Vision Component Plan and Summary Plan Description

Effective date January 01, 2015

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About VSP

Benefits are furnished under a vision care Policy purchased by Cerner and provided by Vision Service Plan Insurance Company (VSP), under which VSP is financially responsible for the payment of claims.

Before using Plan benefits, a Participant needs to know, and understand, how the Plan works. Participants should read this Plan thoroughly and refer to it as necessary. If a Participant has any questions about how the Plan works, contact VSP Customer Service at 800-877-7195.

About This Summary Plan Description

The Vision Component Plan & Summary Plan Description is part of the Cerner Corporation Wraparound Benefits Plan & Summary Plan Description, (the "Wraparound Benefits Plan & SPD"). This document, along with the Wraparound Benefits Plan & SPD, serves as both the Plan document and the Summary Plan Description (the "Plan").

Cerner reserves the right to amend or terminate the Plan at any time. Participants will be notified of any changes that affect their benefits, as required by federal law.

Associate Eligibility

All Associates working a standard 24 hours per week or more for Cerner are eligible. Associates working less than a standard 24 hours per week, or with an Associate class of "Intern" or "Global Assignee" are ineligible.

If an Associate's coverage terminates by reason of layoff, termination of employment or leave of absence, and he/she resumes employment with Cerner, he/she is eligible for coverage on the date he/she resumes employment.

Dependent Eligibility

Associates may enroll his/her "Dependents" under the Plan. A "Dependent" eligible under the Plan is:

1. A Spouse, unless separated by a judicial decree of legal separation. For purposes of this Plan, a Spouse means a husband or wife as defined or recognized under state law for the purposes of marriage in the state where the marriage was celebrated and common law marriage as recognized in the state where the Associate resides.

2. A Child means either of the following:
    a. A child that meets the definition of a "qualifying child" under Code Section 152, as modified by Code Section 105(b). Notwithstanding the foregoing, Child includes the Associate's biological child, stepchild, adopted child, or foster child who has not yet attained age 26.

    b. A child for whom the Associate is the court appointed legal guardian.

    If the Child is permanently and totally disabled he or she may be Covered under the Plan regardless of his or her age. The Associate must provide substantiation from the individual's physician of the individual's permanent and total disability. Such substantiation must be provided within 31 days of the individual's enrollment or disability, whichever is later.

3. A "Domestic Partner." For benefits eligibility, Domestic Partners are persons who either:
    a. Meet the following definition:
        i. At least 18 years of age,

ii. of the same gender as the participating Associate,
iii. competent to contract at the time the domestic partnership is formed,
iv. not legally married to any person and not related in any way that would prohibit marriage in the Associate's state of employment,
v. each other's sole, and committed domestic partner, and
vi. sharing a permanent residence with the participating Associate

or

b. Have filed a Declaration of Domestic Partnership pursuant to Division 2.5 of the California Family Code with the participating Associate.

Domestic Partners are subject to the same enrollment rules as other Dependents.

Once Covered, Domestic Partners (and their enrolled Dependents) receive equivalent benefits as Spouses (and their enrolled Dependents), including continuation of coverage through COBRA and/or individual conversion.

4. The children of a Covered Domestic Partner.

   Children of a Covered Domestic Partner are also eligible to be Covered under the same Plan and terms as the Domestic Partner so long as the child has not yet attained age 26.

5. A child named as an alternate recipient under a state domestic relations order, or who is the subject of a court or administrative order seeking to enforce a law relating to medical child support, which order is determined by the Plan Administrator to be a "qualified medical child support order" (as defined in Section 609 of ERISA).

If a Dependent also works for Cerner, he or she may be Covered as an Associate or a Dependent, but not both. If both parents are Associates of Cerner only one parent can cover the child(ren). A Dependent may not be Covered by more than one Associate.

Proof of a Dependent's eligibility may be requested at any time and must be provided within 31 days of such request ("Eligibility Request Period") or the Dependent's coverage may be terminated. If, based on the information provided, it is determined that a Dependent is ineligible for coverage under the Plan, the Dependent's coverage will terminate as of the date Cerner informs the Dependent that he or she is ineligible for coverage. If proof of a Dependent's eligibility is not provided within the Eligibility Request Period, the Dependent's coverage will terminate immediately following the last day of the Eligibility Request Period.

