VSP VISION CARE, INC.

EASY OPTIONS INDIVIDUAL VISION CARE POLICY

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You, the Policyholder under this Policy, shall be permitted to return this Policy within ten (10) days of its delivery to You and to have the premium paid refunded if, after examination of the Policy, You are not satisfied with it for any reason. If You return this Policy, as described above, to VSP Vision Care, Inc. (“VSP”) at its home office, it shall be void from the beginning. This means that You will be responsible for payment in full of any services received or materials purchased from the Policy Effective Date to the date the Policy is voided. If this Policy is so voided, VSP will not be liable for payment of any Plan Benefits utilized by any Covered Person under this Policy.

The benefits available under this Policy are provided by VSP Vision Care, Inc. (“VSP”). For any questions or problems concerning any provisions of this Plan, please contact VSP at (800) 877-7195 or in writing to 3333 Quality Drive, Rancho Cordova, CA 95670.

REQUIRED PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy, including the Schedule of Benefits, endorsements, and any other attached papers constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of VSP and unless the approval is endorsed on or attached to this Policy. A broker or other agent does not have authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for this Policy shall be used to void this Policy or to deny a claim for a loss incurred, as defined in this Policy, commencing after the expiration of such two-year period.

GRACE PERIOD

Unless, not less than thirty (30) days prior to the premium due date VSP has delivered to the Policyholder, or has mailed to the Policyholder’s last address as shown by VSP’s records, written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium.
REINSTATEMENT

If a renewal premium is not paid before the expiration of the period granted for the Policyholder to make the payment, a subsequent acceptance of the premium by VSP or any agent authorized by VSP to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if VSP or its authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by VSP or, if the application is not approved, on the 45th day after the date of the conditional receipt unless VSP before that date has notified the Policyholder in writing of VSP’s disapproval of the application. The Policyholder and VSP have the same rights under the reinstated Policy as they had under the Policy before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not previously been paid, but not to any period more than sixty (60) days before the date of reinstatement.

LEGAL ACTION

No civil action shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

RENEWABILITY

This Policy is renewable at the option of the Policyholder so long as premiums are paid in a timely manner, the Policyholder has not performed an act or practice that constitutes fraud and VSP continues to offer this plan in the state of Washington.

DEPENDENT ELIGIBILITY

If You purchased coverage for Your dependents under this contract, there are some limitations on their eligibility.

Your dependent children, whether natural or adopted, are covered up through age 26. Their coverage will be extended indefinitely if they are or become incapable of self-sustaining employment because of a developmental disability or physical handicap, and they are chiefly dependent on You for support.

Your dependent children and spouse may continue coverage under this Contract should they become otherwise ineligible as the result of divorce or Your death. They will not be required to have a physical examination, a statement of health or any other proof of insurability in order to continue their coverage.

DEFINITIONS OF WORDS AND PHRASES USED IN THIS POLICY

- **Benefit Authorization**: Authorization from VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled at the time the authorization is issued.
- **Copayment**: An amount 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 ordered.
- **Covered Dependent**: A Policyholder’s eligible dependent who is covered under this Policy.
- **Covered Person**: A person insured under this Policy, including the Policyholder and any Covered Dependent.
- **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 this Policy.
- **Plan Term**: A twelve- (12) month period beginning on the Plan Effective Date of this Policy and on each subsequent anniversary thereof.
- **Policy**: This document and all of its attachments, if any.
Policyholder  The person who signed the application for this Policy and who is responsible for payment of premiums for this Policy.

You, Your  The person insured under this Policy. The Policyholder.

VSP Preferred Provider  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 Plan Benefits on behalf of Covered Persons of VSP.

We, Us, Our, VSP  This refers to VSP Vision Care, Inc.

PLAN BENEFITS

During each Plan Term the following vision care services and/or materials are available to Covered Persons under this Policy:

Examination

Each Plan Term, You and each of Your Covered Dependents are entitled to one complete initial vision analysis which will include an examination of visual functions and prescription of corrective eyewear where needed. At the time of the examination, You will be responsible for paying the VSP Preferred Provider a Copayment of $15.00. You will not be responsible for any other charges relating to the examination.

Frames* and Lenses*

Each Plan Term, You and each of Your Covered Dependents are entitled to one of the following:

1. An allowance of $230.00 toward the purchase of one set of frames. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. You are also entitled to one pair of prescription lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular). For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 and 2), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled “Plan Limitations.”

OR

2. An allowance of $150.00 toward the purchase of one set of frames. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. You are also entitled to one pair of progressive prescription lenses. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 and 2), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled “Plan Limitations.”

OR

3. An allowance of $150.00 toward the purchase of one set of frames. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. You are also entitled to one pair of photochromic prescription lenses. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $25.00 and 2), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled “Plan Limitations.”

Your Plan Benefits for frames and lenses shall also include necessary professional services such as prescribing and ordering proper lenses, assisting in frame selection, verifying accuracy of finished lenses, proper fitting and adjustments of frames, subsequent adjustments to frames to maintain comfort and efficiency and progress or follow-up work as necessary.
† If both frames and lenses are purchased separately during a single Plan Term, the $25.00 Copayment will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Term, only one $25.00 Copayment will be required for the combined purchase.

Contact Lenses*

Each Plan Term You and each of Your Covered Dependents are entitled to an allowance of $230.00 toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. For each pair of extended wear contact lenses or for each supply of disposable contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), any amounts which exceed Your Plan allowance, and 2), any charges for services and/or materials not covered under this Policy. For a list of non-covered services and materials, please refer to the section entitled “Plan Limitations.”

