury, the Enrollee will need to obtain care under her/his medical plan. Enrollees who are covered under their medical plan should be referred back to their primary care physician or participating medical group;
12. Any Covered Services provided by another vision plan; except benefits payable under Coordination of Benefits; and
13. Replacement of lenses or frames which are lost, stolen or broken, except when benefits are otherwise available;
14. Services for treatment directly related to any totally disabling condition, illness or injury;

Cancellation and Reinstatement Provisions

Cancellation of Enrollee Benefits Due to Ineligibility

Benefits will end when the Subscriber or enrolled Enrollee is no longer eligible for Coverage under the requirements established by the Plan and/or Group. In most instances, the Group determines the date on which Coverage will end. Coverage can be cancelled, however, because of other circumstances discussed below.

Cancellation of Benefits Upon Termination of Plan Contract

1. Benefits cease and Enrollees' coverage will end if the Group does not renew the Plan Contract. Benefits will end on the last day for which payment has been received from the Group. Continuing Coverage under the Plan is subject to the terms and conditions of the Plan Contract between the Plan and Group.

2. In the event the Plan Contract is cancelled/terminated by the Plan for any reason, including non-payment of prepaid or periodic payment by the Group, services and Benefits under this Plan will be terminated. The Group will advise Subscribers of the cancellation date by promptly mailing a legible true copy of the Notice of Cancellation to each Subscriber at least fifteen (15) calendar days prior to the effective date of cancellation. The Notice of Cancellation will specify the basis for cancellation of the Plan Contract. Benefits will end on the fifteenth (15th) calendar day after the date the Notice of Cancellation is mailed to the Subscribers. In the event that the Plan Contract is cancelled by the Group for any reason, the Group will advise the Subscribers of the cancellation date by promptly mailing a legible true copy of the Notice of Cancellation to each Subscriber at least fifteen (15) calendar days prior to the effective date of cancellation.

Cancellation of Group Contract

The Plan may cancel this Group Contract, or any part thereof, at any time, after having given at least thirty (30) calendar days written notice to the Group, stating when such cancellation will become effective.

The Contract may also be canceled by the Group upon thirty (30) calendar days prior written notice to the Plan.

If the Group fails to give thirty (30) calendar days written notice of cancellation to the Plan, the termination shall be effective subsequent to date(s) of service rendered to members of the Group or the requested termination effective date, and be subject to, notice requirement, whichever is later.

Reinstatement of Group Contract

Receipt by the Plan from the Group of the proper prepaid or periodic payment after cancellation of the Plan Contract for non-payment of Premiums shall reinstate the Plan Contract as though it had never been cancelled if such payment is received on or before the due date of the next payment, unless one of the following occurs:

1. In the Notice of Cancellation, the Plan notifies the Group that if payment is not received within fifteen (15) calendar days of the date of mailing of the Notice of Cancellation, a new application is required and the conditions under which a plan contract will be issued or the

Plan Contract reinstated; or

2. Such payment is received more than fifteen (15) calendar days after the date of mailing of the Notice of Cancellation, and Plan refunds such payment within twenty (20) business days; or

3. If such payment is received more than fifteen (15) calendar days after the date of mailing of the Notice of Cancellation, and Plan issues to the Group, within twenty (20) business days of receipt of such payment, a new plan contract accompanied by written notice stating clearly those respects in which the new agreement differs from the Plan Contract in benefits, coverage or otherwise.

Cancellation of Enrollee Benefits

The Plan may cancel or refuse to renew a Subscriber or Enrollee's enrollment in the following circumstances:

1. Fraud, misrepresentation, or deception in the use of Plan services or facilities, including, but not limited to, knowingly providing false information (or misrepresenting a meaningful fact) on the Enrollee's enrollment form. Benefits shall be cancelled immediately on the date that the Plan mails the Notice of Cancellation.

