Client Vision Care Plan

vsp vision care

Client Name: **KYOCERA SLD LASER, INC**
Client Number: **40166032**
Effective Date: **JANUARY 1, 2026**

EVIDENCE OF COVERAGE

Provided by:

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

PLEASE READ CAREFULLY. THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE PLAN. THE PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE PLAN WILL BE FURNISHED UPON REQUEST. ALL APPLICANTS HAVE A RIGHT TO REVIEW THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT. IF ANY CHANGES ARE MADE TO THIS DOCUMENT BY ANYONE OTHER THAN VSP, VSP DISCLAIMS RESPONSIBILITY FOR SUCH CHANGES AND CANNOT GUARANTEE THIS DOCUMENT WILL COMPLY WITH ANY STATUTORY REQUIREMENTS INCLUDING BUT NOT LIMITED TO ERISA.

A STATEMENT DESCRIBING VISION SERVICE PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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

NAME OF GROUP:

NAME OF PLAN:

PRIMARY ADDRESS OF GROUP:

PLAN ADMINISTRATOR:

PHONE NUMBER:

ADDRESS:

PLAN TERM: [ ] through [ ]

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document attached as Exhibit C to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
COORDINATION OF BENEFITS	Procedure which allows more than one plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator under which such Enrollee is covered.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

OUT-OF-NETWORK PROVIDER Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

PLAN or PLAN BENEFITS The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

PREMIUMS The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.

SCHEDULE OF BENEFITS The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.

SCHEDULE OF PREMIUMS The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

VSP NETWORK 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 vision care services and/or vision care materials on behalf of Covered Persons of VSP.

ELIGIBILITY FOR COVERAGE

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

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any unmarried child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years. If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated or at such other times as VSP may request proof, but not more frequently than annually.

ANNUAL ENROLLMENT/DISENROLLMENT

Except for new Enrollees joining this plan, Enrollees and Eligible Dependents shall have the right to become covered or cancel coverage once each year during the thirty (30) day period beginning sixty (60) days prior to the anniversary of the effective date of this plan (or as may otherwise be allowed by mutual agreement between the Group and VSP). Any such coverage or cancellation of coverage may be accomplished only by Group giving VSP written notice thereof on behalf of the Enrollee or Eligible Dependent before the end of the prescribed thirty (30) day period and will take effect on the anniversary date following receipt of such notice.

PREMIUMS

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

PROCEDURES FOR USING THIS PLAN

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

1. When you desire to obtain Plan Benefits from a VSP Network Provider, you should contact a VSP Network Provider or VSP. A list of names, addresses, and phone numbers of VSP Network Providers in your geographic location can be obtained from your Group, Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one which does.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the VSP Network Provider. If you contact a VSP Network Provider directly, you must identify yourself as a VSP Covered Person so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against this Plan in spite of your termination of coverage or the termination of this Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a VSP Network Provider, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to the VSP Network Provider for the services covered by this Plan. VSP will pay the VSP Network Provider directly according to their agreement with the doctor. VSP reimburses its VSP Network Providers on a fee-for-service basis. There are no incentives or financial bonuses paid to VSP Network Providers for services covered under this plan.

   Note: If you are eligible for and obtain Plan Benefits from an Out-Of-Network Provider, you should pay the provider his full fee. You will be reimbursed by VSP in accordance with the Out-Of-Network Provider reimbursement schedule shown on the attached Schedule of Benefits or Additional Benefit Rider less any applicable Copayments.

5. Services for medical conditions, including emergencies, are covered by VSP only under specific supplemental eye care plans purchased by the Group. If Group purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Emergency Conditions, Covered Persons with a supplemental eye care plan may can obtain Plan Benefits by contacting a VSP Network Provider or Out-of-Network Provider. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. If Group has not purchased one of these plans. Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

   For Emergency Conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Emergency vision care is subject to the same benefit frequencies, Plan allowances, Copayments and exclusions stated herein. Reimbursement to VSP Network Providers will be made in accordance with their agreement with VSP.