Notwithstanding the previous paragraph, if it is determined that a Dependent is ineligible for coverage under the Plan and the Dependent's coverage was a result of fraud or an intentional misrepresentation of material fact, such coverage will be terminated, following a 30-day notice period, as of the date of the Plan Administrator's request or the date of ineligibility, whichever comes first.

Enrolling in the Plan

If an Associate wants to be Covered by the Plan, the Associate must enroll for this coverage by completing an enrollment election within 31 days of first becoming eligible and according to the process defined by Cerner.

If an Associate has enrolled for dependent coverage the Dependent may not be Covered under the Plan until the Associate is Covered under the Plan.

Initial Enrollment Period

If an Associate does not elect to participate in the Plan within the Initial Enrollment Period, such Associate shall be considered a Late Enrollee. The Initial Enrollment Period is the period of 31 days immediately following an Associate's initial eligibility.

Late Enrollees

If a newly hired Associate waits longer than the 31 days following his/her first day of employment to enroll in the Plan, the Associate and his/her Dependents are considered "Late Enrollees." Late Enrollees shall be eligible to participate only during an Additional Enrollment Period or Annual Enrollment Period thereafter. Coverage will not become effective until the first day of the Plan Year following the Annual Enrollment Period or as specified in the Additional Enrollment Period.

Annual Enrollment Period

An Annual Enrollment Period will be held by the Plan. With the exception of Additional Enrollment Periods, this Annual Enrollment Period is the only time when Late Enrollees may enroll in the Plan. In addition, if this Plan offers any optional coverages, those optional coverages may be elected only during the Annual Enrollment Period.

Additional Enrollment Period for Loss of Other Credible Coverage

In the event that an Associate or his/her Dependent(s) declines coverage under this Plan due to the existence of other health coverage and such other health coverage is subsequently terminated due to (a) loss of eligibility for such other coverage (loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of the other coverage for cause such as making a fraudulent claim or for misrepresentation), or (b) the termination of any company contributions for such other coverage, then the Dependent(s) may enroll in this Plan, provided a properly completed enrollment election is received by the Plan Administrator within 31 days of the loss of other coverage or termination of company contributions. In such a case, the Effective Date of coverage under this Plan will be the date of the event or the date on which the new election was submitted, whichever is later.

Additional Enrollment Period for Newly Acquired Dependents

If an Associate acquires a new Dependent, he or she should notify the Benefits Team immediately.

If an Associate acquires a new Dependent through birth, adoption or placement for adoption and submits an enrollment election to the Plan within 31 days of the birth, date of adoption or placement for adoption, coverage for the new Dependent will become effective on the date of the birth, date of adoption or placement for adoption.

If an Associate acquires a new Dependent through marriage or a Domestic Partnership registration and submits an enrollment election to the Plan within 31 days of the event, coverage for the new Dependent will become effective on the date of the event or date on which the election was submitted, whichever is later.

Additional Enrollment Period Due to Medicaid and CHIPRA Coverage

In the event that an Associate or his/her Dependent(s) declines coverage under this Plan due to health coverage under Medicaid or a state child health plan under title XXI of the Social Security Act ("CHIPRA") and such individual loses coverage for Medicaid or CHIP due to loss of eligibility for such coverage, then such Associate and/or his/her Dependent(s) may enroll in this Plan, provided that the Associate and/or the Dependent properly complete and submit an enrollment election to the Plan Administrator within 60 days of the loss of Medicaid or CHIP coverage or eligibility for the subsidy.

Changing Plan Coverage

Each year Associates must elect among the various benefits offered under the Plan. Outside of this Annual Enrollment and the Additional Enrollment Periods outlined above, an Associate may only change his or her enrollment options (and those of the Associate's Dependents) if the Associate experiences a Change in Status or a Change Event.

To change Plan coverage due to an eligible Change in Status or Change Event, an Associate must notify the Plan Administrator and submit a new election within 31 days of the event. Provided that the Associate submits a new election within 31 days after the Change in Status or Change Event, the effective date for such new election will be the date of the Change Event or Change in Status or the date on which the new election was submitted, whichever is later.

