VISION PLAN OF AMERICA

APPLICATION and GROUP SUBSCRIBER AGREEMENT

EMPLOYER INFORMATION:

COMPANY/ORGANIZATION NAME:_____

STREET
ADDRESS:_____CITY:_____STATE:_____ZIP:_____

BILLING
ADDRESS:_____CITY:_____STATE:_____ZIP:_____

NAME AND TITLE OF PERSON TO WHOM BILLING IS DIRECTED:

_____

DESIRED EFFECTIVE DATE

PHONE#:_____TYPE OF BUSINESS:_____

HAS EMPLOYER FILED FOR BANKRUPTCY IN THE PAST SEVEN YEARS ☐ YES ☐ NO

☐ EMPLOYER PAID _____% ☐ VOLUNTARY

REMARKS:_____

AGENT OF RECORD:

NAME:_____VPA CODE#:_____

Code#

DO NOT WRITE IN SHADED AREAS

PLAN TYPE:_____ Term: _____ Co-payment:_____

	NO. ENROLLED	RATE	TOTAL
EMPLOYEE	_____X	$_____=	$_____
EMPLOYEE PLUS ONE DEP.	_____X	$_____=	$_____
EMPLOYEE PLUS TWO OR MORE DEP.	_____X	$_____=	$_____

MONTHLY ADMINISTRATION FEE **$ 10.00**

FIRST MONTH'S REMITTANCE TOTAL $_____

PLEASE MAKE ALL CHECKS PAYABLE TO:
VISION PLAN OF AMERICA

- And Mail To -
VISION PLAN OF AMERICA
3255 Wilshire Blvd., Suite 1610
Los Angeles, CA 90010

The benefits for which employees and enrolled dependents are eligible under this Group Subscriber Agreement are described in the Combined Evidence of Coverage/Disclosure Form ("Evidence of Coverage"), which is attached to and becomes a part of the Group Subscriber Agreement. The employer ("Subscriber Group") hereby requests the coverage indicated above, subject to the terms and conditions outlined in the Group Subscriber Agreement. The Subscriber Group acknowledges that the term of the Group Subscriber Agreement shall be twelve (12) months if Benefit Plan "A" or "MQ-2" is selected, or twenty-four (24) months if Benefit Plan "B" or "C" is selected. The Subscriber Group understands that the amount of the Prepayment Fee has been calculated based on the term of the Group Subscriber Agreement, and that the Agreement shall remain in effect for the duration of the term in accordance with Section XIV.I of the Group Subscriber Agreement.

_____ BY:_____
Date Applicant's Authorized Representative

APPROVAL:
VISION PLAN OF AMERICA
By:

_____ _____
ADMINISTRATOR DATE

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GROUP SUBSCRIBER AGREEMENT PLAN ABC

I. DEFINITIONS

Key terms used in this Agreement are capitalized and defined below:

"BENEFITS" and **"COVERAGE"** means those vision care services available under the Group Subscriber Agreement in which a Member is enrolled.

"CHILD" means all natural, adopted, foster, and step-children.

"COMBINED EVIDENCE OF COVERAGE/DISCLOSURE FORM" refers to the document which is issued to the Subscriber setting forth the Benefits and Coverage to which the Subscriber and his/her Dependents are entitled.

"CO-PAYMENT" means an additional fee charged to a Member for Benefits that is paid to the Plan Provider by the Member at the time services are rendered.

"COSMETIC" means a service or material that is sought for the purpose of beautification or adornment, but which does not improve visual acuity. In the case of contact lenses, if equivalent results can be attained with eyeglasses, then contact lenses are considered to be Cosmetic.

"DEPENDENT" means: (a) the Subscriber's lawful spouse; (b) an unmarried dependent Child of the Subscriber, up to the Child's 19th birthday; (c) an unmarried child of the Subscriber, up to the Child's 23rd birthday who is a full-time student and who is wholly dependent on the Subscriber for support; and (d) any otherwise eligible Child of the Subscriber, regardless of age, who is wholly dependent upon the Subscriber for support because of mental retardation or physical handicap.

"DESIGNATED PROVIDER" is the Plan Provider chosen by the Member and designated by the Plan to be responsible for the general vision care of the Member. Dependents must choose the same Designated Provider as the Subscriber.

"EFFECTIVE DATE OF COVERAGE" means the date upon which the Member is entitled to receive the Benefits and Coverage which are available under the Group Subscriber Agreement.

"EMPLOYER PAID GROUPS" Employer Paid Groups are Groups in which a true employer-employee relationship exists and: (1) the employer contributes at least 50% of the employee (Subscriber) and Dependent (when applicable) Prepayment Fees; and (2) at least 50% of the Group's employees participate in one of the vision plan options.

"EXCLUSION" is any provision contained in this Subscriber Agreement whereby Coverage for a specified hazard or condition is entirely eliminated.

"FEE-FOR-SERVICE CHARGE" means the amount which the Plan Provider normally or usually charges his/her patients who are not Members.

"GRIEVANCE" is a written or oral expression of dissatisfaction regarding the Plan and/or a Plan Provider, including quality of care concerns, made by a Member or the Member's representative.

"GROUP" means an employer or other entity that contracts with the Plan for Coverage under a Group Subscriber Agreement in order to provide vision care Coverage to Subscribers and their eligible Dependents.

"GROUP SUBSCRIBER AGREEMENT" refers to the agreement between the Plan and the Subscriber Group which establishes the terms and conditions that govern the Benefits and Coverage made available to Members by the Plan. The application is attached to the Group Subscriber Agreement

and together, along with the Combined Evidence of Coverage/Disclosure Form, constitute the entire agreement.

"LIMITATION" is any provision, other than an Exclusion, which restricts Coverage under the Group Subscriber Agreement.

"MEMBER" means any Subscriber or Dependent who is enrolled under the Group Subscriber Agreement and entitled to the Benefits and Coverage available under the Group Subscriber Agreement.

"PLAN" is **Vision Plan of America**, its principal address being 3255 Wilshire Boulevard, Suite 1610, Los Angeles, California 90010. The telephone numbers of the Plan's administrative office are (213) 384-2600 and (800) 400-4VPA.