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

7. VSP will covered provide coverage for health care services appropriately delivered through telehealth on the same basis and to the same extent that VSP is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment, and that coverage is not limited only to services delivered select third-party corporate telehealth providers.

BENEFIT AUTHORIZATION PROCESS

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

Appeals: If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Covered Person may designate any person, including the provider, as Covered Person's authorized representative.

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

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this Evidence of Coverage & Disclosure Form and the attached Schedule of Benefits and Additional Benefit Rider (if applicable). ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

PRINCIPAL BENEFITS AND COVERAGES

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

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

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Covered Person is entitled to a Eye Examination as indicated on the attached Schedule of Benefits.

2. Lenses: The VSP Network Provider will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Covered Person is entitled to new lenses as indicated on the attached Schedule of Benefits.

3. Frames: The VSP Network Provider will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Covered Person is entitled to new frames as indicated on the attached Schedule of Benefits.

4. Contact lenses: Unless otherwise indicated on the attached Schedule of Benefits, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein.

When you obtain Necessary contact lenses from a VSP Network Provider, professional fees and materials will be covered as indicated on the attached Schedule of Benefits.

When Elective contact lenses are obtained from a VSP Network Provider, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the VSP Network Provider's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the VSP Network Provider's usual and customary charges.

5. If you elect to receive vision care services from one of the VSP Network Providers, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Out-Of-Network Provider coverage and you choose to obtain Plan Benefits from a Out-Of-Network Provider, you should pay the Out-Of-Network Provider his full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the attached Schedule of Benefits or Additional Benefit Rider, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Out-Of-Network Provider reimbursement schedule is subject to the same time limits and Copayments as those described for VSP Network Provider services. Services obtained from a Out-Of-Network Provider are in lieu of obtaining services from a VSP Network Provider and count toward plan benefit frequencies.

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

PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Provider or by calling VSP's Customer Care Division at (800) 877-7195.

This Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, this Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra is defined as a Plan Benefit in the enclosed Schedule of Benefits.

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

NOT COVERED
There is no benefit under this plan for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.

- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.

- Medical or surgical treatment of the eyes.

- Corrective vision treatment of an Experimental Nature.

- Costs for services and/or materials above Plan Benefit allowances indicated on the attached Schedule of Benefits or Additional Benefit Rider.

- Services/materials not indicated as covered Plan Benefits on the attached Schedule of Benefits or Additional Benefit Rider.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another plan). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

RENEWAL

VSP shall issue written renewal notice to the Group at least sixty (60) days before the end of the Plan Term and this Plan shall be automatically renewed for an additional period of time and at premium rate(s) specified in such notice. Such renewal shall take effect, without any lapse in coverage, on the first calendar day following the last day of the Plan Term described herein. Group may refuse renewal by notifying VSP in writing prior to renewal. If Group decides to refuse renewal, VSP requests that it receive Group's written refusal at least thirty (30) days prior to the renewal Effective Date.

TERMINATION OF BENEFITS

Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to you as of the termination date of this Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this Plan.

LIABILITY OF COVERED PERSON IN EVENT OF NON-PAYMENT BY VSP

In the event VSP fails to pay the provider, you shall not be liable for any sums owed by VSP other than those not covered by the Plan.

ORGAN AND TISSUE DONATION

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician.

PARTICIPATE IN PUBLIC POLICY OF VSP

In compliance with California law, VSP permits enrollees to participate in establishing the public policy of the Plan by maintaining a standing committee known as VSP's Public Policy Committee. By law, the term "public policy" means acts performed by VSP to assure the comfort, dignity, and convenience of patients who rely on VSP to provide health care services to them, their families, and the public. If you wish to be considered as a candidate for membership on VSP's Public Policy Committee, please send a letter requesting consideration, and the reasons therefor, addressed as follows:

VSP
Attn: Legal Department
3333 Quality Drive
Rancho Cordova CA 95670

Timely Access to Care
Covered Persons have the right to receive care and services in a timely manner.