2. Failure of Enrollee to pay any required Co-payments, or charges owed to a Provider or the Plan for Covered Services. To be subject to cancellation under this provision, Enrollee must have been billed by the Provider or the Plan for two billing cycles and have failed to pay or make appropriate payment arrangements with the Provider or the Plan. Coverage will end on the fifteenth (15th) day after the Plan mails a Notice of Cancellation to Subscriber. If the Enrollee pays or makes appropriate arrangements to pay within the fifteen (15) day notice period, then the cancellation shall not take effect.

Retroactive dis-enrollment is not permitted. In the event that the Group determines an Enrollee was ineligible, after previously identifying such Enrollee as eligible, and the Enrollee has obtained services during the ineligible time period, the Enrollee may be held liable to the Plan or the Group for either the premium or any claims incurred as a result of any services obtained after the term date and prior to the Plan's notification.

Review of Cancellation by the Department of Managed Health Care

Under no circumstances will an Enrollee be cancelled due to health status or the need for services. Any Enrollee, who believes his or her enrollment has been cancelled or not renewed because of his or her health status or requirements for service, may request review by the Department of Managed Health Care of the State of California. For more information, please contact the Plan's Customer Service Department.

Right of Plan to Change Benefits

The Plan reserves the right to change the benefits of the Contract, upon thirty (30) calendar days written notice to the Group.

Right of Cancellation

If you are making any contributions toward coverage for yourself of your Dependent and you are

an active Employee you may only cancel such coverage at the end of the second contract year during your Group's open enrollment.

Any premiums paid to the Plan for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer will be responsible to the Plan for unpaid premiums prior to the date of cancellation.

The Plan will honor all claims for Covered Services provided prior to the effective date of cancellation.

Reinstatement of Enrollee Benefits

The Enrollee may apply for reinstatement during open enrollment if the Enrollee had been making contributions toward the Enrollee's coverage and the Enrollee's Dependents and voluntarily cancelled such coverage. Reinstatement will be subject to approval by the Plan.

Members of the United States Military Reserve and the National Guard who are called to active duty on or after January 1, 2007 will be reinstated upon payment of premium as a covered Enrollee without a waiting period or exclusions of coverage for pre-existing conditions.

Choice of Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Under the Plan, an Enrollee selects a participating Ophthalmologist, Optician or Optometrist to provide Covered Services. The Enrollee may select a Participating Provider from the Plan's website (www.MES*Vision*.com) or may contact the Plan's Customer Service Department **888-859-5841 (toll-free)**.

Any difference between the intermediate (follow-up) examination and comprehensive examination is a patient responsibility if the patient chooses a new provider for the intermediate (follow-up) examination.

Timely Access to Care

The Plan shall provide and arrange for the provision of Covered Services in a timely manner appropriate for the nature of the Enrollee's condition and consistent with good professional practice.

These services may include, but are not limited to:

a. Initial examinations and non-urgent visits shall be available within thirty (30) days.

b. Urgent vision care appointments shall be available within seven (7) days. Urgent vision care appointments are limited to replacement of broken or lost eyewear, which are only covered if the eyewear benefit has not been used in the current benefit period. An eye exam beyond the scope of routine vision, necessitated by trauma to the eye, a painful eye condition, or any such medical symptoms, should be directed to the medical health plan or insurer immediately.

c. When it is necessary for a Participating Provider or Enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Enrollee's vision care needs and ensures continuity of care.

d. Participating Providers shall employ an answering service or utilize an answering machine during non-business hours, which provide instructions regarding how Enrollees may obtain urgent care or how to contact another provider who has agreed to be on-call to triage or screen by phone. When Enrollees call the Plan after hours, the message will advise them to call 911 or their medical provider or medical plan if they are experiencing trauma to the eye or a painful eye condition.

e. The panel of Participating Providers includes offices with bilingual doctors and staff, as indicated on the website and directory. An Enrollee's need for interpreter services shall be coordinated when scheduling the appointment with the Participating Provider's office.

f. During normal business hours, the waiting time for an Enrollee to speak by telephone with a Plan Customer Service Representative who is knowledgeable and competent regarding the Enrollee's benefits and eligibility shall not exceed ten (10) minutes.