"PLAN PROVIDER" refers to providers of vision care services licensed by the State to deliver or furnish these services who have contracts with the Plan to render services to Members in accordance with the provisions of the Group Subscriber Agreement. The names, locations, hours of services, and other information regarding Plan Providers and facilities may be obtained by contacting the Plan's office at (800) 400-4VPA.

"PREPAYMENT FEE" is the amount payable monthly, on a prepayment basis, by the Subscriber Group and/or Subscriber to obtain Benefits and Coverage under the Group Subscriber Agreement.

"SUBSCRIBER" is the person whose employment or other status, except for family dependency, is the basis for eligibility for Coverage under the Group Subscriber Agreement.

"SUBSCRIBER GROUP" is the organization or company that has entered into this Group Subscriber Agreement with the Plan under which Benefits and Coverage are made available to Subscribers and their Dependents.

"VISION CARE FACILITIES" means those centers selected by the Plan to provide vision services for Members.

"VOLUNTARY GROUPS" are Groups that do not meet the requirements of an Employer Paid Group. In the case of a Voluntary Group, the employer distributes enrollment forms to interested employees, deducts the Prepayment Fee from the employee's paycheck and forwards to the Plan in a timely manner the completed forms and monthly Prepayment Fees. Voluntary Group Members are responsible for 100% of the applicable Prepayment Fee, whereas Employer Paid Group Members are responsible for only a portion, or none, of the applicable Prepayment Fee.

II. PREPAYMENT FEE/OTHER CHARGES

A. Prepayment Amounts

The Prepayment Fee is the monthly fee required to maintain Coverage under this Agreement. The Plan makes no distinction in Prepayment Fee amount based upon physical or mental impairment. Please refer to the enrollment form for the Prepayment Fees.

B. Method of Payment

Subscribers who are eligible for Benefits and Coverage under this Agreement shall pay their portion of the Prepayment Fees, if any, directly to the Subscriber Group, which will in turn pay the Plan. Voluntary Group Members are responsible for 100% of the applicable Prepayment Fee, whereas Employer Paid Group Members are responsible for only a portion, or none, of the applicable Prepayment Fee. The total Prepayment Fee must be received by the Plan on or before the twentieth (20th) day of the month to insure eligibility for service on the first (1st) day of the following month. Such payments shall be made at or sent to: **Vision Plan of America, 3255 Wilshire Boulevard, Suite 1610, Los Angeles, California 90010.**

C. Revision of Benefits or Rates

The Plan may alter or revise the Benefits or the Prepayment Fees and Co-payments payable under this Group Subscriber Agreement. Any such alteration or revision of the Benefits, Prepayment Fees, or Co-payments shall become applicable for all Members on the effective date of the alteration or revision (whether or not the Prepayment Fees were paid in advance). The Plan shall give at least thirty (30) days prior notice to the Subscriber Group of any such fee or Benefit alteration or revision. Any such notice shall be considered to have been given when mailed to the Subscriber Group at the address shown in the records of the Plan. The Subscriber Group agrees to provide to all Subscribers copies of such notices within five (5) days of receipt. In no event will the Prepayment Fees be subject to change more than once during each twelve (12) month period – however, if Prepayment Fees are guaranteed for a longer length of time, there will be no change during that period.

D. Copayments

In addition to any Prepayment Fee, the Member shall pay applicable Co-payments, if any, as provided in Exhibit A of this Group Subscriber Agreement. The examination Co-payment amount is also listed on the Member I.D. Card. These Co-payments must be paid directly to the Plan Provider when treatment is received.

III. ELIGIBILITY RULES

A. Subscribers and/or Members

1. Persons Eligible to Become Subscriber - Any Person:

(a) Who is an active (full-time) employee of the Subscriber Group, an elected official of the Subscriber Group, a retired employee of the Subscriber Group, or otherwise affiliated with the Subscriber Group if the Subscriber Group is not an employer; and

(b) Who has not previously been terminated under any subscriber agreement issued by the Plan because of fraud or deception in the use of the services or facilities of the Plan or knowingly permitting such fraud or deception by another, and

(c) For whom the Subscriber has applied for membership, on forms supplied by the Plan.

2. Eligibility Dates Applicable to Dependents:

(a) A person who is eligible for membership as a Dependent on the date the Subscriber becomes eligible for membership shall also be eligible for Coverage on that date, subject, however, to the effective date of Coverage provision (see Section 3 below).

(b) Persons who become eligible for membership subsequent to the date the Subscriber became eligible for membership shall become eligible on whichever of the following dates is applicable:

(i) In the case of a Dependent Child, the date the Subscriber acquires the Child (birth or adoption); or

(ii) In the case of a Dependent spouse, the date the Subscriber marries (spouse becomes eligible).

3. Effective Date of Coverage:

Subject to payment of the applicable Prepayment Fees and to all other applicable provisions of this Agreement, Coverage shall become effective:

(a) In the case of the Subscriber, on the date of enrollment.

(b) In the case of a newborn Child or a Child placed in the Subscriber's home for adoption, on the date of birth of the newborn Child or the date of placement of an adoptive Child.

(c) In the case of a new spouse or other Dependent except as specified in 3 (b) above, on the date of enrollment.

B. Group Enrollment Period

Notwithstanding any provision in this Agreement to the contrary, enrollment may take place anytime during the contract period. Enrollment by the 20th of any month assures services beginning on the first of the following month.

IV. TERMINATION OF BENEFITS

A. Benefits and Coverage to which Members are entitled under this Agreement will continue in effect for the term specified in Part XIV.I, subject to the following:

1. Non-Renewal

(a) Non-Renewal of Group Subscriber Agreement – The Subscriber Group may elect not to renew this Agreement by giving sixty (60) days written notice to the Plan before the end of the term of the Agreement.

(b) Discontinuance of Coverage of Individual Member(s) Upon Renewal Date – Subscribers and Dependents shall have the right to discontinue Coverage sixty (60) days prior to the renewal date with written notice to the Subscriber Group, which in turn must notify the Plan at least forty-five (45) days prior to the renewal date.

