



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

GROUP VISION CARE POLICY

Group Name	PRESIDENT AND FELLOWS OF MIDDLEBURY COLLEGE
Policy Number	30022396
State of Delivery	VERMONT
Effective Date	JANUARY 1, 2020
Policy Term	FORTY-EIGHT (48) MONTHS
Premium Due Date	FIRST DAY OF MONTH

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

A handwritten signature in cursive script, appearing to read "Kate Renwick-Espinosa", is written in black ink.

Kate Renwick-Espinosa, President

**VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY
TABLE OF CONTENTS**

I.	DEFINITIONS.....	1
II.	TERM, TERMINATION, AND RENEWAL.....	3
III.	OBLIGATIONS OF THE COMPANY.....	4
IV.	OBLIGATIONS OF THE GROUP.....	8
V.	OBLIGATIONS OF INSURED UNDER THE POLICY.....	10
VI.	ELIGIBILITY FOR COVERAGE.....	11
VII.	CONTINUATION OF COVERAGE.....	13
VIII.	ARBITRATION OF DISPUTES.....	14
IX.	NOTICES.....	16
X.	MISCELLANEOUS.....	17
	EXHIBIT A	
	SCHEDULE OF BENEFITS.....	19
	SCHEDULE OF BENEFITS.....	24
	EXHIBIT B	
	SCHEDULE OF PREMIUMS.....	29
	SCHEDULE OF PREMIUMS.....	30
	ADDENDUM	
	ADDITIONAL BENEFIT - DIABETIC EYECARE.....	31
	ELIGIBILITY FOR COVERAGE.....	34

**VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY
SECTION 1.
DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.14. **KERATOCONUS**: A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

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

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

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

1.18. **PLAN BENEFITS**: The vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

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

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

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

SECTION II.
TERM, TERMINATION, AND RENEWAL

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

2.02. Early Termination Provision: The premium rate(s) payable by Group under this Agreement is based on an assumption that the Company will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If this Agreement is terminated by Group before the end of the Policy Term or any subsequent renewal terms, for any reason other than material breach by the Company, Group will remain liable to the Company for the lesser amount of any deficit incurred by the Company or the payments which Group would have paid for the remaining term of this Policy, not to exceed one year. A deficit incurred by the Company will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by the Company from Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay the Company within thirty-one (31) days of notification of the amount due.

SECTION III.
OBLIGATIONS OF THE COMPANY

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

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

3.02. Provision of Plan Benefits: Through its Member Doctors (or through other licensed vision care providers where the Insured chooses to receive Plan Benefits from a Non-Member Provider), the Company shall provide Insureds such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), subject to any limitations, exclusions, or Copayments therein stated. When the Insured desires to receive Plan Benefits from a Member Doctor, the Insured shall contact the Company or the Member Doctor. The Company shall provide Benefit Authorization to the Member Doctor or to the eligible Insured for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by the Company in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by the Company shall constitute a certification to the Member Doctor that payment will be made. The Company shall not be held liable to Group for any Benefit Authorizations so issued in error. Insureds are required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Insured obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details). Notwithstanding any other provision, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits, and when purchased by Client, the Additional Benefit Rider. Retail chains may not offer all Plan Benefits. Covered Person may contact Member Doctor for information describing vision care services and vision care materials offered.

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

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

3.04. Confidentiality and Non-Disclosure Agreements The Company and Group have delivered, or will deliver, upon execution and delivery of this Policy, certain information about the properties and operations of their respective businesses. The Company and Group, therefore, agree as follows.

a) **Definition of Confidential Information.** For purposes of this Policy, "Confidential Information" means any data and/or information, in any form, disclosed by the disclosing Party ("Discloser") to the receiving Party ("Recipient") either before or after the Effective Date, which relates to Discloser and/or its Affiliates, and solely by way of illustration and not in limitation shall include the following information: (i) current or future product(s), services, methodologies, plans, designs, costs, prices, customer or doctor names and addresses, finances or financial information (including budgets), marketing plans or strategies (including e-commerce development plans), business plans, matters, opportunities or offerings, equipment and other purchase matters, strategic matters, research, development, know-how and/or personnel, (ii) is identified as confidential at the time of disclosure, (iii) given the nature of the information disclosed and the circumstances surrounding its disclosure, reasonably ought to be treated as Confidential Information by a person in the same industry as Discloser, or (iv) by law must be protected as Confidential Information. Recipient acknowledges that the Confidential Information is proprietary to Discloser and has been developed and obtained through great efforts by Discloser. Confidential Information shall not, however, include information that (A) at the time of disclosure is, or subsequently becomes, available to the public or the industry through no fault or breach on the part of Recipient; (B) Recipient can demonstrate to have had rightfully in its possession prior to disclosure by Discloser; (C) is independently developed by Recipient without the use of any Confidential Information; or (D) Recipient rightfully obtains from a third party who has the right to transfer or disclose it. Confidential Information shall also be deemed to include any and all confidential information defined as Confidential Matters hereunder, the treatment of which shall be as set forth in Paragraph 3.04 of this Policy.