Change in Status

Any Associate may revoke a benefit election under this Plan and make a new benefit election for the remaining portion of the Plan Year if under the facts and circumstances, a Change in Status occurs, and the election change is consistent with the Change in Status

The following events are Changes in Status:

1. a change in the Associate's legal marital status, including marriage or beginning of a registered Domestic Partnership, death, divorce, or ending a registered Domestic Partnership, legal separation, and annulment;

2. changing the number of the Associate's Dependent(s), including through birth, death, adoption, and placement for adoption;

3. a change in the employment status of the Associate or Dependent, including the termination or commencement of employment, a reduction or increase in hours of employment which affects an Associate's eligibility to participate, including the switching from part-time to full-time employment status (or from full-time to part-time status), the commencement or return from an unpaid leave of absence, lockout or strike by the Associate or Dependent, or a change in the employment status of the Associate or Dependent which causes the individual to become (or cease to be) eligible under another employer's plan;

4. an event that causes the Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstances; and

5. a change in the place of residence of the Associate or Dependent.

Changes in Plan coverage made as a result of a Change in Status must be consistent with the change. An Associate's revocation of a benefit election during the Plan Year and a new election for the remaining

portion of the Plan Year (referred to below as an "election change") is consistent with a Change in Status only if:

1. the Change in Status results in the Associate or Dependent gaining or losing eligibility for coverage under the Plan; and

2. the benefit election change corresponds with that gain or loss of coverage.

For example, if as a result of a Change in Status, the individual gains eligibility for elective coverage under a plan of the Dependent's employer, the consistency rules are satisfied only if the affected individual elects the coverage under the Dependent's employer's plan.

Note: If the biological mother is a Covered Participant, that mother's newborn child is considered a Dependent under the Plan immediately after birth until he/she is discharged from the hospital or is 7 days old. If an Associate wants to continue coverage for the newborn child beyond that date, the Associate must enroll the newborn child.

Change Events

Any Associate may revoke a benefit election under this Plan and make a new benefit election for the remaining portion of the Plan Year upon the occurrence of any of the following events:

1. Changes Based on Judgment, Decree, or Order. A judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined in Section 609 of ERISA) that requires accident or health coverage for an Associate's child. The Plan may:

    a. change the Associate's benefit election to provide coverage for the child if the order requires coverage under the Associate's Plan, provided that if the Associate is not enrolled in the Plan, the Plan will enroll both the Associate and the child; or

    b. permit the Associate to make a benefit election change to cancel coverage for the child if the order requires the former Spouse or Domestic Partner to provide coverage.

2. Changes Based on Entitlement to Medicare or Medicaid. If a Participant becomes enrolled in Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Associate may cancel or reduce coverage of such Participant.

3. Changes Based on FMLA Leave. An Associate taking leave under the FMLA may revoke Plan coverage, and may make such other benefit election for the remaining portion of the period of coverage as may be provided for under the FMLA.

4. Significant Cost Changes. If the cost that is charged to an Associate for this Plan significantly increases or decreases, the Associate may make a corresponding change. For example, if the cost significantly increases the Associate may switch to a Plan option with a lower cost or may drop coverage altogether.

5. Changes Based on Curtailment of Coverage. If coverage offered under this Plan is significantly curtailed or terminated during the Plan Year, an affected Associate may elect another option providing similar coverage. In this context, coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage that affects all Associates.

6. Changes Based on Coverage under Another Employer Plan. The Associate may make an election change that is on account of and corresponds to a change made under another employer plan, provided that the other plan permits participants to make a change for a period of coverage than is different than the period of coverage under this Plan. For example, if an Associate becomes enrolled in medical coverage under a plan sponsored by the employer of the Associate's Spouse or Domestic Partner, then depending on the plan year of the other plan, the Associate may be able to drop coverage under this Plan.

7. Other Changes as Determined by the Plan Administrator. The Plan Administrator may determine by written policy any other permissible benefit election changes, provided that such changes are allowed by and are acceptable under rules and regulations adopted by the Treasury Department. Such determination shall be made on a nondiscriminatory basis in accordance with uniform principles consistently applied.

8. Transfer of Coverage. If a husband and wife, or Domestic Partners, are both validly Covered as Associates under the Plan and one of them terminates coverage under the Plan as an Associate, the terminating Spouse, or Domestic Partner, and any Covered Dependents may immediately enroll under the remaining Associate's coverage. Coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which the person was entitled while enrolled as an Associate or Dependent of an Associate.