Appointment Type	**Timeframe**
Routine Eye Exam	Within 15 business days
Non-Urgent Medical	Within 10 business days
Urgent Care	If call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 48 hours
Telephone Screening	Evaluated to determine the severity of the condition and disposition of the patient

LANGUAGE INTERPRETER SERVICES
Covered Persons have the right to receive language interpreter services. When scheduling an appointment, they can tell the provider's office that they need an interpreter at the time of their visit.

COMPLAINTS AND GRIEVANCES
If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. A grievance is any written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, a complaint, dispute, request for reconsideration or appeal made by a Covered Person or the Covered Person's representative. This includes a written or oral expression of dissatisfaction by a Covered Person or group contract holder who believes their plan contract has been or will be improperly cancelled, rescinded, or not renewed. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt

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

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

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

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

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

REQUEST AN INDEPENDENT REVIEW

Review by the Department of Managed Health Care: 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 health plan at **(800) 877-7195** and use your health 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 health 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 an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of the proposed service or treatment, coverage decisions for treatments that are experimental, investigational in nature and payment disputes for emergency or urgent medical reviews. The Department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to Covered Persons, and the failure to use these procedures does not preclude Covered Person's use of any other remedy provided by law. You are not required to use a specific form to submit a grievance to the department. If a Covered Person or group contract holder submits a grievance to the plan or the department before the effective date of a cancellation, rescission, or nonrenewal for reasons other than nonpayment of premiums, the plan shall continue to provide coverage until a final determination regarding the request for review has been made.

REQUEST A SECOND OPINION

If a Covered Person disputes a diagnosis provided by his/her VSP Preferred Provider, or if the treatment provided by his/her VSP Preferred Provider has not improved Covered Person's visual acuity, he/she may request a second opinion by calling VSP's Customer Service Department at **(800) 877-7195**. The telephonic request for a second opinion will be immediately granted and Covered Person may then seek an examination from the VSP Preferred Provider of his/her choice. Covered Person should advise the doctor at the time of the examination that the visit is for purposes of a second opinion.

A second opinion will be paid the same as any other examination covered under this Plan and will be subject to any applicable Copayments and/or Plan Limitations. Payment for a second opinion under this Plan will not reduce any other available Plan Benefits. The VSP Preferred Provider who performs the second opinion will provide You, and the VSP Preferred Provider who performed the initial examination, with a consultation report.

If Your request for a second opinion is denied, VSP will notify You in writing of the reasons for the denial and You will have the right to file a grievance.

All requests for a second opinion shall be directed, in writing, to:

Vision Service Plan
Optometric Consultant
Health Care Services Division
3333 Quality Drive
Rancho Cordova, CA 95670

Important: Under no circumstances will a second opinion be granted if the patient's initial vision examination was performed by a Non-VSP Preferred Provider.

REQUEST CONFIDENTIAL COMMUNICATIONS

Covered Persons have a right to request confidential communications. VSP shall permit Enrollees and Covered Persons to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until the Enrollee or Covered Person submits a revocation of the request or a new confidential communication request is submitted. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

You may request privacy and confidentiality by following these steps:

1. Download the Confidential Communication Request form at

   www.vsp.com/legal/protected-member-confidentiality

2. Print and complete the form.

3. Return to VSP.

   Mail:
   VSP
   Attn: Regulatory Compliance
   3333 Quality Drive, MS-163
   Rancho Cordova, CA, 95670

   Fax: **916.851.4851**

   Email: HIPAA@vsp.com

For assistance completing and submitting the form, call VSP Member Services at **800.877.7195.**

ARBITRATION

Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration. The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of two (2) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

TO OBTAIN FURTHER INFORMATION

Contact VSP at **800-877-7195** or **www.vsp.com**.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Plan or Evidence of Coverage & Disclosure Form to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Group:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

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

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination 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 $25.00 Copayments payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Enhancements, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up until the end of the month in which they attain the age of 26 years.
Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to An Additional Featured Frame Allowance of $50.00 once every 24 months**

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

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

CONTACT LENSES

ELECTIVE
Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a $60.00 Copayment.

Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.
Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Network Provider's fee up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OUT-OF-NETWORK PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination 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 $25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Up to $30.00 - 100.00 * once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Group).

FRAMES: Covered up to $70.00* once every 24 months**
Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.

CONTACT LENSES
Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**
Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Out-Of-Network Provider's fee, up to $1000.00*

Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

*Less any applicable Copayment.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OUT-OF-NETWORK PROVIDERS

1. Exclusions and limitations of benefits described above for VSP Network Providers shall also apply to services rendered by Out-of-Network Providers.
2. Services from an Out-of-Network Provider are in lieu of services from a VSP Network Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Out-of-Network Providers to adhere to VSP's quality standards.

EXHIBIT A

SCHEDULE OF BENEFITS

VSP VISION SAVINGS PASS™

GENERAL

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This Schedule lists the vision care savings benefits to which Covered Persons of Vision Service Plan ("VSP") are entitled, subject to any other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, or ophthalmologist who is a VSP Doctor. This Schedule forms a part of the Agreement and Evidence of Coverage to which it is attached.

VSP Doctors are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Group:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner of Enrollee
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

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

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

PLAN BENEFITS

SERVICE OR MATERIAL	VSP DOCTOR BENEFIT	FREQUENCY
Eye Examination*	Patient payment is $50.	Once per calendar year
Frames and Lenses*	Glass or plastic Lenses (or polycarbonate lenses for dependent children) are available in exchange for the following patient payments: Single vision $40 Lined bifocal $60 Lined trifocal $75 Lenticular $75 with 20-25% off of the VSP Doctor's Usual and Customary professional fee for lens enhancements and 25% of the VSP Doctor's Usual and Customary professional fee for frames on complete sets of prescription glasses.***	Unlimited
Contact Lens Professional Services**	A discount of 15% off of the VSP Doctor 's Usual and Customary professional fee for fitting and evaluation services associated with prescription contact lenses (discount does not apply to materials).***	Unlimited

Discounts apply to the purchase of complete pairs of prescription glasses only.
Discounts do not apply to vision care benefits obtained from Non-VSP Providers.
* This cost is only available with the purchase of a complete pair of glasses; otherwise, Covered Person will receive 20% off of the VSP Doctor's Usual and Customary fee.
** Includes evaluation, design, fitting, and subsequent follow-up services.
***Discounts toward the purchase of materials or services may be obtained by the Covered Person within twelve (12) months of the examination from any VSP Doctor.

EXCLUSIONS AND LIMITATIONS

NOT COVERED

There are no benefits for professional services or materials connected with:

1. Solutions or cleaning products for spectacle glasses or contact lenses.
2. Low vision services and materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
5. Medical or surgical treatment of the eyes.
6. Services and/or materials not indicated on this Schedule as Covered Plan Benefits.
7. Local, state and/or federal taxes

NOTICE: The amount due under this Agreement is subject to change upon renewal (after the end of the Initial Agreement Term or any subsequent Agreement Term) or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Agreement.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

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

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB"). Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Network Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts VSP Network Provider and makes an appointment.

2. Covered Person pays any applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS - VSP NETWORK PROVIDERS
COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

PLAN BENEFITS - OUT-OF-NETWORK PROVIDERS

An eye care professional that is an Out-Of-Network Provider may require Covered Person to pay for all services in full at the time of the visit. Covered Person may then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Urgent/Emergency Care, and Special Ophthalmological Services: Covered up to $300.00 less any applicable Copayment amount; based on coverage limits for the specific medical eye care service and state service was received.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Providers shall also apply to services rendered by Out-Of-Network Providers.
2. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services in full.
3. VSP is unable to require Out-Of-Network Providers to adhere to VSP's quality standards.

vsp vision care

CONTINUATION COVERAGE UNDER CAL-COBRA

If you are covered under a group policy providing coverage to 2 to 19 eligible employees, you may be eligible to purchase continued coverage under this group vision plan under California Health and Safety Code Section 1366.20 et seq. (Cal-COBRA).