b) **Non-Disclosure and Non-Use of Confidential Information.** Recipient shall not, directly or indirectly, without the prior written approval of Discloser in each instance or unless otherwise expressly permitted herein, use for its own benefit, publish or otherwise disclose to others, or authorize the use by others for their benefit, or to the detriment of Discloser, any of Discloser's Confidential Information. Recipient shall carefully restrict access to Discloser's Confidential Information to only those of its and its Affiliates' officers, directors, employees, agents and representatives (collectively, "Representatives") who (i) clearly require such access in order to enable to perform their respective obligations under this

Policy (ii) who are bound by confidentiality obligations that protect third party information which are at least as restrictive and protective as those contained in this Policy, and (iii) are not (or do not work for) direct competitors of Discloser. Recipient shall not use, copy, distribute and/or remove any of Discloser's Confidential Information from Recipient's premises except to the extent necessary or appropriate to carry out its respective obligations under the Policy, without the prior consent of Discloser. Recipient and its Representatives will employ all security measures used for their own proprietary information of similar nature but in no event using less than a reasonable degree of care. Recipient agrees to advise and require its Representatives of their obligations to keep such information confidential and shall each be liable for any acts and omissions of their Representatives related thereto.

c) **Return or Destruction of Confidential Information.** The Receiving Party, including its Personnel, its employees and/or agents shall upon request of Discloser (i) immediately return to Discloser's designated representative any and all documents or other information and materials in whatever form which contain Discloser's Confidential Information, or as permitted by Discloser, (ii) destroy all copies thereof, and certify to Discloser in writing that all copies of such documents or other information and materials have been destroyed; provided, however, that the Receiving Party may retain one set of such documents and other information and materials for archival purposes only, subject to the continuing confidentiality and security obligations set forth under this Policy. Recipient may disclose Discloser's Confidential Information if and to the extent required by a judicial or governmental request, requirement or order; provided that Recipient will take reasonable steps to give Discloser sufficient prior notice (to the extent that sufficient time is available) of such request, requirement or order for Discloser to contest, limit and/or protect such disclosure.

d) **Injunctive Relief.** The Parties understand and acknowledge that any disclosure or misappropriation of any Confidential Information in violation of this Policy may cause irreparable harm, for which monetary damages alone may not be an adequate remedy and, therefore, agrees that Discloser shall have the right to apply to a court of competent jurisdiction for an order immediately restraining any such further disclosure or misappropriation and for other equitable relief, without objection and without the requirement of posting a bond or other form of security. Such right of each Party is in addition to the remedies otherwise available under this Policy or otherwise at law or equity.

e) **Survival:** The obligations laid down in this Section 4 shall continue and survive beyond the termination of this Policy.

3.05. Emergency Vision Care: When vision care is necessary for Emergency Conditions, Insureds may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from the Company is required for Insured to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company only under the Acute EyeCare and Supplemental Primary EyeCare

Plans. If Group has not purchased one of these plans, Insureds are not covered by the Company for medical services and should contact a physician under Insureds' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Insured should contact the Company's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

SECTION IV.
OBLIGATIONS OF THE GROUP

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

4.02. Payment of Premiums: On or before the first day of each month, Group shall remit to the Company the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy for such succeeding month. The amount of such Premiums for each Insured shall be as provided in the Schedule of Premiums incorporated in this Policy as Exhibit B. Only Insureds for whom Premiums are actually received by the Company shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Insured is not received by the time specified above, the Company reserves the right to terminate all rights of such Insured, and such rights may be reinstated only in accordance with the requirements of this Policy.

The Company may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. The Company may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Policy are changed. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy.