Procedure for Using the Plan

To receive Plan benefits, contact VSP or a Member Doctor. A list of names, addresses and phone numbers of Member Doctors in the Participant's area can be obtained from VSP by contacting Member Services at 1-800-877-7195, or through VSP's website at www.vsp.com. If this list does not cover the area in which the Participant desires to seek services, the Participant should call or write VSP to find one that does.

If the Participant contacts the Member Doctor directly, the Participant must identify him/herself as a VSP member so the doctor can obtain Benefit Authorization from VSP. If a Participant is eligible for Plan benefits, VSP will provide Benefit Authorization directly to the Member Doctor.

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 Policy, in spite of a Participant's termination of coverage or the termination of the Policy. It is the Participant's responsibility to verify that the Member Doctor has received the Benefit Authorization directly from VSP prior to receiving services from the Member Doctor.

The Participant shall pay the Copayment (if any), amounts which exceed the Plan allowances, and any amounts for non-Covered services or materials to the Member Doctor. VSP will pay the Member Doctor directly according to its agreement with the doctor.

Note: If a Participant is eligible for and obtains Plan benefits from an Out-of-Network Provider, the Participant should pay the provider's full fee. The Participant will be reimbursed by VSP in accordance with the Out-of-Network Provider reimbursement schedule shown on the attached Schedule of Benefits and Additional Benefit Rider (if applicable), less any applicable Copayments. A Participant is required to submit a claim form to request the reimbursement. Send VSP the original receipts, invoices or other proof of loss (the Participant should retain a copy for his/her records) and sufficient information about the Participant (name, address, Social Security Number). Mail claims to: 3333 Quality Drive, Rancho Cordova, CA 95670. Claims can also be submitted via VSP's website at www.vsp.com.

Benefit Authorization Process

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

Benefits and Coverage

Through its Member Doctors, VSP provides Plan benefits to Participants as may be Visually Necessary or Appropriate, subject to the limitations, exclusions and Copayment(s) described herein. A Participant wishing to obtain Plan benefits from a Member Doctor should contact the Member Doctor, identify his/herself as a VSP member, and schedule an appointment. If the Participant is eligible for Plan benefits, VSP will provide Benefit Authorization for the Participant directly to the Member Doctor prior to the Participant's appointment.

Covered benefits are described on the Schedule of Benefits and Additional Benefit Rider (if applicable).

Premiums

Participants are charged a premium to participate in the Plan. The applicable premium amount varies based on the number of Covered Dependents and can be found in the United States Benefits Brochure.

Copayment

The benefits described herein are available to Participants subject to a Participant's payment of any applicable Copayments as described in this Plan. Amounts that exceed Plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments and are also the responsibility of the Participant.

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

Exclusions and Limitation of Benefits

This Plan is designed to cover visual needs rather than cosmetic materials. If a Participant selects certain options the Plan will pay the basic cost of the Covered services, and the Participant will be responsible for the options' extra cost.

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 Participant.

Liability in the event of non-payment

In the event VSP fails to pay the provider, the Participant shall not be held liable for any sums owed by VSP other than those not Covered by the Plan.

Explanation of Benefits

A savings statement can be obtained by logging into www.vsp.com and printing/viewing it online or you may request a savings statement from your VSP provider. It tells the Participant what services were Covered and what, if any, were not. An explanation of how to appeal a claim is on the front of the EOB as well as in this Plan.

Coordination of Benefits

If a Participant has other vision care coverage, benefits under this Plan are coordinated with benefits under any such other program to avoid duplication of payment. The two programs together will not pay more than 100% of Covered expenses.

Benefit Outline

The Schedule of Benefits included in this Plan and SPD will show the Plan benefits and copayments that the Participant is responsible for.

For the benefit maximum(s) and the Covered percentage(s), refer to Your Schedule of Benefits.

Schedule of Benefits

Enhanced Plan B

GENERAL

This Schedule lists the vision care benefits to which Participants are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan benefits are available for Out-of-Network Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether such provider is a Member Doctor or Out-of-Network Provider. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan benefits are received from Member Doctors, benefits appearing in the Member Doctor Benefit column below are subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan benefits are received from Out-of-Network Providers, the Participant is reimbursed for such benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Participant 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 Out-of-Network Providers.

Claim Filing Deadline

Your claims must be filed by the end of the calendar year following the year in which services were rendered. VSP is not obligated to pay claims submitted after this period. If a claim is denied due to a participating vision care providers failure to make timely submission, you will not be liable to such provider for the amount which would have been payable by VSP, provided you advised the vision care provider of your eligibility for benefits at the time of treatment.