You may qualify for Cal-COBRA continuation coverage if you lose coverage for one of the following reasons:

a. The death of the covered employee.
b. The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.
c. The divorce or legal separation of the covered employee from the covered employee's spouse.
d. The loss of dependent status by a dependent enrolled in the group benefit plan.
e. With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

As a condition of receiving benefits, you must notify VSP within 60 days of the loss of coverage for one of the foregoing reasons. FAILURE TO NOTIFY VSP WITHIN THE REQUIRED 60 DAY PERIOD WILL DISQUALIFY YOU FROM RECEIVING CONTINUATION COVERAGE.

You must request the continuation in writing and deliver the written request to VSP by first class mail or other reliable means of delivery within the 60 day period following the later of (1) the date your coverage under the group benefit plan terminated or will terminate by reason of a qualifying reason, or (2) the date you were sent notice from the group benefit plan or VSP of eligibility to continue coverage under Cal-COBRA.

In order to continue receiving coverage under this plan, you are responsible for making all of the required premium payments in accordance with the terms and conditions of the plan contract. The first premium payment must be made to VSP by first-class mail, certified mail or other reliable means of delivery including personal delivery, express mail, or private courier within 45 days of the date you provided written notice to VSP of your election of continuation of benefits. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify you from receiving continuation coverage.

Notice: If the contract between VSP and the employer is terminated prior to the date your continuation coverage would terminate pursuant to the Cal-COBRA statute, you may elect continuation coverage under the employer's subsequent group benefit plan, if any, for the balance of the period you would have remained covered under this plan. However, continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in and payment of premiums to the new benefit plan within 30 days of receiving notice of termination of the prior group benefit plan.

All notices to VSP must be sent to:

VISION SERVICE PLAN
Attn: COBRA Administration
3333 Quality Drive
Rancho Cordova, CA 95670

Matrix

THIS MATRIX IS INTENTED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS SUMMARY ONLY. THE EVIDENCE OF COVERAGE, INCLUDED HEREIN, AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Heading		**Copayment**	**Limitations**
Deductibles	None		
Lifetime Maximums	None		
Professional Services (Not all services are listed.) Call VSP or check official plan documents for details.	Eye Examination Frame Lenses Contact Lenses (Elective) Contact Lenses (Necessary) Low Vision	Normally ranges from $0-50.00 (can be group specific) Normally ranges from $0-50.00 (can be group specific and may be a combined Copayment with lenses) Normally ranges from $0-50.00 (can be group specific and may be a combined Copayment with frame) Normally ranges from $0-50.00 (can be group specific) Normally ranges from $0-50.00 (can be group specific) 25-50% of approved allowable amount (Maximum allowable is $500-1,000. Can be group specific.)	**You will be responsible for any costs which exceed Your Plan allowance or maximum allowable amount and any charges for services and/or materials not covered by Your Plan.**
Outpatient Services	No Coverage		
Hospitalization Services	No Coverage		

Emergency Health Coverage	In emergency cases, when immediate vision care is necessary, Covered Persons may obtain Plan Benefits by contacting a VSP Network Provider or Out-Of-Network Provider. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments, and exclusions stated herein for VSP Network Doctor and Out-Of-Network Provider services.		
Ambulance Services	No Coverage		
Prescription Drug Coverage	No Coverage		
Durable Medical Equipment	No Coverage		
Mental Health Services	No Coverage		
Chemical Dependency Services	No Coverage		
Home Health Services	No Coverage		

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **KYOCERA SLD LASER, INC**
Group ID: **40166032**
Effective Date: **JANUARY 1, 2026**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.