SUMMARY PLAN DESCRIPTION

FOR THE

GROUP VISION CARE PLAN BENEFITS UNDER THE HELMERICH & PAYNE, INC. INSURED BENEFITS PLAN

Effective January 1, 2017

ERISA SUMMARY PLAN DESCRIPTION DISCLOSURES

This Section, along with the accompanying booklet "Group Vision Care Plan Evidence of Coverage" is intended to constitute the Summary Plan Description for the group vision care benefits under the Plan. Defined terms which are used in this Section and which are not defined herein will have the meaning set forth in the accompanying booklet.

ERISA INFORMATION

PLAN NAME, NUMBER AND TYPE:

Plan – Helmerich & Payne, Inc. Insured Benefits Plan

Plan Number – 504

Plan Type – Employee Welfare Benefit Plan providing fully insured welfare benefits which include the group vision care insurance benefits described in this Evidence of Coverage and Summary Plan Description.

NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR, PLAN ADMINISTRATOR AND POLICYHOLDER:

Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119
Phone: 918-742-5531
EIN: 73-0679879

PARTICIPATING EMPLOYERS:

The Employer is Helmerich & Payne Inc., 1437 S. Boulder Ave., Tulsa, OK 74119. Any subsidiaries or affiliates of Helmerich & Payne Inc., which adopt the Plan, are also eligible. A complete updated list of employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available in the office of the Plan Administrator for examination.

NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS:

For disputes relating to the Plan or the Policyholder, service of legal process may be made upon the Plan Administrator at The Corporation Company, 1833 S. Morgan Rd., Oklahoma City, OK 73128. For disputes relating to the vision care insurance plan #01111645 insured by Vision Services Plan, Inc., Oklahoma, service of legal process may be made upon Vision Services Plan, Inc. Oklahoma at 333 Quality Drive, Rancho Cordova, CA 95670.

SOURCE OF CONTRIBUTIONS AND PLAN FUNDING:

The source of contributions to pay premiums to the insurance company are employee contributions.

The name and address of the Insurance Company providing the vision care insurance policy is as follows:

Vision Services Plan, Inc., Oklahoma
3333 Quality Drive
Rancho Cordova, CA 95670
Plan Number: 01111645

ELIGIBILITY FOR BENEFITS:

The provisions relating to eligibility for vision care benefits are described in the sections of the Evidence of Coverage entitled “Eligibility for Coverage” and “Schedule of Benefits.”

DESCRIPTION OF BENEFITS:

The vision care benefits provided under the Plan include those described in the vision care plan #01111645, issued by Vision Services Plan, Inc. Oklahoma. You may request a complete copy of this vision care policy to review from the Plan Administrator. In the Evidence of Coverage, Vision Services Plan has provided a summary of the vision care insurance benefits provided under the vision care plan #01111645.

If there is a discrepancy between Vision Care Services summary of vision care insurance benefits in the Evidence of Coverage and the Vision Services Plan insurance policy, the provisions of the Vision Services Plan insurance policy will control.

PLAN YEAR:

The Plan year for purposes of maintaining the Plan’s records is the annual period from January 1 through December 31.

PLAN ADMINISTRATOR’S POWERS AND DUTIES:

The Plan shall be administered by a Plan Administrator. The Plan Administrator has the right to change the insurance company or the group insurance policy insuring the vision care insurance benefits.

The Plan Administrator has appointed the Insurance Company as the designated fiduciary for review of claims for benefits to the extent that such benefits (“Benefits”) are funded by policies of insurance issued by such Insurance Company (“Policy”). Within the scope of this appointment, the Insurance Company shall be responsible for adjudicating claims for Benefits under the Plan, and for deciding any appeals of adverse claim determinations. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, including the Policy; to decide questions of eligibility for coverage or Benefits under the Plan; and to make any related findings of fact. All decisions made by such Insurance Company shall be final and binding on Participants and Beneficiaries of the Plan to the full extent permitted by law.

Except as provided above, the Plan Administrator shall have such duties and powers as may be necessary to discharge the duties of the Plan Administrator hereunder, including, but not by way of limitation, the following:

1) To distribute information explaining the Plan in such a manner as the Plan Administrator determines to be appropriate;

2) To receive from the participating employers and covered persons such information as shall be necessary for the proper administration of the Plan;

3) To handle the receipt and deposit of any required contributions, the maintenance of certain records of covered persons, authorization and payment of plan administrative expenses, selection of insurance consultants, selection of the insurance carrier, and the determination of eligibility to participate in the Plan.