Copayment

The benefits herein are available to each Participant subject only to payment of the applicable Copayment by the Participant. Plan benefits received from Member Doctors and Out-of-Network Providers require Copayments. Participants must also follow Benefit Authorization procedures set forth in the Section entitled “Benefit Authorization Process”.

There is a Copayment of $15.00 for the examination payable by the Participant to the Member Doctor or the Out-of-Network Provider at the time services are rendered. If materials (lenses, frames or Visually Necessary Contact Lenses) are provided, there shall be an additional $35.00 Copayment payable at the time the materials are ordered. There is a Copayment of $30.00 for anti-reflective coating payable by the Participant to the time the materials are ordered. The Copayment shall not apply to elective Contact Lenses.

Plan Benefits

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	OUT-OF-NETWORK 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.

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*	
Anti-reflective coating	Covered in full *	Not Covered	
Plan benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			
Frames	Covered up to $175.00 + an additional 20% off over the allowance	Up to $ 70.00*	Available every 24 months, or 12 months for dependents under the age of 18**
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.			
Contact Lenses			
Visually Necessary			Available once every 12 months**
Professional Fees/Materials	Covered in full*	Up to $ 210.00*	
Elective			Available once every 12 months**
Professional Fees/Materials***	Up to $ 125.00	Up to $ 105.00	
*Less any applicable Copayment .			

**Beginning with the first day of the Benefit Period.
***Additional Discount applies to Member Doctor's Usual and Customary fee for contact lens evaluation and fitting.

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

Utilization of contact lens benefits exhausts all of the Participant'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.

Low Vision

Professional services, as necessary, 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 approved amount up to $1000.00*	75% of approved amount up to $1000.00*	

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

All Low Vision services are subject to prior approval by VSP's Optometric Consultants.

Low Vision benefits secured from Out-of-Network Providers (if covered) are subject to the same time and Copayment provisions described above for Member Doctors. The Participant should pay the Out-of-Network Provider's full fee at the time of service. If Low Vision services are approved, Participant will be reimbursed an amount not to exceed what VSP would pay a Member 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.

Additional Discount

Each Participant shall be entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a Member Doctor. Additional pairs are those purchased beyond the benefit frequency allowed under this Plan.

Also, Participants shall be entitled to receive a discount of fifteen percent (15%) off Member Doctor professional fees for elective contact lens evaluations and fittings. The Participant pays the Member Doctor the difference between the Plan Benefit Allowance and the Member Doctor's discounted Usual and Customary Fees, plus any Copayments and charges for services or materials not Covered under this Plan. Contact lens materials are provided at the doctor's Usual and Customary Fees.

Discounts are applied to the Member Doctor's Usual and Customary Fees for such services and are available within twelve (12) months of the Covered eye examination from the Member Doctor who provided the Covered eye examination.

Additional discounts noted on this schedule are subject to change as deemed appropriate by VSP with prior notification to Cerner.

DISCOUNTS DO NOT APPLY TO VISION CARE BENEFITS OBTAINED FROM OUT-OF-NETWORK PROVIDERS.

Additional Benefit Rider

Diabetic Eye Care Program - please see attached Addendum.

Exclusions and Limitation of Benefits

This Plan is designed to cover visual needs rather than cosmetic materials. When a Participant selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Participant 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

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 ±38 diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Plan 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 Plan as covered Plan benefits
- Emergency Conditions of a medical nature

Appeals

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

that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Participants also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 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 Participant to indicate VSP's expected resolution date. Upon final resolution, the Participant will be notified of the outcome in writing.

How to Appeal a Claim

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

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

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

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

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

Leaving the Plan and When Coverage Ends

Benefit coverage for a Participant will end upon the earliest of the following events:

- the Participant experiences a Change in Status or Change Event and opts out of the Plan,
- a Covered Dependent(s) no longer qualify as a Dependent(s) under the Plan, either through a Plan amendment or otherwise,
- Cerner discontinues the Plan,
- the Covered Associates is no longer eligible under the Plan, either through a Plan amendment or otherwise
- a Participant fails to make required contributions for coverage,
- a Participant's coverage ends for any reason,
- a Covered Associate terminates employment with Cerner for any reason, or
- any other disqualifications for benefits.