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

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

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

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

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

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

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

SECTION V.
OBLIGATIONS OF INSUREDS UNDER THE POLICY

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

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

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

5.03. Authorization of Services: The Insured must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or the Company. Should the Insured receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Insured, the provider will be considered a Non-Member Provider, and the benefits available will be limited to those for a Non-Member Provider, if any. Retail chains may not offer all Plan Benefits. Covered Person may contact Member Doctor for information describing vision care services and vision care materials offered.

5.04. Complaints and Grievances: Time of Action: Insureds shall report any complaints and/or grievances to the Company at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to the Company verbally or in writing. Insured may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in the Company's review. The Company will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after the Company's receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, the Company will notify the Insured of the expected resolution date. Upon final resolution, the Company will notify the Insured of the outcome in writing.

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

SECTION VI.
ELIGIBILITY FOR COVERAGE

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

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

- (1) currently be an employee or member of Group; and
- (2) meet the coverage criteria mutually agreed upon by Group and the Company.

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

- (1) the legal spouse of any Enrollee; and
- (2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependent children shall be eligible until the end of the month in which they attain the age of 26, or
- (3) as further defined by Group.

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

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

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

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

As stated in Section 4.04. herein, the Company may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Insured is entitled under the Policy.

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

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

SECTION VII.
CONTINUATION OF COVERAGE

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

SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

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

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

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

b) Second Level Appeal: If the Insured disagrees with the response to the initial appeal of the claim, the Insured has a right to a second level appeal. Within sixty (60) calendar days after receipt of the Company's response to the initial appeal, the Insured may submit a second appeal to the Company along with any pertinent documentation. The Company shall communicate its final determination to the Insured in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

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

8.02. Disputes: Any dispute or question arising between the Company and Group or any Insured involving the application, interpretation, or performance under this Policy shall be settled, if possible by amicable and informal negotiations allowing 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.

8.03. Procedure for Arbitration: The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

SECTION IX.
NOTICES

9.01. Notices: Any notices required under this Policy to either Group or the Company shall be in written format. Notices sent to the Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by Group. Notices to the Company shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

SECTION X.
MISCELLANEOUS

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

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

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

10.04. Right to Reject Claims: The Company reserves the right to reject any and all claims for services or benefits that are filed with it more than three hundred sixty-five (365) days after completion of services.

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

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

10.07. Choice of Law: While recognizing that question(s) and dispute(s) hereunder are to be resolved by arbitration, if there are any matters arising in connection with this Policy that do become the subject of legal process, the applicable law shall be that of the State of Delivery of this Policy.

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

10.09. Equal Opportunity: The Company is an Equal Opportunity and Affirmative Action employer.

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

EXHIBIT A

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
SIGNATURE PLAN
Base Plan**

GENERAL

This Schedule lists the vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY ("the Company") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are received from Non-Member Providers, the Insured is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

PLAN BENEFITS

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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VISION CARE SERVICES

Eye Examination	Covered in Full*	Up to \$ 50.00*
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Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.

Subsequent regular eye examinations once every **plan year beginning on January 1st.**

VISION CARE MATERIALS

**MEMBER DOCTOR
BENEFIT**

NON-MEMBER PROVIDER BENEFIT

Lenses

Single Vision	Covered in Full*	Up to \$ 50.00*
Bifocal	Covered in Full*	Up to \$ 75.00*
Trifocal	Covered in Full*	Up to \$ 100.00*
Lenticular	Covered in Full*	Up to \$ 125.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive lenses covered in full

*Less any applicable Copayment

Available once every plan year beginning on January 1st.

Frames	Covered up to Plan Allowance*	Up to \$ 70.00*
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

*Less any applicable Copayment.

Available once every other plan year beginning on January 1st.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available **once every plan year** in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

NECESSARY

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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Professional Fees and Materials - Covered in Full*	Professional Fees and Materials - Up to \$ 210.00*
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ELECTIVE

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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Materials - Up to \$ 150.00 Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum \$60.00 Copayment.	Professional Fees and Materials - Up to \$ 105.00
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*Less any applicable Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT

The benefits described above are available to each Insured from any participating Member Doctor at no cost to the Insured, with the exception of any applicable Copayment as described below.

A Copayment amount of \$15.00 shall be payable by the Insured to the Member Doctor at the time services are rendered.

LOW VISION BENEFIT

The Low Vision benefit is available to Insureds who have severe visual problems that are not correctable with regular lenses.

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Supplementary Testing	Covered in Full	Up to \$125.00*
Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplementary Care	75% of Cost	75% of Cost*
Subsequent low vision therapy.		

Copayment

75% of the benefits payable by the Company and 25% payable by Insured.