4) To furnish covered persons, upon request, such annual reports as are reasonable and appropriate with respect to the administration of the Plan;

5) To appoint or employ such consultants, agents, subcontractors, and representatives to assist in the administration of the Plan and such other agents, including claims administrators, accountants, legal and actuarial counsel.

The Plan Administrator shall exercise such authority and responsibility that is appropriate in the opinion of the Plan Administrator in order to employ with ERISA and governmental regulations issued thereunder.

PLAN AMENDMENT AND TERMINATION:

The Plan may be changed and/or benefits may be reduced or eliminated by execution of an amendment to the Plan by the Plan Sponsor. The Plan Sponsor shall have the right to amend the Plan, at any time and from time to time, to any extent deemed advisable in its discretion, without prior notice to or consent of any covered person or of any person entitled to receive payment of benefits under the Plan.

All changes to the Plan shall become effective as of a date established by the Plan Sponsor, and thereupon all covered persons, whether or not they became covered persons prior to such amendment, shall be bound thereby.

The Plan shall continue in full force and effect unless and until the Plan Sponsor terminates the Plan. Although the Plan Sponsor has the intention and expectation that the Plan will be maintained indefinitely, the Plan Sponsor is not and shall not be under any obligation or liability whatsoever to continue or maintain the Plan or any benefit under the Plan for any given length of time. The Plan Sponsor, in its sole and absolute discretion, may discontinue or terminate the Plan or any benefit under the Plan at any time by providing notice to the covered employees. Such termination will become effective on the date set forth in such written notice.

The Plan Sponsor has the right to terminate, amend or modify the Plan or any benefit under the Plan, in whole or in part, at any time. The Employee Benefits Committee is authorized to amend, modify or terminate this Plan. The Plan Sponsor also has the right to change the insurance company or the vision benefits insurance policy insuring the vision insurance benefits of the Plan.

CLAIM APPEALS FOR VISION SERVICES PLAN INSURANCE BENEFITS:

The claim appeal process for vision care insurance benefits is determined by Vision Services Plan, Inc. Oklahoma. Vision Services Plan, Inc., Oklahoma is the insurance company that provides the vision care plan insuring these benefits. If your claim is denied, you may appeal to Vision Services Plan, Inc., Oklahoma for review of the denied claim. Vision Services Plan, Inc., Oklahoma will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file

suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which are generally a prerequisite to bringing a suit in state or federal court). See the section of the Evidence of Coverage entitled "Claim Payments and Denials" for information about how to file a claim and how to appeal a denied claim.

ELIGIBILITY REQUIREMENTS

A. EMPLOYEE ELIGIBILITY REQUIREMENTS

All full-time regular employees and part-time employees working a minimum of 20 hours per week are eligible to participate in the Plan on the first day of the month coinciding with or next following 2 months of regular employment.

Persons classified by the Employer as independent contractors, temporary employees, seasonal employees or leased employees are not eligible for coverage under the Plan even if such persons are subsequently reclassified as an employee by a governmental agency or court of law.

Enrollment is not mandatory; however, eligible employees and dependents that enroll agree to remain enrolled until the next plan anniversary date, except in the event of a qualifying change in status.

B. DEPENDENT ELIGIBILITY REQUIREMENTS

An eligible dependent includes the eligible employee's spouse to whom the eligible employee is legally married unless divorced or legally separated (documentation proving a legal marital relationship may be required), and all children of the eligible employee under 26 years of age. For this purpose, "children" means the employee's natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children, alternate recipients under Qualified Medical Child Support Orders, and any other child for whom the eligible Employee along with the employee's spouse, if applicable, has obtained sole legal guardianship and who is living with the eligible Employee in a regular parent-child relationship. Foster children are not considered as eligible dependent children under the Plan. A grandchild who resides in the Employee's household is not considered as an eligible dependent child under the Plan unless the Employee along with the employee's spouse, if applicable, has been appointed by a court as sole legal guardian for the grandchild or has adopted the grandchild, and the grandchild is living with the eligible Employee in a regular parent-child relationship.

It is the responsibility of the Employee to notify the Plan Administrator within 45days of a dependent's loss of eligibility.

A dependent child, as defined above, is eligible for coverage until midnight of the last day of the month on which such dependent child attains age 26.