In most cases coverage will terminate as of midnight on the date that the Participant is no longer in an eligible class. Benefit coverage for an Associate's Covered Dependents will terminate upon the termination of the coverage for the Associate. If the Covered Associate is on an approved leave of absence from Cerner, and such leave is consistent with the Family and Medical Leave Act, other law, or Cerner's Leave of Absence Policy such Associate may be able to continue coverage.

If it is determined that a Participant is ineligible for coverage under the Plan and the Participant's coverage was a result of fraud or an intentional misrepresentation of material fact, such coverage will be terminated, following a 30-day notice period, as of the date of the Plan Administrator's request or the date of ineligibility, whichever comes first.

Right to Purchase Continuation Coverage

If a Participant loses coverage under the Plan, such Participant may have the right to COBRA continuation coverage. Associates should have received a statement regarding their rights to COBRA continuation coverage in certain circumstances. To request an additional copy of a statement regarding a Participant's rights to COBRA continuation coverage, contact the Cerner Benefits Administrator or see the Wraparound Benefits Plan.

Other Plan Information

Payment When a Participant is Incompetent

If a Participant is legally, physically or mentally incapable of receiving benefits, the Plan Administrator may make payment to another person or institution determined to maintain or have custody of the Participant.

Amendment to or Termination of the Plan

Any increase in coverage (because of a Plan amendment or change in eligibility) or the addition of a new benefit will take effect on the effective date of the increase. Any decrease in coverage or deletion of a benefit takes effect on the effective date of the decrease or deletion for the Participant, whether or not such Participant is Actively at Work.

Cerner may amend the Plan in order to add or delete any Plan benefit, implement Associate contributions or change the amount or percentage of any required Associate contributions, or otherwise change the terms of the Plan at any time without prior notice to You, unless the amendment materially affects collectively bargained terms.

Although it is Cerner's intention that this Plan continue, Cerner reserves the right to terminate the Plan at any time without the consent of or advance notice to Participants.

Definitions

Actively at Work

Performing all of an Associate's customary duties of employment with Cerner for which the Associate is receiving regular earnings from Cerner, either at the Associate's usual place of employment or at a location to which the business of Cerner requires the Associate to travel, except that (i) an Associate is deemed actively at work on each day of regular paid vacation or on a regular nonworking day, provided the Associate was actively at work on the last preceding regular working day and (ii) an Associate is deemed actively at work on each day that the Associate is absent from work due to a physical or mental health condition.

Associate

A person employed by Cerner.

Benefit Authorization

Authorization issued by VSP identifying the Participant and those Plan Benefits to which a Participant is entitled.

Benefit Period

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

Claims Administrator or VSP

Organization contracted by Cerner Corporation (i.e., Vision Service Plan) who provides administrative services for specific Cerner vision benefit programs offered to Cerner Associates and their Dependents.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

A federal law that enables Participants to continue vision coverage under the Plan in the event that they lose coverage as the result of certain change events.

Cerner

Cerner Corporation and any of its Participating Employers.

Copayment

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

Covered

When modifying person, Associate, or Dependent, means eligible and enrolled for coverage in accordance with all the terms of the Plan. When modifying services, charges, expenses, injury, sickness

or any word that describes an injury or sickness, it means payable under the terms and conditions of the Plan.

Effective Date

The first day an Associate or Dependent becomes a Participant under the Plan.

Emergency Condition

A condition, with sudden onset and acute symptoms, that requires the Participant to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

Employee Retirement Income Security Act of 1974 (ERISA)

A federal law that provides certain rights and protections to which Participants are entitled. The act imposes duties upon the people who operate employee benefit plans, to do so prudently and in the best interest of employees and other plan participants and beneficiaries.

Experimental Nature

A procedure or lens that is neither used universally nor accepted by the vision care profession, as determined by VSP.

Member Doctor

An optometrist, optician 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 Participants of VSP. Member Doctors are a part of the VSP Choice network.

Optometrist

Professional trained to provide primary eye and vision care and improve vision with glasses, contact lenses, etc. An optometrist is an o.d. (doctor of optometry), not an m.d.

Ophthalmologist

A doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to examine, diagnose, and treat disorders and diseases of the eye as well as prescribe corrective lenses (glasses or contact lenses).