Liability of Enrollees

In accordance with the Plan's established policies, and by statute, every contract between the Plan and its Participating Providers stipulates that the Employee will not be responsible to the Participating Provider for compensation for any Covered Services to the extent that they are provided in the Contract. When Covered Services are provided by a Participating Provider, the Enrollee is responsible for any applicable Copayment/Deductible.

When a covered service specifies a maximum benefit allowance, any difference between the allowance and the provider's charge is the responsibility of the Enrollee (items such as contact lenses, non-standard frames).

Payments under the Plan are made in accordance with the Schedule of Allowances. If Enrollee goes to a Non-Participating Provider the Enrollee is responsible for all charges.

If the Enrollee selects contact lenses for cosmetic reasons, a non-standard frame, or non-standard lenses, the Enrollee is responsible for payment of any difference between the Plan's allowance and the provider's charge.

Prepayment Fees

The monthly premiums for the Enrollees and Dependents are indicated in the Group Contract. The initial premiums are payable on the effective date under the Contract, and subsequent premiums are payable on the first date (called the transmittal date) of each succeeding month. Premiums are payable in full on each transmittal date and must be made for all Enrollees and Dependents.

All premiums required for covered Enrollees and Dependents will be handled through the Employer, and must be sent to the Plan in Santa Ana, California. Payment of premiums will continue the benefits of the Contract up to the date immediately preceding the next transmittal

date, but not thereafter.

Renewal Provisions

The benefits and rates of the Contract are subject to change following at least thirty (30) calendar days written notice by the Plan. Benefits for Covered Services furnished after the effective date of any change in benefits will be provided based on the change.

Facilities (Participating Providers)

A list of Participating Providers may be obtained from the Plan's website at www.MES*Vision*.com or by contacting the Customer Service office listed on the back cover of this booklet.

Grievance Procedure and Independent Medical Review

Definitions:

1. "Grievance" means a written or oral expression of dissatisfaction regarding MES and/or one of its providers, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

2. "Complaint" is the same as "grievance."

3. "Complainant" is the same as "grievant," and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

4. "Resolved" means that the grievance has reached a final conclusion with respect to the Enrollee's submitted grievance, and there are no pending Enrollee appeals within the MES' grievance system, including entities with delegated authority.

Procedures:

1. The Plan will notify Enrollees if services are denied, in whole or in part, stating the specific reasons for the denial based on the pertinent provisions of the contract or the clinical reasons relating to medical necessity. Notice of the right to review and the procedure to follow under such circumstances will be included. After receipt of a notice of denial, the Enrollee may make a request for review of such denial by addressing the request to:

   Medical Eye Services, Inc.
   Attention: Benefit Resolutions Department
   Post Office Box 25209
   Santa Ana, CA 93799-5209
   888-859-5841

2. If the Enrollee wishes to file a grievance, grievance forms may be obtained from the Group, a Participating Provider's office, the Plan's Customer Service Department, or the Plan's website at (www.MES*Vision*.com). A grievance must be filed no later than one hundred-eighty (180) calendar days after the occurrence. A toll-free TTY/TDD line (1-877-735-2929)

is also available for the hearing and speech impaired. Access to interpreters and translations to grievance procedures are available upon request. The Enrollee may contact the Plan's Customer Service Department for assistance in completing the grievance form. The Enrollee should file the form as soon as possible after the occurrence.

Patients may obtain assistance from the Department of Managed Health Care (DMHC) and seek an Independent Medical Review (IMR) that is available in non-English languages through the Department's website. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

Patient grievance forms and procedures in the Plan's threshold language(s) are readily available to Enrollees and Participating Providers for distribution upon request. A grievance form and IMR form, in English and Spanish, may be completed and submitted directly online through the Medical Eye Services website at www.mesvision.com. Grievance forms may also be obtained from a Participating Provider's office, or by calling Medical Eye Services (MES) Customer Service Department at **888-859-5841 (toll-free)**.