An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap upon attaining the age limit requirement may be considered as an eligible dependent while remaining incapacitated and continuously covered under the Plan provided he or she is chiefly dependent on the eligible employee for support. To continue a child under this provision, proof of incapacity must be submitted within 30 days of the child's attainment of the age limit requirement. Proof of continuing incapacity may be required by the

Plan Administrator from time to time, but not more frequently than annually after the two-year period following the attainment of age 26.

Any person who is covered as an eligible employee shall not be considered as an eligible dependent under the Plan. If two employees work for the same company and one spouse is covered under the Plan as the other's dependent, he shall not also be covered as an employee. Also, if both parents are employed at the same company, children will be covered as dependents of one parent only.

An employee must be covered under the Plan in order to cover any eligible dependents under the Plan.

C. PROOF OF DEPENDENT ELIGIBILITY

The Plan Sponsor retains the right to request whatever documentation is necessary to confirm that a dependent meets the Plan's dependent eligibility requirements.

In all cases, we may require proof of dependency (and, in the case of an adopted Child or a Child placed with you for adoption, proof of the adoption or placement for adoption) as a condition to enrolling an eligible Dependent or retaining an enrolled Dependent on the Plan. If we ask you for documentation to prove the eligibility status of one or more persons you have enrolled or are seeking to enroll as a Dependent under the Plan, and you fail to supply the requested documentation within the time prescribed by the Plan, the Plan may in its discretion decline to enroll the person(s) or, if the person(s) is/are already enrolled, disenroll them, and in the event of a disenrollment, may in the Plan's discretion disenroll the person(s) retroactively. You may treat any such adverse action as adverse action with respect to a claim, and appeal the Plan's action under the Plan's claims and appeals provisions.

D. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Vision coverage shall be provided to the child of an eligible employee who is the subject of a QMCSO in accordance with the Omnibus Budget Reconciliation Act of 1993, as amended, or who is the subject of a National Medical Support Notice (NMSN) that is deemed to operate as a QMCSO.

The term "Alternate Recipient" means any child of an eligible employee who is recognized under a QMCSO as having a right to enrollment under a group vision plan.

A QMCSO is a court order that usually results from a divorce that provides for child support or vision care coverage for the child of an eligible employee. The court order creates or recognizes the existence of the alternate recipient's right to, or assigns to the alternate recipient the right to, receive benefits for which the employee is eligible under the Plan. The QMCSO must specify:

1) the name and last known mailing address of the employee required to pay for the coverage and the name and mailing address of each alternate recipient;

2) a reasonable description of the type of coverage to be provided by the Plan or the manner in which such coverage is to be determined;

3) each Plan to which the order applies; and

4) the period for which coverage must be provided.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

When a Plan Administrator receives a medical child support order, the following steps must be taken. The Plan Administrator must:

1) notify both the eligible employee and each alternate recipient of receipt of the order;

2) furnish an explanation of the Plan's procedures for determining whether the court order is a QMCSO;

3) determine if it is qualified; and

4) notify the eligible employee and each alternate recipient of the determination and, if the order is determined to be qualified, provide the alternate recipient with a full explanation of the benefits hereunder.

The Plan Administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

E. ENROLLMENT REQUIREMENTS FOR EMPLOYEES AND DEPENDENTS

Coverage does not become effective until the eligible employee completes an enrollment for himself and/or his eligible dependent(s). Eligible dependents enrolled after the effective date of the Plan will become covered on the same date as the eligible employee or the date the dependent is acquired, whichever is later. If the employee does not request enrollment for himself and/or his eligible dependent(s) by the deadline designated by the Plan Administrator after becoming eligible to enroll in the Plan, then the employee may only request enrollment for himself and/or his eligible dependent(s) as follows:

1) upon the occurrence of a "change in status" which means any of the following events:

   (a) change in employee's legal marital status including marriage, death of spouse, divorce, legal separation, or annulment;

   (b) change in employee's number of dependents, including birth of a child, adoption or placement for adoption of a child, or death of a child;

   (c) termination or commencement of employment by employee, his spouse or child;

   (d) change in work schedule of employee, his spouse or child, including a switch between part-time and full-time status, a strike or lockout, or commencement of or return from an unpaid leave of absence, an FMLA leave (as required by FMLA), or absence on account of being in "uniformed service" (as defined under USERRA);

   (e) a dependent satisfying or ceasing to satisfy the dependent eligibility requirements on account of attainment of a specified age; or

   (f) change in place of residence or work of employee, his spouse or dependent.