2. Nonpayment

(a) If the Subscriber Group fails to make any past due monthly payment within fifteen (15) days after written notice of termination is sent to the Subscriber Group, then the Plan may terminate the Group Subscriber Agreement effective 15 days after the date of the notice. Notice of the Plan's termination of the Group Subscriber Agreement shall be mailed to the Subscriber Group at the address of record maintained with the Plan. The Subscriber Group's representative will then be responsible for disseminating this information to Subscribers within five (5) days of receipt. Benefits and Coverage will cease fifteen (15) days after the date of the notice of termination.

(b) If such past due payment is received more than fifteen (15) days after issuance of the notice of termination, the Plan will not reinstate the contract. Instead, the Plan shall, within twenty (20) business days of receipt of such payment, either:

(i) refund such payment; or

(ii) issue to the Subscriber Group a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the cancelled contract in Benefits, Coverage or otherwise. Any new contract issued by the Plan may differ from the cancelled contract with respect to the amount and method of payment of Prepayment Fees; Co-payments; Benefits; or in other respects.

3. Furnishing Incorrect or Incomplete Information

If a Member knowingly furnishes materially incorrect or materially incomplete information on the application, questionnaire, forms, or statements submitted to the Plan incident to enrollment, then the rights of the Member and all Dependents may be terminated effective immediately upon written notice.

4. Misuse of Identification Card

If any Member permits the use of his/her Plan identification card by any other person, or uses another person's card, the card so misused may be retained by the Plan, and all rights of the Member who wrongfully permitted use of such card or who wrongfully used such card may be terminated effective immediately upon written notice.

5. Loss of Eligibility

If any Member loses his/her eligibility status as set forth in Section III of this Agreement, then the Plan may terminate his/her Coverage under this Agreement effective immediately upon written notice.

B. Return of Pro Rata Portion of Monthly Payment

If the rights of a Member hereunder are terminated, Prepayment Fees received on behalf of the terminated Member which are applicable to periods after the effective date of termination, less any amounts due to the Plan, will be refunded within thirty (30) days after the effective date of termination.

C. Opportunity for Review

A Member who alleges that his/her Coverage hereunder was terminated or not renewed because of health status or requirements for health care services may request a review of such termination by the Department of Managed Health Care as permitted by Section 1365(b) of the California Health and Safety Code. The Department of Managed Health Care can be contacted at (800) HMO-2219.

D. Payment for Benefits After the Subscriber Agreement is Cancelled. The Plan will not be responsible for payment for Benefits that are rendered after the effective time and date of cancellation of the Group Subscriber Agreement, regardless of whether a Member is hospitalized or undergoing a course of treatment. However, the Plan will take every opportunity to ensure the continuity of care for such Members.

V. INDIVIDUAL CONTINUATION OF BENEFITS

A. Loss of Group Eligibility and Loss of Eligibility due to Termination of Group Subscriber Agreement

The Subscriber and/or Member who becomes ineligible for Coverage under this Agreement, whether due to loss of Group eligibility or termination of this Agreement, may apply within thirty (30) days after the date of ineligibility to continue Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the California Consolidated Omnibus Budget Reconciliation Act (Cal-COBRA). COBRA and Cal-COBRA require that, under certain circumstances, health plan benefits be made

available to a Subscriber and his/her eligible Dependents for purchase by said persons upon the occurrence of a qualifying event. See the Addendum to this Agreement for more information on COBRA and Cal-COBRA terms and conditions of Coverage. If and only to the extent COBRA or Cal-COBRA applies, the Plan shall make the statutorily-required continuation Coverage available for purchase in accordance with COBRA or CAL-COBRA. After the COBRA or Cal-COBRA Coverage expires, the Subscriber and Dependents may apply for Coverage with the Plan under an individual subscriber agreement. The Subscriber and/or Member shall be liable for Prepayment Fees and Co-payments required by the terms of the individual subscriber agreement during the contract period.

B. Conversion Upon Death or Divorce

A covered Dependent spouse who ceases to be an eligible Dependent by reason of termination of marriage or death of the Subscriber will be afforded the same conversion rights and conditions granted to the Subscriber and eligible Dependents under Section V.A above.

VI. CHOICE OF PLAN PROVIDER / LIABILITY OF MEMBER FOR PAYMENT

Upon enrollment in the Plan, the Member shall select a Plan Provider to act as his/her Designated Provider in providing vision care services to the Member. Enrolled Dependents must use the same Designated Provider as the Subscriber. The Plan's telephone numbers are (213) 384-2600 and (800)400-4VPA. These numbers may be called for assistance. The Plan reserves the right to reassign Members at any time to a different Designated Provider. The benefits and Coverage listed in Exhibit A are only available if such benefits and services are obtained from the Designated Provider and are not available if the Member chooses to go to any other provider. If a Member obtains services from a provider who is not his/her Designated Provider, the Member will be responsible for the full cost of those services.

The Subscriber may change Designated Providers; however, the Plan must be contacted thirty (30) days prior to the **first visit** to the Plan Provider so that the necessary paperwork can be accomplished.

The Plan shall provide the Subscriber Group with an updated list of Plan Providers' names, addresses, and telephone numbers for distribution to Subscribers twice a year. Members may also obtain a copy of the Plan Provider directory by contacting the Plan's Customer Service Department's toll-free telephone number at 1(800) 400-4872, the Plan's website at **www.visionplanofamerica.com**, or by written request to the Plan's administrative office located at 3255 Wilshire Boulevard, Suite 1610, Los Angeles, California 90010.

All Plan Providers agree by contract that should the Plan fail to pay for vision care services, the Plan Providers' sole remedy will be against the Plan and not the Member.

VII. REIMBURSEMENT PROCEDURES

In addition to any Copayments the Plan Provider receives from Members, the Plan pays its Plan Providers a fixed per Member per month amount. The Plan Provider receives no additional payments from the Plan in the form of incentive payments or bonuses.

The Plan will not reimburse the Subscriber and/or Member for the cost of any services received from a non-Plan Provider. All services must be obtained from Plan Providers.

