VISION SERVICE PLAN INSURANCE COMPANY

PLEASE ATTACH TO YOUR
GROUP VISION CARE POLICY

AMENDMENT TO GROUP VISION CARE POLICY

To be attached and made part of Group Vision Care Policy Number 12139952 issued to DRIVETIME AUTOMOTIVE GROUP, INC.

EXCEPT as specifically amended herein, said Policy shall remain in full force and effect.

IT IS HEREBY AGREED that effective January 1, 2018, the Group Vision Care Policy shall be amended as attached hereto.

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
Signature Plan
Premier

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Policy to which it is attached.

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

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $15.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 50.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 50.00*
Bifocal	Covered in full*	Up to $ 75.00*
Trifocal	Covered in full*	Up to $ 100.00*
Lenticular	Covered in full*	Up to $ 125.00*

Available once every 12 months.

Frames	Covered up to Plan Allowance*	Up to $ 70.00*

Available once every 24 months.

*Less any applicable Copayment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

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

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

Lens Options

Anti-reflective coating	Covered in full	Not Covered
Polycarbonate lenses	Covered in full	Not Covered
Scratch Coating	Covered in full	Not Covered

CONTACT LENSES

Contact lenses are available once every 12 months.

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

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	**Professional Fees and Materials**
Covered in full*	Up to $210.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum $60.00 Copayment.	
Materials	**Professional Fees and Materials**
Up to $150.00	Up to $105.00

Contact Lenses and Frames covered within the same year.

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

LOW VISION BENEFIT

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

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy 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.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit 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 pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Policy 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 on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member 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 Person should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

There shall be a Copayment of $15.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. The Copayment for materials shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

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

LENS OPTIONS
Anti-reflective Coating-Covered in full once every 12 months**
Polycarbonate Lenses-Covered in full once every 12 months**
Scratch Coating-Covered in full once every 12 month**

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

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months.

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

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

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

Contact Lenses and Frames covered within the same year.

*Less any applicable Copayment.
**Beginning with the first date of service.

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 Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member 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 B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
Signature Plan
Premier

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

$	10.95	per month for each eligible Enrollee without Eligible Dependents.
$	21.35	per month for each eligible Enrollee with an Eligible Spouse.
$	31.72	per month for each eligible Enrollee with Eligible Child(ren).
$	33.70	per month for each eligible Enrollee with Eligible Spouse and Child(ren).

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