The employee must request enrollment for himself and/or such dependent(s) within a 45 day period that begins on the date of the change in status event, provided that the change in status results in a gain or loss of coverage and the request for enrollment corresponds with such gain or loss coverage. If enrollment is requested and the required documentation is received by the Plan Administrator within 45days of the change in status event, the requested coverage will be effective as of the first day of the month following receipt of request.

The Plan Sponsor may administratively define other changes in circumstances as "changes in status" as long as any such definition is consistent with applicable laws, regulations, rulings and announcements of the Internal Revenue Service and is applicable to participants on a uniform, non-discriminatory basis.

2) as a result of a Qualified Medical Child Support Order (QMCSO) which requires the employee to provide health coverage for his child.

3) as a result of a significant change (increase or decrease) in cost or significant curtailment of coverage (with or without a loss of coverage) by an independent third-party provider, previously elected by the employee and/or his eligible dependent. The employee must request enrollment for himself and/or such dependent(s) within a 45-day period which begins on the date that the significant change in cost or significant curtailment of coverage occurs. If enrollment is requested and the required documentation is received by the Plan Administrator within 45days of the change in cost or curtailment of coverage, the requested change in coverage will be effective as of the first day of the month following receipt of request.

4) as a result of termination of entitlement to Medicare and Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act that provides for the distribution of pediatric vaccines) provided that the employee requests enrollment for himself and/or such dependent(s) within a 30-day period which begins on the date that the termination of entitlement to Medicare or Medicaid occurs. If enrollment is requested and the required documentation is received by the Plan Administrator within 45 days of termination of entitlement to Medicare or Medicaid, the requested enrollment will be effective as of the first day of the month following receipt of request.

5) as a late entrant as defined by the Plan but **only** during an open enrollment period held once each year at a time established by the Plan Sponsor.

F. COVERAGE IN THE EVENT OF:

AUTHORIZED LEAVE OF ABSENCE: If a covered employee ceases to be actively at work on a full-time or part-time basis due to an authorized leave of absence, coverage may be continued at the option of the Plan Sponsor but not beyond the expiration of the authorized leave of absence, subject to the payment of any required contributions.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA): The Plan shall at all times comply with FMLA as outlined in the regulations issued by the Department of Labor. During any leave taken under the FMLA, the Employer will maintain coverage under the Plan on the same basis as coverage would have been provided if the employee had been continuously employed during the entire leave period subject to payment by the Employee of any required premiums.

LAPSE IN COVERAGE: For the purpose of coverage under the Plan, if a previously covered individual requests enrollment when there has been a lapse in coverage, the individual may **only** be enrolled as provided in **"Enrollment Requirements for Employees and Dependents"** (except in the case that COBRA has been elected and continued with no lapse in coverage).

REHIRED EMPLOYEES: For the purpose of coverage under the Plan, if an employee is rehired within 30 days following the day in which he terminated employment, the employee's previous election will be reinstated as if the termination never occurred. If the employee is rehired after 30 days, he will be entitled to make a new election when he becomes eligible again.

TRANSFERRED EMPLOYEES: If an employee transfers with no break in service from one wholly owned subsidiary that is covered under the Plan to another, the employee will be treated as if the transfer never occurred as far as coverage under the Plan is concerned (including, but not limited to, the waiting period, pre-existing condition exclusion period, applicable deductibles, out-of-pocket maximum, etc.).

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA): The Plan shall fully comply with USERRA. If any part of the Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent that there is no conflict with this Act.

G. TERMINATION WITH RESPECT TO EMPLOYEES

An employee's coverage under the Plan shall terminate on the earliest of the following dates:

1) the date of termination of the Plan;
2) in the event employment terminates (except as provided in **"Coverage in the Event of"**), the last day of the month for which the required contribution has been paid;
3) the last day of the month during which an employee ceases to meet the Plan's eligibility requirements for employees, except as provided in **"Coverage in the Event of"**;
4) the date all coverage or certain benefits are terminated for a particular class by modification of the Plan;
5) the last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due;
6) the date the Employer terminates coverage under the Plan;

See **CONTINUATION BENEFITS (COBRA)** for coverage continuation options.