VIII. FACILITIES

Information regarding the services available and the locations and hours of Plan Providers may be obtained by calling the Plan's administrative office at (800) 400-4VPA. Members may also visit our website at: **www.visionplanofamerica.com.**

IX. RENEWAL PROVISIONS / RENEWAL OR REINSTATEMENT; NO INDIVIDUAL MEMBER RIGHTS

The Plan will solicit the Subscriber Group to renew the Agreement by notifying the Subscriber Group sixty (60) days before the end of the term of any changes in terms or conditions that will occur upon renewal.

Members have no individual rights to renewal or reinstatement of this Agreement if it is terminated by the Plan because the Subscriber Group fails to make monthly payments when due or otherwise breaches this Agreement.

X. OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

Once a Member has enrolled and chosen a Designated Provider, the Member then must contact the Designated Provider and schedule an appointment. The name and telephone number of the Designated Provider will be printed on the Member's I.D. card. The first appointment scheduled will usually be for the purpose of performing a complete eye examination and selection of frames for eyeglasses, or fitting of contact lenses.

The examination Co-payment amount, if any, shall be paid directly to the Designated Provider at the time of service. (See Exhibit A and the Member I.D. Card for the examination Co-payment amount.)

Members have the following responsibilities:

- To identify him/herself to the Designated Provider office as a Plan Member. If the Member fails to do so, the Member may be charged the Designated Provider's usual and customary fees instead of the applicable Benefit Co-Payment.

- Treat the Designated Provider and his/her office staff with respect and courtesy and cooperate with the prescribed course of treatment. The Plan will permit the Member to change Designated Providers; however, the Plan will not interfere with the doctor/patient relationship and cannot require a Plan Provider to perform particular services.

- Keep scheduled appointments or contact the Designated Provider's office twenty-four (24) hours in advance to cancel an appointment. If the Member fails to do so, he/she may be charged a missed appointment fee.

- Make Co-payments at the time of service.

- Notify the Plan of changes in family status. If not, the Plan will be unable to authorize vision care for the Member or Dependents.

XI. MEMBER GRIEVANCES

A. Members are encouraged to contact the Plan regarding any problems that are encountered while obtaining services. The Plan maintains a grievance system to deal with Members' problems and complaints. Complaints or grievances can be made in person at the Plan's administrative office, 3255 Wilshire Boulevard suite#1610, Los Angeles, CA 90010 or by telephoning the Plan at (213) 384-2600 or (800) 400-4VPA, or in writing and sent by fax to (213) 384-0084 or by e-mail at: **memberservices@visionplanofamerica.com**. Complaint forms may be obtained from any Plan Provider or the Plan's administrative office and should be returned to the administrative office located at

3255 Wilshire Boulevard, Suite 1610, Los Angeles, California 90010; or by visiting the Plan's website at **www.visionplanofamerica.com**. Members will receive an acknowledgement letter within five (5) calendar days and a resolution letter within thirty (30) calendar days.

B. 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 800-400-4VPA 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 IMR, the IMR process will provide an impartial review or medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

XII. RELATIONS AMONG PARTIES AFFECTED BY AGREEMENT

The relationship between the Plan and any Plan Provider is an independent contractor relationship. Plan Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of any Plan Provider.

Plan Providers maintain the doctor-patient relationship with Members and are solely responsible to Members for all vision care services.

XIII. LIMITATIONS AND EXCLUSIONS

A. Limitations - The following describe Limitations on Benefits available to Members under this Agreement:

1. If the Member selects a frame which is more expensive than those allowed under this Agreement, the Member shall be responsible for the difference between the actual retail price of the frame and what the Plan allows.

2. Benefits are not available if the Member receives such services from a Plan Provider who is not his/her Designated Provider.

3. The Member will be responsible for the Fee-for-Service Charge for the following services or materials:

a. Blended or no-line bifocals
b. Double segment bifocals
c. Oversize lenses (diagonal dimension of 58mm or greater; narrow pupillary distance in conjunction with frame dimension)

d. Photo chromatic-lenses
e. Tinted lenses except for tint #1, any color (plastic lenses only)
f. Progressive multi focal lenses

4. The Subscriber and/or Member will be responsible for the Fee-for-Service Charge for the coating of a lens or lenses, or the laminating of a lens or lenses.

B. Exclusions - the following professional services and/or materials are excluded from Coverage:

1. Orthoptics (process for improvement of visual perception and coordination of the two eyes for good binocular vision).

2. Visual training.

3. Plano (non-prescription) lenses.

4. A second pair of glasses in lieu of bifocals.

5. Replacement of lost, stolen or destroyed lenses and frames.

6. Medical or surgical treatment of the eyes or any procedure requiring an ophthalmologist or any hospital or medical charges.

7. Orthokeratology (a procedure for decreasing refractive error by use of contact lenses).

8. Subnormal vision care (treatment and devices used to assist those persons who are partially sighted).

9. Prolonged occlusion tests associated with special remedial care or a diagnosis of strabismus (a visual defect in which one eye cannot focus with the other on an object because of imbalance of the eye muscles).

10. The services of ophthalmologists or specialist optometrists are not Benefits under this Agreement. If, in the opinion of the Designated Provider, it is in the best interest of the Member to be referred to an ophthalmologist or specialist for such services, the Member will be responsible for the Fee-for-Service Charges for services rendered by ophthalmologists, or specialist optometrists, or other specialist. A specialist optometrist is an optometrist who specializes in the diagnosis and treatment of binocular vision disorders, dyslexia and other related disorders such as reading disabilities.

11. Any eye examination required by an employer as a condition of employment, unless it is in conjunction with an eye examination for which the Member is otherwise entitled under this Agreement.

12. Dispensing of any drugs or prescriptions.

13. Services which cannot be performed due to the general health of the Member. The Member is entitled to a second opinion in such a situation as well as filing a formal grievance in the event of a dispute. (See Section XIV.N regarding second opinions. See Section XI regarding how to file a grievance with the Plan.)