3. The Plan's Benefit Resolutions Department will acknowledge receipt of the request within five (5) calendar days, and follow-up with a complete investigation. Grievances of all types will be reviewed fully and fairly. Attached to the acknowledgment letter is the Notice of Availability of Language Assistance Services advising Enrollees how to access interpretation and translation services.

4. The Plan will send a grievance resolution letter within thirty (30) calendar days of receipt along with the Notice of Availability of Language Assistance Services. Record of all such grievances and a file will be maintained for a minimum of five (5) years in the MES office.

5. If the Enrollee receives a denial for requested medically necessary services after utilizing the Plan's grievance process, and the Enrollee believes that these services have been improperly denied, modified or delayed by the Plan or one of its Participating Providers, the Enrollee may request an independent medical review (IMR) of the disputed health care services from the Department. A disputed health care service is any health care service eligible for coverage and payment under the Contract that has been denied, modified or delayed by the Plan or one of its Participating Providers, in whole or in part because the service is not medically necessary.

   The IMR process is in addition to any other procedures or remedies that may be available to the Enrollee. The Enrollee pays no application or processing fees of any kind for IMR. The Enrollee has the right to provide information in support of the request for IMR. The Plan will provide the Enrollee with an IMR application form with any grievance disposition letter that denies, modifies or delays medically necessary health care services. A decision not to participate in the IMR process may cause the Enrollee to forfeit any statutory right to pursue legal action against the Plan regarding disputed health care service.

   The application for IMR will be reviewed by the Department of Managed Health Care to confirm that:

a.
   (1) The Participating Provider has recommended a health care service as medically necessary; or
   (2) The Enrollee has received urgent care or emergency services that a Participating Provider determined was medically necessary; or
   (3) The Enrollee has been seen by a Participating or Non- Participating Provider for the diagnosis or treatment of the medical condition for which the Enrollee seeks independent review. The Provider recommending the disputed health care service may be a Non-Participating Provider, even when services rendered by out-of-plan providers are not covered by the Plan.

b. The disputed health care service has been denied, modified or delayed by the Plan or one of its Participating Providers based in whole or in part on a decision that the health care service is not medically necessary; and

c. The Enrollee has filed a grievance with the Plan or its Participating Provider and the disputed decision is upheld or the grievance remains unresolved after thirty (30) calendar days. If the grievance requires expedited review (due to an imminent or serious threat to the Enrollee's health), the Enrollee may bring it immediately to the Department's attention. The Department may waive the requirement that the Enrollee follow the Plan's grievance process in extraordinary and compelling cases.

   The Enrollee must apply for IMR within 6 months of whichever occurs first: the disputed decision being upheld by the Plan or thirty (30) calendar days after the grievance is filed if no decision is reached within that thirty (30)-day period.

   If the case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. The Enrollee will receive a copy of the assessment made in the case. If the IMR determines the service is medically necessary, the Plan will provide the health care service.

   For non-urgent cases, the IMR organization designated by the Department must provide its determination within thirty (30) calendar days of receipt of the application and supporting documents. For urgent cases involving imminent and serious threat to the Enrollee's health including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the Enrollee's health, the IMR organization must provide its determination within three (3) business days.

   For more information regarding the IMR process, or to request an IMR application form, please call the Plan's Customer Service Department at **888-859-5841 (toll-free).**

   The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at **888-859-5841 (toll-free)**, or for **TTY/TDD access** (**1-877-735-2929**) for the hearing and speech impaired, and use the Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a

grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department has also a **toll-free telephone number (1-888-HMO-2219) and a TDD Line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **(http://hmohelp.ca.gov)** has grievance forms, IMR application forms, and instructions online.