Out of Network Provider

An 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 Participants of VSP.

Participant

A Covered Associate and his/her Covered Dependents.

Plan

The Vision Component Plan, which includes this document and the Cerner Corporation Wraparound Benefits Plan.

Plan Administrator

Cerner Corporation, unless Cerner Corporation designates another person to hold the position. The Plan Administrator shall be responsible for the for the administration of the Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret the Plan, and decide all questions concerning the Plan and its administration. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. In addition to other duties, the Plan Administrator shall have full responsibility for compliance with the reporting and disclosure rules under the Code and ERISA.

Plan Benefit Allowance

Plan Benefit allowance is the maximum amount that is offered to a Participant based on their elected coverage.

Plan Year

A twelve (12) consecutive month period ending every December 31.

Policy

The contract between VSP and Group upon which this Plan is based.

Premium

The payments made to VSP by or on behalf of a Participant to entitle him/her to Plan Benefits.

Schedule of Benefits

Lists the vision care services and vision care materials that a Participant is entitled to receive by virtue of the Plan.

Schedule of Premiums

States the payments to be made to VSP by or on behalf of a Participant to entitle him/her to Plan benefits.

Usual and Customary Fee

A Usual and Customary Fee is the charge for a particular service or procedure that is customarily charged by providers in the community in which the service or procedure is performed.

Visually Necessary or Appropriate

Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

You, Your

Refers to an Associate Covered under the Plan.

Other Facts You Should Know

Right to Discharge

This Plan is provided as an Associate benefit and does not constitute a contract of employment, give any Associate the right to be retained in the service of Cerner or interfere with the right of Cerner to discharge or otherwise terminate the employment of the Associate.

Nonpayment of Expenses

In the unlikely event that neither the Plan nor Cerner pays the vision expenses that are eligible for payment under the Plan, the Participant may be liable for the payment of the expenses.

Named Fiduciary and Plan Administrator

Cerner Corporation is the Named Fiduciary and Plan Administrator as defined in ERISA, and, as such, Cerner Corporation has the authority to control and manage the operation and administration of the Plan. Cerner Corporation may delegate such authority to the extent allowable by ERISA.

Interpretation of Plan

The Plan Administrator has the exclusive power and authority, in its sole discretion, to construe and interpret the Plan, to determine all questions of Plan coverage and eligibility for benefits, the methods of providing or arranging for such benefits and all other related matters. Any construction of the Plan adopted by the Plan Administrator in good faith and in a consistent and nondiscriminatory manner is binding upon Participants.

Lawsuits Concerning Benefits

No lawsuit may be brought by any person or entity to recover benefits under the Plan more than one year from the date Plan benefits are finally denied.

Workers' Compensation Not Affected

The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

Conformity with Law

If any provision of the Plan is contrary to any law to which it is subject, such provision is automatically amended to conform thereto.

Failure to Enforce

Failure to enforce any provision of the Plan shall not affect Cerner's right thereafter to enforce such provision, nor shall such a failure affect its right to enforce any other provision of the Plan.

Protection against Creditors

No benefit payment under this Plan is subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish the same is void. If Cerner finds that such an attempt has been made, it may, in its sole discretion, elect to pay the benefits due the Participant to the Participant’s Spouse, Domestic Partner, parent, adult child, legal guardian of a minor child, sibling or other relative. Any such payment constitutes a complete discharge of Cerner's liability with respect to such benefits.

This provision does not apply to assignments of benefits to the provider of medical care upon which a claim is based.

Overpayment

Cerner reserves the right to recover payments made to a Participant or the Participant’s assignee in excess of the benefits payable under the Plan. Cerner also reserves the right to withhold the amount of such excess payment from future benefits payable to the Participant or the Participant’s assignee.

Plan Administration/ERISA

This Vision Component Plan is an option under the Cerner Corporation Wraparound Benefits Plan. Benefits are furnished under a vision care Policy purchased by Cerner and provided by VISION SERVICE PLAN INSURANCE COMPANY (VSP) under which VSP is financially responsible for the payment of claims.

Employer Address: 2800 Rockcreek Pkwy
North Kansas City, MO 64117

Employer ID Number: 43-1196944
Plan Identification Number: The Plan Identification Number is 501

Participating Employers:

Participating Employer's include all entities, except for Cerner International, Inc., that (i) are part of Cerner Corporation's controlled group of corporations, and (ii) are domestic corporations with their principal place of business in the United States.