14. Any service which is reimbursed by other insurance coverage held by the Member or is reimbursable under another group or health service plan which covers the Member. In the event the Member is covered for vision care benefits by such other coverage, the Plan shall be considered the secondary carrier and such other coverage shall be considered the primary carrier. The Plan shall provide benefits at the time of need, but the Member shall execute and deliver such documents or take such other actions as may be necessary to assure the assignment of any right to reimbursement of the

Plan for services rendered to the Member for which Benefits are payable by the primary carrier. However, the Member shall not be personally liable for more than the Member would have been liable for had there not been coverage by another health carrier.

15. Any pathology arising from and due to the Member's employment for which Workers' Compensation is liable. In such a case, Workers' Compensation is the primary carrier and the Plan is the secondary carrier. The Plan shall provide benefits at the time of need but the Member shall execute and deliver such documents or take such other actions as may be necessary to assure the assignment of any right to reimbursement of the Plan for services rendered to the Member for which Workers' Compensation is liable as the primary carrier.

XIV. MISCELLANEOUS PROVISIONS

A. Acceptance of Contract

The Subscriber Group may accept this Agreement either by execution of the application and agreement or by making payment to the Plan pursuant to Section II. B hereof, and such acceptance shall render all terms and provisions hereof binding on the Plan and the Subscriber Group.

B. Contract Binding

By this Agreement the Subscriber Group makes Benefits and Coverage available to persons who are eligible under Section III; however, this Agreement shall be subject to amendment or modification in accordance with any provision hereof or by mutual agreement between the Plan and the Subscriber Group without the consent or concurrence of the Members.

C. Application, Statements, Etc.

Subscribers and/or Members or those persons applying for membership shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. Subscribers and/or Members warrant that all information contained in such applications, questionnaires, forms or statements submitted to the administration hereof are true, correct and complete, and all rights to benefits hereunder are subject to the condition that all such information is true, correct and complete.

D. Liability of the Plan

In the event the Plan fails to pay a Plan Provider who has provided Benefits to a Member in accordance with the terms of this Agreement, the Member shall not be liable to the Plan Provider for any sums owed by the Plan.

E. Notice of Certain Events

The Plan shall give the Subscriber Group written notice within ten (10) days of any termination or breach of contract by, or inability to perform of, Plan Providers, or any other person with whom the Plan has a contact to provide services and benefits hereunder, if the Subscriber Group can be materially and adversely affected thereby.

F. Governing Law

The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and to Chapter 1 of Division 1 of Title 28 of the California Code of Regulations, and any provision required to be in this Group Subscriber Agreement by either of the above shall bind the Plan whether or not set forth herein.

G. Administration of Contract

The Plan may adopt reasonable policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Agreement.

H. Termination of a Provider

In the event that a Plan Provider contract is terminated, the Plan will be liable for covered services rendered by such Provider to an eligible Member under the Group Subscriber Agreement or by operation of law, for care provided at the time of the termination until the services being rendered are completed. The Plan reserves the option to make reasonable and medically appropriate provision for the assumption of such services by a Plan Provider. Members may request continuation of care after a provider is terminated by contacting the Plan's Provider Relations Department. When a Plan Provider terminates, the Plan will transfer Members assigned to that provider to a new Designated Provider or the Member may select a new Designated Provider from the Plan Provider list.

I. Term; No Termination By Subscriber Group Without Cause

This Agreement shall remain in force and effect for a period set forth in the Subscriber Group application and enrolled Members will participate for the period of time so specified. The amount of the Prepayment Fee has been calculated based on the term of this Agreement. The Subscriber Group therefore agrees that it shall have no right to terminate this Agreement prior to the expiration of its term, except for cause (see Section XIV.J below). If the Subscriber Group terminates this Agreement prior to its expiration, the plan shall be entitled to recover the costs of any action taken to enforce reasonable attorney and collection fees. The Subscriber Group further agrees that Members shall not be permitted to cancel their Coverage until the earliest of the following: (i) the Agreement has expired; (ii) the Member is no longer eligible (in the case of a Dependent); or (iii) the Subscriber's employment has terminated.

J. Termination for Cause by Subscriber Group

The Subscriber Group may terminate this Agreement upon thirty (30) days prior written notice to the Plan if the Plan is in material breach of this Agreement. Material breach includes, but is not limited to, the Plan's failure to provide the Benefits required under this Agreement. The Subscriber Group shall set forth in the notice of intended cancellation the facts underlying its claim that the Plan is in breach of this Subscriber Agreement. If such breach is remedied within twenty (20) days of the receipt of such notice, then the Subscriber Agreement shall continue in effect for the remainder of its term.

K. Public Policy Committee

The Plan has established a Public Policy Committee, which is responsible for participating in establishing the public policy of the Plan. The Committee consists of the Plan's representatives, Plan Providers, and Members. Members interested in participating in the Public Policy Committee should contact the Plan's administrative office at (800) 400-4VPA.

L. Notices

Any notice to the Plan required to be given under this Agreement may be given by United States mail, postage paid, addressed as follows:

Vision Plan of America
3255 Wilshire Boulevard, Suite 1610
Los Angeles, California 90010

M. Change of Address

Subscribers must notify the Plan's administrative office within thirty (30) days of a change in a Subscriber's mailing address by telephoning the Plan at (213) 384-2600 or (800)400-4VPA, or by writing the Plan at 3255 Wilshire Boulevard, Suite 1610, Los Angeles, California 90010.

N. Second Opinion

During routine optometric care, a second opinion is generally not required. If a Member feels that the prescription, after refraction, is incorrect and therefore requires a second opinion, or believes he/she requires a second opinion for another reason, the Member must contact the Plan at (800) 400-4VPA. The Plan's Optometric Director will determine if a second opinion is warranted. The Optometric Director

shall notify the Member within 72 hours of his/her decision. If the Optometric Director determines that a second opinion is warranted, the Member will be referred to another Plan Provider for the second opinion. More information regarding second opinions may be obtained by calling the Plan at (800) 400-4VPA.