6. Health plans as well as vision plans are required by law to resolve, on an expedited basis, grievances involving an imminent and serious threat to the health of the Enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function and will consider the Enrollee's medical condition when determining the response time. Although MES does not expect to receive grievances of this nature, since MES only covers services within the scope of routine vision care, MES will immediately inform the Enrollee in writing of their right to notify the Department of Management Health Care (DMHC) of the grievance. MES will provide the Enrollee and the DMHC with a written resolution letter or pending status of the expedited review within three (3) days from receipt of the grievance. Enrollees have a right to an interpreter. The Notice of Availability of Language Assistance Services provides instructions on how to access verbal interpretation services.

Information Practices

If the Enrollee applies for, or is covered by the Contract, the Plan may collect personal information about the Enrollee in order to evaluate your application or to properly process the Enrollee's claim. This information is normally limited to information relating to the condition of the Enrollee's health, what services were provided and at what cost. The Plan will only use or disclose an Enrollee's personal information as necessary to administer the Enrollee's vision plan, as permitted by law.

Coordination of Benefits

Coordination of Benefits applies when an Enrollee has coverage with more than one plan. The benefits payable under the secondary plan shall be reduced so that the sum of such reduced benefits and all other benefits payable do not exceed the total allowable expenses. A plan which has no coordination of benefits provision, pays before a plan with said provision.

Determining Primary and Secondary Coverage

If a plan covers a claimant as an Enrollee or member of an association, it is considered the primary coverage and determines benefits first. The plan which covers the claimant as a Dependent, pays as the secondary coverage.

The "Birthday Rule" is the generally accepted method of determining primary coverage for dependent children. The vision plan of the parent whose birthday is earlier in the year using

month and day only is primary for the child. If the parents have the same birthday, the vision plan which has covered the parent for the longer period is primary.

For children with divorced or separated parents, primary coverage is determined in the following order:

1. the parent with the court decree stating that he/she has the financial responsibility to provide health care,
2. the vision plan of the parent with custody,
3. the vision plan of the spouse of the parent with custody,
4. the vision plan of the parent not having custody.

In the event that the Enrollee is covered under the Plan and is also entitled to benefits under any of the conditions listed below, the Plan's liability will be reduced by the amount of benefits paid, or the reasonable value of the Covered Services provided without any cost to the Enrollee, because of Enrollee's entitlement to such other benefits. This exclusion is applicable to benefits received from any of the following sources:

Covered Services provided by any federal or state governmental agency, or by any county or other political subdivision, or for the reasonable costs of services provided to the Enrollees at a Veteran's Administration facility for a condition unrelated to military service or at a Department of Defense facility provided that the Enrollee is not on active duty.

This exclusion is not applicable to any entitlements to Medi-Cal benefits under chapter 7 (commencing with Section 14000) or chapter 8 (commencing with Section 14500) or part 3 of division 9 of the Welfare and Institutions Code, or benefits under the California Crippled Children Services program under Section 10020 of the Welfare and Institutions Code or any other coverage provided for or required by law when, by law, it benefits are excess to any private insurance or other non-governmental program.

Right of Recovery

If payments have been made by the Plan in excess of the maximum amount of payment necessary to satisfy these provisions, the Plan shall have the right to recover the excess from any Enrollee or other entity to or with respect to whom such payments were made.

Right to Receive and Release Information

The Plan may release to or obtain from any organization or Enrollee, as permitted by law, any information which is necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other vision plan. Any Enrollee claiming benefits under the Contract shall furnish the Plan with such information as may be necessary to implement these provisions.

Public Policy Committee

A Public Policy Committee has been created and procedures have been established to assure the comfort, dignity, and convenience of the Groups who rely on the Plan to arrange for the provision of Covered Services to their Enrollees and to the public.

The Plan welcomes comments, suggestions and criticisms from consumers and Enrollees as to how the Plan, as a Knox-Keene Health Care Service Plan licensed entity, may improve service and satisfaction for its Enrollees.