As of January 1, 2015, the Participating Employers are as follows:

- Cerner Corporation
- Cerner Campus Redevelopment Corporation
- Cerner Capital, Inc.
- Cerner Chouteau Data Center, Inc.
- Cerner Galt, Inc.
- Cerner Health Connections, Inc. d/b/a Healthe Clinic
- Cerner Health Services, Inc.
- Cerner Healthcare Solutions, Inc.
- Cerner Innovation, Inc.
- Cerner Lingologix, Inc.
- Cerner Math, Inc.
- Cerner Multum, Inc.
- Cerner Properties, Inc.
- Cerner Property Development, Inc.
- Cerner RevWorks, LLC
- Rockcreek Aviation, Inc.
- The Health Exchange, Inc. d/b/a Cerner HealthPlan Services

Type of Administration:
The Plan is administered by the Plan Administrator through VSP. Certain functions are performed on behalf of the Plan by VSP. These functions include, but are not limited to, administration and payment of claims, and customer service assistance.

Plan Administrator: Cerner Corporation
2800 Rockcreek Parkway

North Kansas City, MO 64117
Phone: 816-982-7547

Agent for Service of Legal Process:

Registered Agent - Delaware
The Corporation Trust Company
1209 Orange Street
Wilmington DE 19801

Registered Agent - Missouri
CT Corporation System
120 South Central Avenue
Clayton MO 63105

Service of process may also be made upon the Plan Administrator.

Claims Administrator:

Vision Service Plan
PO Box 997105
Sacramento, CA 95899-7105
800-877-7195

In addition, service of process may be made upon the Administrator or Trustee.

Trustee: N/A
Plan's Fiscal Year Ends: 12/31
Funding Is: Contributory

Associates pay the full cost of coverage. To be covered by benefits, Associates make pre-tax contributions. This practice can be stopped or modified at any time without prior notice to the employee.

This document, along with the Cerner Corporation Wraparound Benefits Plan & Summary Plan Description, intends to serve as both the Plan document and the Summary Plan Description (SPD).

This Plan document and SPD has been amended and restated effective January 1, 2015.

Addendum

Additional Benefit Rider

Diabetic Eyecare Program

GENERAL

This Rider lists additional vision care benefits to which Covered Participants of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayment and other conditions, limitations and/or exclusions stated herein. Plan benefits under the Diabetic Eyecare Program ("DEP") are available to Participants who have been diagnosed with Type 1 diabetes and specific phthalmological conditions, and who are Covered under the Plan. The Diabetic Eyecare Program allows Participant's Member Doctor to provide diagnostic services not available under the Plan. The Diabetic Eyecare Program does not cover medical treatment for Participants with diabetic or any other medical conditions.

PROCEDURES FOR OBTAINING DIABETIC EYECARE PROGRAM SERVICES

Participant's Member Doctor will provide services under the DEP as needed following Participant's routine Plan eye examination. No referrals or authorizations are required for services provided under the DEP.

COPAYMENT

A Copayment of $20.00 is required for each Ophthalmological service and office visit under the DEP, and is paid to the Member Doctor at the time of service. Other Copayments may apply to services under Participant's Plan.

PLAN BENEFITS

SERVICE*	MEMBER DOCTOR BENEFIT	BENEFIT FREQUENCY†	NON-VSP PROVIDER BENEFIT
Ophthalmological services and Office Visits	Covered in full, less $20.00 Copayment	Once every 12 months	Up to current Non-VSP Provider Schedule of Allowances
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	

COVERED SERVICES	(The following list is subject to change without notice.)
Description	Procedure Code
Ophthalmological services	92002, 92004, 92012, 92014
Office Visits	99201 - 99205, 99211 - 99215
Gonioscopy	92020
Extended Ophthalmoscopy	92225, 92226
Fundus Photography	92250

*Service and/or diagnosis limitations apply, or certain procedures require special handling. Member Doctors must consult the VSP Provider Reference Manual for details before rendering services.

†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the DEP for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

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 makes insufficient insulin or can't efficiently use it.

Fundus Photography
Taking photos of the inside of the eye that show the optic nerve and retinal vessels.

Extended Ophthalmoscopy
A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.

Gonioscopy
Use of a special contact lens to look at the eye's acqueous drainage area.