*Important: Under this Policy, each Plan Term You and each of Your Covered Dependents may purchase either 1) one pair of prescription eyeglasses (frame and lenses), or 2) one pair of extended wear contact lenses or a supply of disposable contact lenses.

WHAT YOU NEED TO KNOW ABOUT USING YOUR PLAN BENEFITS

How to obtain services and materials under this Policy

When You or any of Your Covered Dependents want to receive Plan Benefits, contact a VSP Preferred Provider and make an appointment. Identify Yourself as a VSP insured and the VSP Preferred Provider will contact VSP to verify Your eligibility and obtain a Benefit Authorization. You should refer to the VSP List of VSP Preferred Provider provided to You with Your Policy for the names of the VSP Preferred Providers in Your area. You may also find the locations of VSP Preferred Providers by visiting VSP's web site at www.vsp.com or by calling VSP Customer Care toll-free at (800) 877-7195. Covered Persons are not limited to any geographic area when they wish to use Plan Benefits. They may select and utilize a VSP Preferred Provider anywhere throughout the United States.

Why a Benefit Authorization is required

A Benefit Authorization is VSP’s way of confirming to You and to the VSP Preferred Provider that You and Your Covered Dependents are eligible to receive Plan Benefits. If VSP issues a Benefit Authorization, and You or a Covered Dependent receive Plan Benefits based on that Authorization before it expires, VSP will pay for those Plan Benefits even if this Policy is terminated. If You or a Covered Dependent receive Plan Benefits without a Benefit Authorization, You would be responsible for paying the full amount of the services and/or materials to the doctor. If You cancel and return this Policy within ten (10) days of purchase, You will be responsible for payment of all expenses incurred by You or Your Covered Dependents for services or materials, even if VSP had issued a Benefit Authorization.

Emergency services

Plan Benefits provided by VSP under this Policy are for routine vision care services and materials only. This Policy does not cover treatment for medical conditions, whether due to an emergency or to any other cause. If You or any of Your Covered Dependents require medical treatment for any reason, You should contact a medical provider.

Your rights under this Policy if You have problems or questions

For any questions You may have regarding Your coverage under this Policy, please contact VSP’s Customer Care Division at (800) 877-7195, Monday through Friday, from 6 AM to 7 PM, Pacific Time. Many of Your questions may also be answered by visiting VSP’s web site at www.vsp.com.

If You should ever have a complaint about the quality of the care You receive from a VSP Preferred Provider, wish to request reconsideration from VSP of a claim denied for payment, or for any other matter, Your first step should be to contact VSP’s Customer Care Division. If they are not able to resolve Your complaint, they will assist You in the procedures for pursuing a formal review of Your concerns by VSP. For additional information on this matter, please refer to the section of this Policy entitled “How VSP handles payment of claims.”

HOW VSP HANDLES PAYMENT OF CLAIMS

Plan Benefits under this Policy are underwritten by VSP Vision Care, Inc., a Washington Limited Healthcare Service Provider, and are subject to preferred provider arrangements.
A preferred provider, referred to in this Policy as a “VSP Preferred Provider”, is an optometrist or ophthalmologist that has signed a contract with VSP to provide Plan Benefits to Covered Persons under VSP policies. Each VSP Preferred Provider has agreed to accept discounted fees as payment from VSP in exchange for being listed in VSP’s directory of its contracting doctors. A doctor who is not a preferred provider has no contractual arrangement with VSP and can charge whatever fee he or she desires. You can obtain more information regarding VSP’s preferred providers, including a list of doctors in your area, by visiting VSP’s web site at www.vsp.com, by calling VSP’s Customer Care Division at (800) 877-7195 or by writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

When you or your Covered Dependents receive services or materials from a VSP Preferred Provider, the doctor will submit any required claims directly to VSP. VSP will then pay the doctor for the Plan Benefits you or your Covered Dependents received. You will never be required to file a claim with VSP. If VSP fails to pay the VSP Preferred Provider, neither you nor any of your Covered Dependents will be held liable for any sums owed by VSP other than those not covered by VSP under this Policy.

Other insurance coverage

VSP will not coordinate Plan Benefits payable under this Policy with any other private or government insurance plan, including any other plan underwritten by VSP.

Denial of payment for claims

If VSP denies a claim, you have the right to request a reconsideration of the denial. Also, if VSP denies your request for reconsideration of the claim, you have the right to appeal this decision.

You may obtain more information concerning VSP’s appeals process by contacting VSP’s Customer Care Division at (800) 877-7195.

PLAN LIMITATIONS

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses 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 Preferred Provider or by calling VSP’s Customer Care Division at (800) 877-7195.

NOT COVERED

The following services and/or materials are not covered under this Policy.

1. Services and/or materials not included as Plan Benefits in this Policy.
2. Orthoptics or vision training and any associated supplemental testing.
3. Corneal Refractive Therapy (CRT)
4. Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
5. Refitting of contact lenses after the initial (90-day) fitting period.
6. Plano lenses (lenses with refractive correction equal to or less than ± .50 diopter).
7. Two pair of glasses in lieu of bifocals.
8. Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available.
9. Medical or surgical treatment of the eyes.
10. Plano contact lenses to change eye color cosmetically.
11. Artistically-painted contact lenses.
12. Contact lens insurance policies or service contracts.
13. Additional office visits associated with contact lens pathology.
14. Contact lens modification, polishing or cleaning.
15. Costs for services and/or materials exceeding Plan Benefit allowances.
16. Services or materials of a cosmetic nature.
17. Local, state and/or federal taxes, except where VSP is required by law to pay.