Enrollees are polled each year by a questionnaire which asks their opinion as to:

1. services provided
2. facility impressions
3. personnel attitudes
4. the date last services were provided
5. whether they would recommend the Plan
6. any additional comments

The questionnaire is available on the Plan's website at www.MES*Vision*.com and, upon request, will be sent to all Groups for distribution to Enrollees and will be accompanied by a brief report on Public Policy Committee activities over the preceding year.

The Public Policy Committee is a standing committee of the Board of Directors. The committee consists of five (5) members, one of whom is a member of the Board of Directors, one of whom is a Participating Provider of the Plan who is not a member of the Board of Directors, and the balance are Enrollee representatives. None of the Enrollee representatives of the committee may be employees of the Plan or any of its Participating Providers. The Enrollee representatives of the committee are drawn from those Groups contracting with the Plan. Factors in the selection of Enrollee representatives include ethnic extraction, demography, occupation and geography. The selection shall be conducted on a fair and reasonable basis.

The Enrollee representatives of the committee are approved by the Board of Directors of the Plan with due consideration to the foregoing factors and shall serve at the pleasure of the Board of Directors. Notwithstanding the foregoing the Committee term is three years, except however, the initial Enrollee representatives of the Committee shall be divided at random to serve initial one-, two- and three-year terms.

The committee shall meet at least quarterly with meetings to be called with no more than sixty (60) and no less than ten (10) calendar days' written notice from the Chairperson or Vice Chairperson of the committee. Notice of the meeting shall be accompanied by reports of the nature and volume of grievances received by the Plan, directly or through the Department of Managed Health Care, their disposition, pertinent financial information and other information from the Plan regarding public policy. The committee recommendations are reported to the Board of Directors for action at the Board's next meeting. The actions of the Board are reported in the meeting minutes.

The Plan notifies Enrollees of procedures to encourage their participation in establishing public policy. Any material changes affecting the public policy relating to the Plan are communicated to Enrollees.

Privacy Policy

THE PLAN'S "NOTICE OF PRIVACY PRACTICES" DESCRIBING THE PATIENT'S RIGHTS AND THE PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF PATIENT RECORDS MAY BE DOWNLOADED FROM THE PLAN'S WEBSITE (WWW.MESVISION.COM) OR WILL BE FURNISHED TO YOU UPON REQUEST.

Medical Eye Services (the Plan) is committed to protecting and securing the confidentiality of all personal and health information of its Enrollees. All such information created, maintained, stored or disposed of shall be treated in a manner that preserves the confidentiality of the information contained therein.

Any disclosure of patient information beyond the provisions of the law is prohibited. Patient information will not be released without the Enrollees' express written authorization, unless permitted by law, and will be used only for the purpose of processing vision claims in accordance with group and carrier vision plan contracts.

Patients have the following rights with respect to their medical records: access and/or amend, request an accounting of disclosures, request a restriction on uses and disclosures, and request to receive confidential communications. The Plan maintains physical, administrative, and technical security measures to safeguard patient information. Please refer to the "Notice of Privacy Practices" for more information.

Submit all claims and inquiries to:

Medical Eye Services, Inc.
P.O. Box 25209
Santa Ana, CA 92799-5209

888-859-5841 (Toll-Free)
www.MES*Vision*.com

Language Assistance Services

Important Information from MES*Vision*
Regarding Available Language Assistance Services

We are pleased to help you obtain vision care services in the language you understand at no charge to you.

Interpreter Services
If you or a family member have limited English speaking skills and need verbal interpreter services or assistance arranging vision care services:

Call **888-859-5841 (toll-free)** for assistance with interpreter services; or
Call the TTY/TDD Line at 1-877-735-2929 for the hearing and speech impaired.
Hours of Operation: Monday – Friday, 8:00 am – 5:00 pm Pacific Time

Translation of Written Information to MES*Vision* Enrollees
The language most frequently requested to be translated among our membership is Spanish. Upon your request, MES*Vision* will translate written information that impacts your vision care coverage in Spanish. To request translation of vision benefit documents:

Call **888-859-5841 (toll-free)**, MES*Vision* Customer Service; or
Call the TTY/TDD Line at 1-877-735-2929 for the hearing and speech impaired.
Hours of Operation: Monday – Friday, 8:00 am – 5:00 pm Pacific Time

If unable to reach us, please contact the Department of Managed Health Care's (DMHC) Help Center at **1-888-HMO-2219** or TDD Line **1-877-688-9891.** The DMHC provides telephone translation services in over 100 languages.

