VSP VISION PLAN

HIGHLIGHTS

The Company offers the VSP Vision Plan. VSP provides the following benefits.

- Exams
- Lenses
- Frames
- Necessary contact lenses
- Elective contact lenses

Participants may choose between prescription eyeglasses or contact lenses. If a participant chooses contact lenses, they will not be eligible to receive benefit coverage for eyeglasses (lenses and a frame) in the same benefit period.

Vision care services are available from VSP Doctors, participating Retail Chains or out-of-network providers. When a participant obtains services from a VSP Doctor or a participating Retail Chain, VSP covers the benefits described herein (examination, lenses and frames) at no expense to the participant, except for a $10 copayment. Any additional care, services, and/or materials above VSP limits may be arranged between the participant and the doctor and paid for by the participant.

When a participant obtains services from out-of-network providers, the participant will be reimbursed up to a certain amount depending on the services provided.

Cost of Coverage

The retiree pays the full cost for coverage. The annual cost of VSP depends on the coverage option chosen. Information about retiree health care premiums will be provided during every Annual Open Enrollment period.

Schedule of Benefits

Please refer to the Vision Summary for a copy of the VSP Vision Plan schedule of benefits.

HOW VSP WORKS

VSP Doctors

To use the VSP Vision Plan, a participant calls a participating VSP Doctor for an appointment and identifies themselves as a VSP participant. The participant is not required to complete any up-front paperwork or obtain a benefit form. For assistance in locating a VSP Doctor, participants may call VSP at (800) 877-7195 or go to www.vsp.com.

After a participant has scheduled an appointment, the provider will contact VSP to verify eligibility and plan coverage. The doctor will also obtain authorization for services and materials. If a participant is not eligible for benefits at that time, the doctor will notify the participant.

Network Benefits

Eye Examination − A complete vision analysis which includes an appropriate examination of visual functions is covered in full, after a $10 copayment.

Prescription Eyewear − Covered participants may choose between eyeglasses or contact lenses. If a covered participant chooses contact lenses, they will not be eligible to receive eyeglasses (lenses and frame) in the same benefit period.

Lenses − Single vision, lined bifocals or lined trifocals (more complex lenses) are covered in full. The VSP Doctor or participating Retail Chain will order the lenses and verify the accuracy of the finished lenses.

Frames − Frames are covered up to a $200 allowance. If a covered participant selects a frame that exceeds the vision plan's allowance, they will be responsible for the difference. If the covered participant purchases a pair of non-covered prescription eyeglasses (including prescription sunglasses) from any VSP Doctor within 12 months of their last WellVision Exam, they will receive a 20% savings. Participants may visit www.vsp.com or ask a VSP doctor for details.

Elective Contact Lenses – The contact lens exam (fitting and evaluation) and lenses are covered up to a $200 allowance. A 15% discount applies to a VSP Doctor's usual and customary professional fees for the contact lens exam. The contact lens exam is performed in addition to the routine eye exam to check the eye for health risks associated with improper wearing or fitting of contact lenses. When this benefit is paid, no other materials benefit (eyeglasses (lenses and frame)) is payable for the benefit period.

Medically Necessary Contact Lenses − Contact lenses and necessary ophthalmic materials are covered in full under the vision plan when specific benefit criteria are satisfied. The following conditions may meet the criteria:

- As a result of cataract surgery,
- Extreme visual acuity problems that may not be corrected with spectacle lenses,
- Significant anisometropia, and
- Keratoconus.

Diabetic Eye Care Program – For services related to Diabetic Eye Disease (Type 1 and Type 2 Diabetes), glaucoma and age-related macular degeneration (AMD). Under this program, medical eye care examinations are covered in full, after a $20 copayment. In addition, this program provides coverage for limited vision-related medical services. The frequency at which these services may be provided is dependent on the specific service and the diagnosis associated with such service. A current list of these services is available from VSP upon request. Participants may visit www.vsp.com or call VSP at (800) 877-7195 for more information.

Laser Vision Care − VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering discounts in PRK, LASIK and Custom LASIK surgeries available through these contracted surgery centers. Participants may visit www.vsp.com for more information.

For more information, refer to the sections of this highlights titled Extra Cost and What VSP Does not Pay For.

Open Access (Out-of-Network) Reimbursements

Participants will be reimbursed directly according to the Open Access reimbursement schedule listed in the section of this summary titled Schedule of Benefits.

There is no assurance that the open access (out-of-network) reimbursement schedule will cover the entire cost of the examination or the lenses. VSP may not guarantee patient satisfaction when services are received from other providers.

EXTRA COST

This plan is designed to cover visual needs rather than cosmetic. There may be extra costs involved if you select a frame above the plan allowance or purchase lens enhancements such as:

- Optional cosmetic processes
- Anti-reflective coating
- Color coating

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

WHAT VSP DOES NOT PAY FOR

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 +50 diopter power); or two pairs of glasses instead of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated as covered Plan Benefits.

CLAIMS AND APPEALS

How to File a Network Claim

If a participant uses a VSP Doctor or participating Retail Chain, the provider will handle the claims process.

How to File an Out-of-Network Claim

If a participant uses another Provider (out-of-network), the participant must pay the provider in full at the time of service.

To ensure a timely reimbursement, participants may access the Out-of-Network Reimbursement Form at www.vsp.com or send the following information to VSP:

- An itemized receipt listing the services received;
- The name, address and phone number of the out-of-network provider;
- The participant's name, phone number, address and date of birth;
- The last four digits of the participant's identification number (Social Security Number);
- Indicate "VSP coverage provided through Valero" on the receipt;
- The patient's name, date of birth, phone number and address; and
- The patient's relationship to the participant (such as self, spouse or child).

Please keep a copy of the information and mail the originals to the following address:

VSP
Attn: Out-of-Network Provider Claims
P.O. Box 385018
Birmingham, AL 35238-5018

Out-of-network claims must be submitted to VSP within 365 days of the date of service for reimbursement.

COMPLAINTS AND GRIEVANCES

If a participant ever has a question or problem, the participant's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer the participant's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a participant, the participant may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department.

Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Participants also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to the participant to indicate VSP's expected resolution date. Upon final resolution, the participant will be notified of the outcome in writing.

Claim Payments and Denials

Initial Determination

VSP will pay or deny claims within 30 calendar days of the receipt of the claim from the participant or the participant's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than 15 calendar days.

Request for Appeals

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

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

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

If the participant disagrees with VSP's determination, he/she may request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

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

WHEN VISION COVERAGE BEGINS AND ENDS

For information on when coverage begins and ends, refer to the section in the handbook titled Plan Administration.

Participants may have the option to continue this coverage through COBRA. For more information, refer to the section in the handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

USE AND DISCLOSURE OF HEALTH INFORMATION

This plan is permitted in some circumstances to disclose information relating to a participant's health or coverage. Federal law limits the uses and disclosures the VSP Vision Plan may make of a participant's Protected Health Information (PHI). For more information, refer to the section in the handbook titled HIPAA Privacy Notice.

AMENDMENT AND TERMINATION

The Company reserves the rights to amend, in whole or in part, any provision of the vision plan, including the right to terminate the plan altogether, at any time and for any reason, without regard to whether expenses have already been incurred by a participant or whether a course of treatment has been initiated. Participants should remember that any such amendment or termination of the plan could affect their future benefits and expectations from the plan. If the plan should end, benefits will be paid for eligible charges incurred before the termination.