O. Urgent/Emergent Procedures

Benefits do not include, and Plan Providers do not provide, diagnosis or treatment of conditions (such as a serious eye injury) requiring medical emergency or urgent care services beyond the scope of practice of an optometrist. In the event of a medical condition that requires emergency care, the Member should call 911, or go immediately to the nearest emergency room. Conditions requiring urgent care should be reported as soon as possible to the Member's regular physician. Members may also need to see an ophthalmologist for medical treatment of eye injuries. The Plan will not pay for any of these services. However, Plan Providers will provide, subject to applicable Co-payments, urgent/emergent optometric services within the Plan Provider's scope of licensure (such as assisting Members with a contact lens removal problem, or repair or replacement of broken eyeglass frames or lenses, or torn or lost contact lenses).

P. Organ and Tissue Donations

Thousands of lives are saved each year through organ and tissue donations. If a Member decides to become a donor, he/she is encouraged to share the decision with his/her family, and to fill out an organ donation card and keep it handy. For more information on organ donation, Members should talk to their physicians.

Q. Preservation of Confidentiality

The Plan shall hold in strict confidence all medical and other information concerning Members and shall exercise its best efforts to prevent any of its Plan Providers, employees, or agents from disclosing any such information, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Agreement, or complying with applicable law. Access to all such information, however, will be granted to the California Department of Managed Health Care as required by the Knox-Keene Health Care Service Plan Act of 1975, as amended. Any confidential medical information held by the Plan will be maintained and disposed of in a manner prescribed by law after a period of time prescribed by law. Members and/or Groups that want more information on the Plan's confidentiality policy may obtain a copy of the policy by contacting the Plan's Customer Service Department at 1(800) 400-4VPA or VPA's website at **www.visionplanofamerica.com.**

R. Criteria for Reviewing Treatment Authorization Requests. Plan Providers will provide a vision examination to Members in accordance with professionally recognized optometric standards. Plan Providers do not need to receive authorization from the Plan prior to rendering Benefits. However, in the event that a Plan Provider or a Member were to request authorization for a particular service, the Plan would review such a request to determine if the requesting Plan Provider's or Member's determination of medical necessity is consistent with the Plan's criteria. If the request is consistent with the Plan's criteria, the service will be authorized. If the request is not consistent with the Plan's criteria, the decision to authorize, modify or deny the service will be made by the Optometric Director or another appropriately qualified optometrist. A decision by the Plan to authorize, modify or deny a request for services is made within five (5) business days after the Plan's receipt of the information reasonably necessary to make a determination. The decision will be completed on an expedited basis, not to exceed 72 hours after our receipt of all reasonably necessary information, if required by the Member's condition. A copy of the written policies and procedures the Plan uses to approve, modify or deny a request for services, and a description of this process, are available upon request. Members or their Designated Providers may request a copy of the Plan's criteria with respect to a particular type of health care service.

Exhibit A[1]

Uniform Health Plan and Benefits Coverage Matrix: Co-Payments and Deductibles

"12/12/12" PLAN A

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

PLAN A BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
DEDUCTIBLES	NONE
LIFETIME MAXIMUMS	NONE
PROFESSIONAL SERVICES	
Eye Examination (includes refraction)	$[_____] Co-payment[2] A member is entitled to one eye examination each twelve (12) months with a follow-up visit at the Member's request, if necessary
OUTPATIENT SERVICES	NOT COVERED
HOSPITALIZATION SERVICES	NOT COVERED
EMERGENCY HEALTH COVERAGE	NOT COVERED
AMBULANCE SERVICES	NOT COVERED
PRESCRIPTION DRUG COVERAGE	NOT COVERED
DURABLE MEDICAL EQUIPMENT	NOT COVERED
MENTAL HEALTH SERVICES	NOT COVERED
CHEMICAL DEPENDENCY SERVICE	NOT COVERED
HOME HEALTH SERVICES	NOT COVERED
OTHER:	
Frames:	Limited to one pair of ophthalmic eyeglass frames each twelve (12) months. The Plan will pay up to $[_____][3] ("the allowable amount") toward the Plan Provider's usual and customary retail fee. Any charges over the allowable amount must be paid directly to the provider at the time of service

[1] **NOTE**: The Plan has one matrix for each of its Benefit Plans A, B and C. The matrix that is attached to the copy of the Subscriber Agreement given to the Subscriber Group will depend upon the plan selected.

[2] **NOTE**: The actual amount of the Co-payment selected by the Subscriber Group will be typed into the matrix attached to the copy of the Subscriber Agreement given to the Subscriber Group. Eye examination Co-payments can range from $0 - $50.

[3] **NOTE**: The actual amount to be covered by the Plan (chosen by the Subscriber Group) will be typed into the matrix attached to the copy of the agreement given to the Subscriber Group. This amount can range from $45 - $120.

PLAN A BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
Frame Repair (when possible) Assisting in the selection of frames Proper fitting and adjustment of frames Subsequent frame adjustments	No Charge
Lenses:	No Charge, subject to the limitations stated below. Limited to one pair of plastic ophthalmic lenses including tint #1, any color each twelve (12) months, if the examination indicates the need for visual correction or a prescription change. Prescription change is defined as: (1) a change of 0.5 Diopters or more in one or both eyes. (2) A shift in the axis of astigmatism of 15 degrees, or (3) a difference of vertical prism greater than 1 prism diopter. The lens benefit includes: (1) Single vision lenses up to ±6.00 diopters with ±3.00 cyl. (2) Bifocal Lenses up to +3.00 add and including round top and flat top (22-28mm) (3) Trifocal Lenses flat top (7x22 and 7x25) (4) Lenticular lenses both single lenses and bifocal. --- These benefits are designed to cover visual needs rather than Cosmetic/elective options. The Plan makes available many enhanced lens options at each Plan Provider's office at reduced costs. Progressive lenses are a popular choice as they are line-free, whereas traditional bifocal and trifocal lenses have a line in the middle of the lens. Coatings, thin materials and other specialty items are all available lens option upgrades at reduced costs. All enhanced lens option charges are to be paid directly to the selected Plan Provider at the time of service, by the Member.
Prescribing and ordering proper lenses Verifying accuracy of finished lenses Follow-up care as necessary	No Charge
Contact Lenses (Medically Necessary)	One pair of contact lenses each twenty-four (24) month period when medically necessary and required for anisometropia, keratoconus or following cataract surgery, or when visual acuity cannot be corrected in the better eye to better than 20/70 by standard means (eye glasses) except through the use of contact lenses. ("Anisometropia" means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other. "Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone-shaped due to a