H. TERMINATION WITH RESPECT TO DEPENDENTS

A dependent's coverage shall terminate under the Plan on the earliest of the following dates:

1) the date of termination of the Plan;

2) the date of termination of all coverage under the Plan with respect to dependents;

3) in the event a participant's employment terminates (except as provided in **"Coverage in the Event of"**), the last day of the period for which the required premium has been paid if the required premium for the next period is not paid when due;

4) the date the dependent becomes covered under the Plan as an employee;

5) the last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due;

6) the date the person ceases to meet the Plan's eligibility requirements for dependents, except as provided in **"Coverage in the Event of".**

It is the responsibility of the Employee or Qualified Beneficiary to notify the Plan Administrator within **60** days of the dependent's loss of eligibility as outlined above, in order to be offered Continuation of Coverage (COBRA). Additionally, it is the responsibility of the Employee to notify the Plan Administrator within **30** days of a loss of eligibility in order to terminate that dependent's benefit coverage and corresponding premium deductions.

CONTINUATION OF BENEFITS (COBRA)

Continuation of vision coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) shall not duplicate vision coverage continued under any state or federal law. This Section shall not extend coverage to eligible employees and dependents beyond the minimum required by Section 4980B of the Code and Sections 601 through 607 of ERISA, nor provide lesser coverage than required by such statutes.

A. DEFINITIONS

As used in this provision, the following terms shall mean:

"Entitlement to Medicare" or **"Entitled to Medicare"** means the covered employee has enrolled in either Medicare Part A or Part B.

"Qualified Beneficiary" means:

1) a covered employee, for termination or reduced hours;

2) a spouse or a dependent child who were covered dependents under the Plan on the day before the covered employee's Qualifying Event occurred;

3) a child who is born to a covered employee, or placed with a covered employee for adoption, during a period of COBRA continuation coverage.

"Qualifying Event" for a covered employee means a loss of coverage due to:

1) termination of employment for any reason other than gross misconduct;

2) reduction in hours of employment.

"Qualifying Event" for a covered dependent means a loss of coverage due to:

1) a covered employee's termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;

2) a covered employee's death;

3) a spouse divorce or legal separation from a covered employee;

4) a covered employee's entitlement to Medicare; or

5) a dependent child's loss of dependent status under the Plan.

Termination of employment following a Qualifying Event that is a reduction in hours of employment is not a second Qualifying Event entitling the Qualified Beneficiary to an extension of the period of COBRA coverage continuation.

"Timely contribution payment" means that the required contribution payment is made within the applicable time period. The applicable time period is 30 days of the due date. A timely contribution payment is deemed to have been made if it is not significantly less than the amount due unless the Qualified Beneficiary is notified of the deficiency and given 30 days to pay the balance.

B. CONTINUATION OF VISION COVERAGE

Continuation of vision coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event. To continue vision coverage, the Plan Administrator must be notified of a Qualifying Event by the employee or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:

1) for a spouse divorce or legal separation from a covered employee;

2) for a dependent child, loss of dependent status under the Plan; or

3) the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

Notice by an Employee or Qualified Beneficiary must be given to the Plan Administrator using the procedures specified in the Section entitled "Notice Procedures" below. An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events using such procedures will lose his rights to be offered COBRA continuation coverage or an extension of the COBRA continuation coverage due to a second qualifying event under COBRA.

The Plan Administrator must, within 14 days of receiving such notice, notify any Qualified Beneficiary of their right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined by the Social Security Administration to be disabled under Title II or Title XVI of the Social Security Act on such date, or at any time during the first 60 days of COBRA continuation

coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified of such disability within 60 days from the date of determination and before the end of the 18-month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Such notice must be provided in accordance with the procedures specified in the Subsection below entitled "Notice Procedures". In addition, the notice must include the name of the disabled Qualified Beneficiary, the date that the Qualified Beneficiary became disabled, and the date the Social Security Administration made its determination. The notice must also include a copy of the Social Security Administration's determination. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the later of: (i) date of final determination that they are no longer disabled, or (ii) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

NOTICE PROCEDURES:

Any notice that an employee or a Qualified Beneficiary provides to the Plan Administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. The employee or Qualified Beneficiary must mail or hand deliver his or her notice to the Human Resources-Benefits Manager at the following address, as applicable:

Mailing Address:
Human Resources-Benefits Manager
Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119

Hand Delivery Address:
Human Resources-Benefits Manager
Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name of the Plan, the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). The notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