Benefit Maximum

The maximum benefit available is \$1,000.00 (excluding Copayment) every two years.

***NON-MEMBER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Insured should pay the Non-Member Provider his/her full fee. The Insured will be reimbursed in accordance with an amount not to exceed what the Company would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

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 Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Insured will pay the additional costs for the options.

- 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.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

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

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear required by an employer as a condition of employment;
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE COMPANY MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF THE COMPANY'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE INSURED.

EXHIBIT A

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
SIGNATURE PLAN
Buy up Plan**

GENERAL

This Schedule lists the vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY ("the Company") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are received from Non-Member Providers, the Insured is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

PLAN BENEFITS

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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VISION CARE SERVICES

Eye Examination	Covered in Full*	Up to \$ 50.00*
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Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.

Subsequent regular eye examinations once every **plan year beginning on January 1st.**

VISION CARE MATERIALS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

Lenses

Single Vision	Covered in Full*	Up to \$ 50.00*
Bifocal	Covered in Full*	Up to \$ 75.00*
Trifocal	Covered in Full*	Up to \$ 100.00*
Lenticular	Covered in Full*	Up to \$ 125.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive lenses covered in full

*Less any applicable Copayment

Available once every plan year beginning on January 1st.

Frames	Covered up to Plan Allowance*	Up to \$ 70.00*
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

*Less any applicable Copayment.

Available once every plan year beginning on January 1st.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available **once every plan year** in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

NECESSARY

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Professional Fees and Materials - Covered in Full*	Professional Fees and Materials - Up to \$ 210.00*

ELECTIVE

<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Materials - Up to \$ 200.00 Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum \$60.00 Copayment.	Professional Fees and Materials - Up to \$ 105.00

*Less any applicable Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT

The benefits described above are available to each Insured from any participating Member Doctor at no cost to the Insured, with the exception of any applicable Copayment as described below.

A Copayment amount of \$15.00 shall be payable by the Insured to the Member Doctor at the time services are rendered.

LOW VISION BENEFIT

The Low Vision benefit is available to Insureds who have severe visual problems that are not correctable with regular lenses.

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Supplementary Testing	Covered in Full	Up to \$125.00*
Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplementary Care	75% of Cost	75% of Cost*
Subsequent low vision therapy.		

Copayment

75% of the benefits payable by the Company and 25% payable by Insured.

Benefit Maximum

The maximum benefit available is \$1,000.00 (excluding Copayment) every two years.

***NON-MEMBER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Insured should pay the Non-Member Provider his/her full fee. The Insured will be reimbursed in accordance with an amount not to exceed what the Company would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

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 Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Insured will pay the additional costs for the options.

- 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.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

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

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear required by an employer as a condition of employment;
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE COMPANY MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF THE COMPANY'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE INSURED.

Exhibit B

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
SIGNATURE PLAN
Base Plan**

The Company shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

- \$ 8.22 per month for each eligible Enrollee without dependents.
- \$ 16.42 per month for each eligible Enrollee with one eligible dependent.
- \$ 26.46 per month for each eligible Enrollee with two or more eligible dependents.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

Exhibit B

**VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
SIGNATURE PLAN
Buy up Plan**

The Company shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

- \$ 13.25 per month for each eligible Enrollee without dependents.
- \$ 26.48 per month for each eligible Enrollee with one eligible dependent.
- \$ 42.69 per month for each eligible Enrollee with two or more eligible dependents.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Insureds who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the POLICY or Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee.
- The legal spouse of Enrollee.
- The domestic partner of the same or opposite gender as Enrollee including their dependent children, pursuant to Group's eligibility.
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to 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.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Insureds group medical plan. Providers will first submit a claim to Insureds group medical insurance plan, and then to the Company. Any amounts not paid by the medical plan will be considered for payment by the Company. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Insured does not have a group medical plan, providers will submit claims directly to the Company.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Insured Member Doctor cannot provide Covered Services, the doctor will refer the Insured to another Member Doctor or to a physician whose offices provide the necessary services.

If the Insured requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Insured receive the appropriate level of care for their presenting condition. Insured do not require a referral from a Member Doctor in order to obtain Plan Benefits.

**PLAN BENEFITS
MEMBER DOCTORS**

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of \$20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Insured upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where the Company is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY

VI. ELIGIBILITY FOR COVERAGE

6.01 (b) **Eligible Dependents**, Add the Following:

(1a) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2b) Any children of the domestic partner provided they depend upon the Enrollee for support and maintenance.