The DMHC Help Center also provides a written translation of the Independent Medical Review and Complaint Forms in Spanish and Chinese.

The DMHC Help Center is available 24 hours a day, seven days a week to answer questions.

Schedule of Allowances

Benefits are provided for Covered Services described below, and are subject to all provisions, Copayments/Deductibles, Exclusions, and Limitations of this Contract.

Copayments/Deductible Amounts: The Copayments/Deductible is an amount of covered Vision charges incurred by an Enrollee for which no benefits will be paid. The Copayments/Deductible amount will apply within any 12 consecutive months to each Enrollee.

Exam	$0

	Benefits	
	Participating Provider	**Non-Participating Provider**
Examination:		
Comprehensive Examination	Covered in Full	$0
Ophthalmologic Examination	Covered in Full	$40
Optometric Examination	Covered in Full	$40
Lenses:		
Single Vision	Covered in Full	$30
Bifocal	Covered in Full	$50
Trifocal	Covered in Full	$65
Standard Progressive [4]	Covered in Full	$65
Premium Progressive [5]	$86.81	$65
Aphakic/Lenticular Monofocal	Covered in Full	$125
Aphakic/Lenticular Multifocal	Covered in Full	$125
Polycarbonate for children up to age 19:		
Single Vision	Up to $85	$55
Bifocal	Up to $85	$55
Contact Lenses: [1]		
Non-Elective/Medically Necessary (one pair) [2]	Covered in Full	$250
Elective/Cosmetic	$105	$100
Elective/Cosmetic with UV Protection	$115	$0
Frame: [3]		
Selection up to a retail amount of	$125	$40

[1] The contact lens allowance is in lieu of other eyewear benefits. The Plan will pay up to the benefit amount toward the contact lens evaluation, fitting costs, and materials. Any difference between the allowance and the provider's charge is the responsibility of the Enrollee. Disposable contact lenses should be purchased up to the maximum benefit allowance or receipts should be accumulated within the benefit period and submitted together for reimbursement. To determine the appropriate benefit allowance, all contact lens claims must include the contact lens manufacturer and brand. Some retail and wholesale providers do not participate in this program. Please check with your provider before placing your order.

[2] If the patient meets criteria for medically-necessary contact lenses through the pre-approval process, the participating provider will determine the type of contact lenses suitable to restore visual acuity based on the patient’s eye condition. When the patient elects a specific brand of contact lenses, any

difference between the benefit amount and the charges will be a patient responsibility. Please see the “Limitations” section.

(3) The difference between the benefit amount and the charges for more expensive frames or unusual lenses, such as oversize, will be the responsibility of the Enrollee. Some designer frames may be restricted by the manufacturer. The retail frame allowance will be converted to wholesale or warehouse equivalent prices at provider locations using warehouse or wholesale pricing. These providers are identified in the Provider Directory at www.MES*Vision*.com. The wholesale and warehouse equivalent may be approximately 30% less than the allowance; please confirm this benefit before ordering eyewear.

(4) Standard progressive lenses (also referred to as no-line bifocals) allow you to see distance, mid-range and near clearly; however, there may be some peripheral distortion. Standard progressive lenses also need to be a minimum height in order to transition properly between distance and near vision. Standard progressive lenses are a covered-in-full benefit.

(5) Premium progressive lenses are digitally surfaced so they provide a wider reading area, less peripheral distortion and less height restrictions, than standard progressive lenses. Premium progressive lenses with higher levels of customization, including high definition lenses, are not a covered-in-full benefit; the patient is responsible for the balance between the maximum plan benefit and the provider’s usual and customary charge.