ELECTION PROCEDURES:

A Qualified Beneficiary must elect Continuation of Vision Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the **"ELIGIBILITY REQUIREMENTS"** section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue Vision coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided below, if the initial coverage election and required contribution payments are made timely, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

C. PREMIUMS FOR COBRA COVERAGE

The Qualified Beneficiary may be required to pay premiums for any period of COBRA coverage equal to 102% of the applicable premium, in accordance with applicable law. However, any Qualified Beneficiary (including all family members of such individual who are Qualified Beneficiaries) who is entitled to the disability extension (as specified above), may be required to pay premiums equal to 150% of the applicable premium for the coverage period following the initial 18-month period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

D. TERMINATION OF COVERAGE

COBRA continuation coverage will end upon the earliest of the following to occur:

1) if an employee is terminated or has his hours reduced:
   - (a) 18 months from the date of the Qualifying Event; or
   - (b) 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first **60** days of COBRA continuation coverage and provides notice as required by law (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).

2) the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is determined to be no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).

3) for a covered dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:

   (a) the covered employee's death;

   (b) the covered employee's entitlement to Medicare;

   (c) a spouse's divorce or legal separation from a covered employee; or

   (d) a dependent child's loss of dependent status under the Plan.

4) if any of the Qualifying Events listed in 3) occurs during the 18 month period after the date of the initial Qualifying Event listed in 1), coverage terminates 36 months after the date of the initial Qualifying Event listed in 1).

5) the date on which the Employer ceases to provide any group vision plan coverage to any employee.

6) the last day of the month in which the last contribution payment was made if the Qualified Beneficiary fails to make any required contribution payments within the allotted **30**-day grace period as described in this section.

7) the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group vision plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary.

8) the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.

PROHIBITION AGAINST FALSE INFORMATION

A covered Participant is prohibited from submitting false or fraudulent information, or fraudulently omitting information, related to eligibility or benefit determinations, subrogation, coordination of benefits, or any other purpose under the Plan.

If the Plan Administrator determines that any covered Participant submitted false or fraudulent information, or fraudulently omitted information, for the purpose of receiving benefits under the Plan, the Plan Administrator can take appropriate actions to remedy the covered Participant's actions terminating their future participation in the Plan. This possible termination applies to the covered employee and his or her eligible dependents, regardless of which covered Participant was responsible for the fraudulent act or omission.

ERISA RIGHTS STATEMENT

YOUR RIGHTS:

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (previously known as the Pension and Welfare Benefit Administration).

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES:

In addition to creating rights for plan participants ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS:

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Este **resumen descriptivo del plan** contiene un resumen en inglés de sus derechos y beneficios del plan bajo el Programa de Beneficios para Asegurados de Helmerich & Payne, Inc. Si tiene dificultad entendiendo cualquier parte de este informe, comuníquese con el administrador del plan, Helmerich & Payne, Inc. Departamento de Beneficios, en sus oficinas ubicadas en 1437 S. Ave. Boulder, Tulsa, OK 74119. Las horas de oficina son de 8:00 A.M. a 5:00 P.M. de lunes a viernes. También puede llamar a la oficina del administrador del plan al (918) 742-5531 o sin cargo al 1-(800) 331-7250 para obtener ayuda.

Group Vision Care Plan

Vision Care for Life

Group Name:	**HELMERICH & PAYNE, INC.**
Group Number:	**01111645**
Effective Date:	**JANUARY 1, 2016**

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information is guilty of a felony.

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICES PLAN, INC., OKLAHOMA
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

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

NAME OF EMPLOYER:
NAME OF PLAN:
PRINCIPAL ADDRESS:

EMPLOYER I.D.#:

GROUP #:

PLAN ADMINISTRATOR:
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

Benefits are furnished under a vision care Policy purchased by the Group and provided by VISION SERVICES PLAN, INC., OKLAHOMA (VSP) under which VSP is financially responsible for the payment of claims.

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request.

DEFINITIONS:

ADDITIONAL BENEFITS RIDER The document, attached as Exhibit C to the Group Policy maintained by the Group Administrator, which lists selected vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.

BENEFIT AUTHORIZATION Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

COORDINATION OF BENEFITS Procedure which allows more than one insurance plan to consider Covered Persons vision care claims for payment or reimbursement.

COPAYMENTS Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

COVERED PERSON An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.