PLAN A BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	thinning and stretching of the tissue in its central area.) The Plan will pay up to $250 to include the eye examination, fitting, and the medically necessary contact lenses. The balance, if any, in excess of the Plan payment must be paid by the Member to the Plan Provider at the time of service.
Contact Lenses (Cosmetic)	Members may elect contact lenses for Cosmetic usage instead of lenses and frames once every twelve (12) months. The Plan will pay $100 (the allowable amount) toward the Plan Provider's usual and customary contact lens package fee, which includes the eye examination, fitting, and contact lenses. The balance, if any, above the allowable amount must be paid directly to the Plan Provider at the time of service or, after the eye examination and eyeglass selection. If Cosmetic contact lenses are desired, then through the Plan's Optional Contact Lens Enhancement, the Member may elect contact lenses in addition to the basic benefit at the Plan Provider's office for a fixed additional fitting fee paid directly to the Plan Provider at the time of service of $50 (non-toric or multifocal) plus a reduced cost for the contact lenses. This cost-controlled lens enhancement brings additional choice and value to the Benefit plan.

Uniform Health Plan and Benefits Coverage Matrix:
Co-Payments and Deductibles

"12/12/24" PLAN B

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

PLAN B BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
DEDUCTIBLES	NONE
LIFETIME MAXIMUMS	NONE
PROFESSIONAL SERVICES	
Complete Eye Examination	$[_____] Co-payment A member is entitled to one eye examination each twelve (12) months with a follow-up visit at the Member's request, if necessary
OUTPATIENT SERVICES	NOT COVERED
HOSPITALIZATION SERVICES	NOT COVERED
EMERGENCY HEALTH COVERAGE	NOT COVERED
AMBULANCE SERVICES	NOT COVERED
PRESCRIPTION DRUG COVERAGE	NOT COVERED
DURABLE MEDICAL EQUIPMENT	NOT COVERED
MENTAL HEALTH SERVICES	NOT COVERED
CHEMICAL DEPENDENCY SERVICE	NOT COVERED
HOME HEALTH SERVICES	NOT COVERED
OTHER:	
Frames:	Limited to one pair of ophthalmic eyeglass frames each twenty-four (24) months. The Plan will pay up to $[_____] ("the allowable amount") toward the Plan Provider's usual and customary retail fee. Any charges over the allowable amount must be paid directly to the provider at the time of service
Frame Repair (when possible) Assisting in the selection of frames Proper fitting and adjustment of frames Subsequent frame adjustments	No Charge
Lenses:	No Charge, subject to the limitations stated below: Limited to one pair of plastic ophthalmic lenses including tint #1, any color each twelve (12) months, if the examination indicates the need for visual correction or a prescription change. Prescription change is defined as:

PLAN B BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	(1) a change of 0.5 Diopters or more in one or both eyes. (2) A shift in the axis of astigmatism of 15 degrees or (3) a difference of vertical prism greater than 1 prism diopter. The lens benefit includes: (1) Single vision lenses up to ±6.00 diopters with ±3.00 cyl. (2) Bifocal Lenses up to +3.00 add and including round top and flat top (22-28mm) (3) Trifocal Lenses flat top (7x22 and 7x25) (4) Lenticular lenses both single lenses and bifocal. --- These benefits are designed to cover visual needs rather than Cosmetic/elective options. The Plan makes available many enhanced lens options at each Plan Provider's office at reduced costs. Progressive lenses are a popular choice as they are line-free, whereas traditional bifocal and trifocal lenses have a line in the middle of the lens. Coatings, thin materials and other specialty items are all available lens option upgrades at reduced costs. All enhanced lens option charges are to be paid directly to the selected Plan Provider at the time of service, by the Member.
Prescribing and ordering proper lenses Verifying accuracy of finished lenses Follow-up care as necessary	No Charge
Contact Lenses (Medically Necessary)	One pair of contact lenses each twenty-four (24) month period when medically necessary and required for anisometropia, keratoconus or following cataract surgery, or when visual acuity cannot be corrected in the better eye to better than 20/70 by standard means (eye glasses) except through the use of contact lenses. ("Anisometropia" means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other. "Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.) The Plan will pay up to $250 to include the eye examination, fitting, and the medically necessary contact lenses. The balance, if any, in excess of the Plan payment must be paid to the Plan Provider at the time of service, by the Member.
Contact Lenses (Cosmetic)	Members may elect contact lenses for Cosmetic usage instead of lenses and frames once every twelve (12) months. The Plan will pay $100 ("the allowable amount") toward the Plan Provider's usual and customary contact lens package fee which includes the eye examination, fitting, and contact lenses. The balance, if any, above the allowable amount must be paid directly to the Plan Provider by the Member at the time of service or, after the complete eye examination

PLAN B BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	and eyeglass selection. If Cosmetic contact lenses are desired then through the Plan's Optional Contact Lens Enhancement, the Member may elect contact lenses in addition to the basic benefit at the Plan Provider's office for a fixed additional fitting fee paid directly to the Plan Provider at the time of service of $50 (non-toric or multifocal) plus a reduced cost for the contact lenses. This cost controlled lens enhancement brings additional choice and value to the Benefit plan.