ELIGIBLE DEPENDENT Any legal dependent of an Enrollee of Group who meets the eligibility criteria established by Group and approved by VSP under section VI. ELIGIBILITY FOR COVERAGE of the Policy under which such Enrollee is covered.

EMERGENCY CONDITION A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

ENROLLEE An employee or member of Group who meets the eligibility criteria specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.

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

GROUP An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

VSP NETWORK DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
NON-VSP PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN or PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).
POLICY	The contract between VSP and Group upon which this Plan is based.
PREMIUMS	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by the Group Administrator.
RENEWAL DATE	The date on which the Policy shall renew or terminate if proper notice is given.
SCHEDULE OF BENEFITS	The document, attached as Exhibit A to the Group Policy maintained by the Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
SCHEDULE OF PREMIUMS	The document, attached as Exhibit B to the Group Policy maintained by the Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

ELIGIBILITY FOR COVERAGE

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

Eligible Dependents: If dependent coverage is provided, the persons eligible are indicated on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

PREMIUMS

Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.

PROCEDURE FOR USING THE PLAN

1. When Covered Person wants to receive Plan Benefits, contact VSP or a VSP Network Doctor. A list of names, addresses and phone numbers of VSP Network Doctors in Covered Person's area can be obtained from Group, the Plan Administrator or VSP. If this list does not cover the area in which Covered Person desires to seek services, call or write the VSP office nearest Covered Person to find one that does.

2. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the VSP Network Doctor. If Covered Person contacts the VSP Network Doctor directly, Covered Person must identify him or herself as a VSP member so the doctor can obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Plan, in spite of Covered Person's termination of coverage or the termination of the Plan Should Covered Person receive services from a VSP Network Doctor without such Benefit Authorization or obtain services from a Non-VSP Provider, Covered Person is responsible for payment in full to the provider.

4. Covered Person pays the Copayment (if any) amounts which exceed the Plan Allowances and any amounts for non-covered services or materials to the VSP Network Doctor for services under this Plan. VSP will pay the VSP Network Doctor directly according to their agreement with the doctor.

   Note: If Covered Person is eligible for and obtains Plan Benefits from an Non-VSP Provider, Covered Person should pay the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown on the enclosed Schedule of Benefits and Additional Benefit Rider (if applicable), less any applicable Copayments.

   WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-VSP PROVIDERS ARE USED.

   Covered Persons should be aware that when they elect to utilize the services of an Non-VSP Provider for a covered service in non-emergency situations, benefit payments for services from such Non-VSP Providers are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Non-VSP Provider fee schedule.

   COVERED PERSONS CAN EXPECT TO BE LIABLE FOR MORE THAN THE COPAYMENT AMOUNT DEFINED IN THE ATTACHED SCHEDULE OF BENEFITS OR ADDITIONAL BENEFIT RIDER (if applicable) AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

   When payment is made to the Non-VSP Provider, the provider may bill Covered Person for any amount up to the billed charge after the Plan has paid its portion of the bill. VSP Network Doctors have agreed to accept discounted payments for services with no additional billing to the Covered Person other than copayments, co-insurance and non-covered services or materials. Covered Persons may obtain further information about the participating status of providers and information on out-of-pocket expenses through vsp.com, or by calling VSP's Customer Service Department at 1-800-877-7195.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a VSP Network Doctor (or Non-VSP Provider if the attached Schedule of Benefits and, if applicable, Additional Benefits Rider, indicates Covered Person's Plan includes such coverage). No prior authorization from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If there is no Additional Benefit Rider for one of these plans attached to this Evidence of Coverage, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care.

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

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

BENEFIT AUTHORIZATION PROCESS

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

BENEFITS AND COVERAGES
Through its VSP Network Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions and Copayment(s) described herein. When Covered Person wishes to obtain Plan Benefits from a VSP Network Doctor, Covered Person may contact any VSP Network Doctor, identify Covered Person as a VSP member and schedule an appointment. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization for Covered Person directly to the VSP Network Doctor prior to Covered Person's appointment.

Specific benefits for which Covered Person is covered are described on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

COPAYMENT
The benefits described herein are available to Covered Person subject to Covered Person's payment of any applicable Copayments as described in this Evidence of Coverage, the Schedule of Benefits and Additional Benefit Riders (if applicable). Amounts which exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN COVERED PERSON AND THE DOCTOR.

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS
This vision service plan is designed to cover *visual needs* rather than *cosmetic materials.* Some professional services and/or materials are not covered under this Plan. Please refer to the NOT COVERED section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for details.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of our Optometric Consultants, this is necessary for the visual welfare of the Covered Person.

LIABILITY IN EVENT OF NON-PAYMENT
IN THE EVENT VSP FAILS TO PAY THE PROVIDER, COVERED PERSON SHALL NOT BE HELD LIABLE FOR ANY SUMS OWED BY VSP OTHER THAN THOSE NOT COVERED BY THE PLAN.

COMPLAINTS AND GRIEVANCES:
If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form which 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. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

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

Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make an oral or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the

Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed.

VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

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

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

If Covered Person disagrees with VSP's final review determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

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

TERMINATION OF BENEFITS

After the Plan Term, this Plan will continue on a month to month basis or until terminated by either party giving the other party sixty (60) days notice. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by Group or by VSP due to nonpayment of Premium.

If Covered Person is receiving service as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be available to an eligible participant and his or her dependents upon the termination of employment of said participant, or the termination of the relationship between said participant and his or her dependents. If, and only to the extent, COBRA applies to Covered Person's Group Plan, VSP shall make the statutorily required continuation coverage available in accordance with COBRA.

EXHIBIT A

SCHEDULE OF BENEFITS
SIGNATURE PLAN (Low)

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICES PLAN, INC., OKLAHOMA ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers . This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

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

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

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

A Copayment amount of $25.00 shall be payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 50.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
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*	
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Covered in full	Not Covered	
** Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 24 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period. Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full *	Up to $ 210.00*	
Elective			Available once each 12 months**
Professional Fees/Materials* **	Up to $ 130.00	Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full	Up to $125.00 (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

There 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).
- 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.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

A Copayment amount of $25.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once each 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses		
Single Vision, Lined Bifocal or Lined Trifocal,	Covered in Full*	Available once each 12 months**

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months**

Frames	Covered up to the Plan allowance*	Available once each 24 months**

CONTACT LENSES

Elective Contact Lenses	Up to $ 130.00	Available once each 12 months**

The Elective Contact Lens allowance applies to materials only.

Necessary Contact Lenses	Up to $210.00*	Available once each 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

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

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

LOW VISION

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

Supplemental Testing: Up to $ 125.00†
-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

EXHIBIT A

SCHEDULE OF BENEFITS
SIGNATURE PLAN (High)

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICES PLAN, INC., OKLAHOMA ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers . This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

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

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

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

A Copayment amount of $25.00 shall be payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 50.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
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*	
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Covered in full	Not Covered	
Polycarbonate Lenses	Covered in full	Not Covered	
UV (ultraviolet) protected	Covered in full	Not Covered	
** Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 12 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary.			
*Less any applicable Copayment. **Beginning with the first day of the Benefit Period. Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full *	Up to $ 210.00*	
Elective			Available once each 12 months**
Professional Fees/Materials* **	Up to $ 170.00	Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- 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 ± .50 diopter power).
- 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.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

A Copayment amount of $25.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once each 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses		
Single Vision, Lined Bifocal or Lined Trifocal,	Covered in Full*	Available once each 12 months**

LENS OPTIONS
Scratch Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full once every 12 months**
UV (ultraviolet) protected-Covered in full once every 12 months**

Frames	Covered up to the Plan allowance*	Available once each 12 months**

CONTACT LENSES

Elective Contact Lenses	Up to $ 170.00	Available once each 12 months**

The Elective Contact Lens allowance applies to materials only.

Necessary Contact Lenses	Up to $210.00*	Available once each 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

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

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $ 125.00†
-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

ADDENDUM

VISION SERVICES PLAN, INC., OKLAHOMA
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICES PLAN, INC., OKLAHOMA ("VSP") 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 Plus Program are available to Covered Persons 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.
- Any child of Enrollee, including any natural child from the date of birth, adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

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 Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (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 Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an 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 Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

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

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

PLAN BENEFITS
VSP NETWORK 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 Covered Person 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 VSP 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.

PLAN BENEFITS
NON-MEMBER PROVIDERS

1. A Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to $ 100.00 after a $20.00 Copayment.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: **HELMERICH & PAYNE, INC.**
Group ID: **01111645**
Effective Date: **JANUARY 1, 2016**

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

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	*	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees	$25.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first day of the Benefit Period.

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