Uniform Health Plan and Benefits Coverage Matrix:
Co-Payments and Deductibles

"12/24/24" PLAN C

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

PLAN C BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
DEDUCTIBLES	NONE
LIFETIME MAXIMUMS	NONE
PROFESSIONAL SERVICES	
Complete Eye Examination	$[_____] Co-payment A Member is entitled to one eye examination each twelve (12) months with a follow-up visit at the Member's request, if necessary
OUTPATIENT SERVICES	NOT COVERED
HOSPITALIZATION SERVICES	NOT COVERED
EMERGENCY HEALTH COVERAGE	NOT COVERED
AMBULANCE SERVICES	NOT COVERED
PRESCRIPTION DRUG COVERAGE	NOT COVERED
DURABLE MEDICAL EQUIPMENT	NOT COVERED
MENTAL HEALTH SERVICES	NOT COVERED
CHEMICAL DEPENDENCY SERVICE	NOT COVERED
HOME HEALTH SERVICES	NOT COVERED
OTHER:	
Frames:	Limited to one pair of ophthalmic eyeglass frames each twenty-four (24) months. The Plan will pay up to $[_____] ("the allowable amount") toward the Plan Provider's usual and customary retail fee. Any charges over the allowable amount must be paid directly to the Plan Provider at the time of service, by the Member.
Frame Repair (when possible) Assisting in the selection of frames Proper fitting and adjustment of frames Subsequent frame adjustments	No Charge
Lenses:	No Charge, subject to the limitations stated below. Limited to one pair of plastic ophthalmic lenses including tint #1, any color each twenty-four (24) months, if the examination indicates the need for visual correction or a prescription change. Prescription change is defined as:

PLAN C BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	(4) a change of 0.5 Diopters or more in one or both eyes. (5) A shift in the axis of astigmatism of 15 degrees, or (6) a difference of vertical prism greater than 1 prism diopter. The lens benefit includes: (5) Single vision lenses up to ±6.00 diopters with ±3.00 cyl. (6) Bifocal Lenses up to +3.00 add and including round top and flat top (22-28mm) (7) Trifocal Lenses flat top (7x22 and 7x25) (8) Lenticular lenses both single lenses and bifocal. --- These benefits are designed to cover visual needs rather than Cosmetic/elective options. The Plan makes available many enhanced lens options at each Plan Provider's office at reduced costs. Progressive lenses are a popular choice as they are line-free, whereas traditional bifocal and trifocal lenses have a line in the middle of the lens. Coatings, thin materials and other specialty items are all available lens option upgrades at reduced costs. All enhanced lens option charges are to be paid directly to the selected Plan Provider at the time of service, by the Member.
Prescribing and ordering proper lenses Verifying accuracy of finished lenses Follow-up care as necessary	No Charge
Contact Lenses (Medically Necessary)	One pair of contact lenses each twenty-four (24) month period when "Medically Necessary" and required for anisometropia, keratoconus or following cataract surgery, or when visual acuity cannot be corrected in the better eye to better than 20/70 by standard means (eye glasses) except through the use of contact lenses. ("Anisometropia" means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other. "Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.) The Plan will pay up to $250 to include the eye examination, fitting, and the medically necessary contact lenses. The balance, if any, in excess of the Plan payment must be paid by the Member to the Plan Provider at the time of service.
Contact Lenses (Cosmetic)	Members may elect contact lenses for Cosmetic usage instead of lenses and frames once every twenty-four (24) months. The Plan will pay $100 (the allowable amount) toward the Plan Provider's usual and customary contact lens package fee, which includes the eye examination, fitting, and contact lenses. The balance, if any, above the allowable amount must be paid directly to the Plan Provider at the time of service or, after the eye examination and eyeglass

PLAN C BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	selection. If Cosmetic contact lenses are desired, then through the Plan's Optional Contact Lens Enhancement, the Member may elect contact lenses in addition to the basic benefit at the Plan Provider's office for a fixed additional fitting fee paid directly to the Plan Provider at the time of service of $50 (non-toric or multifocal) plus a reduced cost for the contact lenses. This cost-controlled lens enhancement brings additional choice and value to the Benefit plan.

ADDENDUM

VISION PLAN OF AMERICA
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) and Cal-COBRA CONTINUATION COVERAGE

The following provisions are hereby incorporated in the Group Subscriber Agreement if and only to the extent COBRA or Cal-COBRA applies to the parties under this Agreement:

COBRA is a federal law that applies to employers with 20 or more eligible employees. The California Continuation Benefits Replacement Act of 1997 (Cal-COBRA) applies to employers with 2 to 19 eligible employees. COBRA and Cal-COBRA require the Plan to offer continuation coverage for purchase by qualified beneficiaries (any individual who on the day before a "qualifying event," as defined herein, is enrolled in a group benefit plan and has a qualifying event) upon concurrence of a qualifying event. The Plan and Subscriber Group are subject to the following obligations in connection with this continuation coverage:

1. The Subscriber Group agrees to provide the Plan with notice of any qualified beneficiary who has had a "qualifying event," within thirty (30) days of the qualifying event. A "qualifying event" means any of the following events that, but for the election of continuation coverage provided there under, would result in a loss of coverage under the group benefit plan to the qualified beneficiary:

    a. The death of the covered employee;
    b. The termination or reduction of 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; or
    e. With respect to a dependent only, the covered employee's eligibility for coverage under Title XVIII of the United Stated Social Security Act (Medicare).

2. All eligible employees who are qualified beneficiaries of the health plan must notify the health plan or their employer group (if the employer group provides administration of their benefits) of any qualifying events within sixty (60) days of the qualifying event. Failure to notify the employer or the Plan will disqualify the beneficiary from receiving continuation coverage. Within 14 days of receipt of the foregoing notice of a qualifying event from the Subscriber Group or the Member, the Plan will send to the qualified beneficiary's last known address, as provided by the Subscriber Group, the necessary benefits information, premium information, enrollment forms, and instructions to allow the qualified beneficiary to formally elect continuation coverage.

3. The Subscriber Group agrees to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered under Cal-COBRA, as specified in Health and Safety Code Section 1366.27, a minimum of 30 days prior to the termination, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance for the period the qualified beneficiary would have remained covered under the prior group benefit plan. The Subscriber Group agrees to provide qualified beneficiaries subject to this paragraph with the necessary benefits information, premium information, enrollment forms, and instructions to allow the qualified beneficiary to continue coverage. This information shall be sent to the qualified beneficiary's last known address, as provided by the plan currently providing continuation coverage to the qualified beneficiary.