

No vision
insurance?

Look

into VSP
Direct.™



Look into VSP Direct for affordable individual and family vision insurance.

When you enroll in individual vision insurance through eHealth, you'll enjoy the best value on your eyecare. As the only national not-for-profit vision care company, we reinvest in the things you value most—the best care at the lowest out-of-pocket cost.

You'll like what you see when you look at VSP.®

Lowest Out-of-pocket Cost

You'll enjoy the lowest out-of-pocket cost in individual vision care, saving you hundreds on your eye exam and glasses.

Convenient Locations

With more than 30,000 network doctors, you're sure to find a VSP doctor close to you. Visit the "Find a Doctor" section on vsp.com to locate a VSP doctor near you.

Great Selection in Eyewear

With the largest choice in frames, you'll find the pair that's right for you and your budget.

Satisfaction Guaranteed

We guarantee your satisfaction. That's why we're consumers' #1 choice in vision care.¹ If you're not 100% happy, we'll make it right.



**Don't wait.
Enroll through
eHealth now.**

Contact us.
ehealthinsurance.com
or **866.787.877**

| Save with VSP coverage: | Without VSP Coverage* | With VSP Coverage |
|--|--------------------------|----------------------|
| Eye Exam | \$152 | \$15 |
| Frame | \$120 | \$25 |
| Single Vision Lenses | \$84 | |
| Anti-reflective Coating | \$108 | \$69 |
| Light-to-dark Tinting (Photochromic Lenses) | \$101 | \$70 |
| Impact-resistant Lenses (Polycarbonate Lenses) | \$54 | \$31 |
| Annual Plan Cost** | N/A | \$182 |
| Total | \$619 | \$392 |

*Comparison based on national averages for comprehensive eye exams and most commonly purchased brands. This chart represents typical savings for VSP members when they see a VSP doctor.

**Plan costs vary by state.

Typical
Annual Savings
\$227
with a
VSP Doctor

Look and see why over 65 million members love VSP, and you will too:

- **Eye exam:** fully covered after a \$15 copay
- **Prescription lenses:** fully covered after a \$25 copay
- **Frames:** a wide-selection covered up to \$120, plus 20% savings on the amount over your allowance. And, maximize your benefit with an extra \$20 toward your allowance when you purchase a featured frame brand,² giving you even more fully covered frame options to choose from
- **Contact lenses (instead of glasses):** \$120 allowance toward contacts
- **Lens enhancements:** an average of 20%-25% savings on lens enhancements

Look! It's easy.

Enrollment through eHealth is a simple process.⁴ And, once you're enrolled, your great benefits are easy to use.

Visit **ehealthinsurance.com** or call **866.787.8773** to enroll.

**Enroll in VSP Direct
through eHealth today.
You'll be glad you did.**

Exclusive Member Extras

As a VSP member, you'll enjoy exclusive savings and promotions on eyecare, including laser vision correction services.³ The average savings are 15% off the regular price or 5% off the promotional price. Discounts are only available from contracted facilities.

As an added bonus, you or any family member can enjoy savings of up to \$1,200 per hearing aid compared to retail pricing on state-of-the-art digital hearing aids through TruHearing®.

For more information visit **vsp.truhearing.com**. Or call **877.396.7194** and be sure to mention that you're a VSP member.



1. Ipsos National Vision Plan Member Research, 2012 2. Before purchase, ask your VSP doctor about qualifying frame brands. Brands are subject to change 3. Applies using wavefront technology with the microkeratome surgical device only. Other LASIK procedures may be performed at an additional cost to the member. VSP Laser VisionCare discounts are only available from VSP-contracted facilities 4. This insurance policy has exclusions and limitations. For costs and complete coverage details, call 866.787.8773

Terms and conditions and availability may vary from state to state according to state law.

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VSP is a registered trademarks, VSP Direct is a trademark, and VSP Laser VisionCare is a service mark of Vision Service Plan. All other brands and marks are the property of their respective owners.

By enrolling in VSP's Individual Vision Care Policy, you indicate you have read the following terms and conditions of the plan.

Terms & Conditions

THIS POLICY PROVIDES VISION BENEFITS ONLY.

Monthly Payment Option: If you selected the monthly payment option for the annual benefit term, you agreed to pay the required annual premium in twelve (12) payments. The first payment will be withdrawn from your credit card or checking account at the time of enrollment and the remainder eleven (11) payments will be withdrawn on or around the 15th of each month. If you enroll between the 15th and last day of the month and choose to expedite your enrollment by selecting the current month effective date, you will be charged for current month and the following month at time of enrollment. If payment is not received for any reason, VSP may cancel your coverage after 30 days from when your premium was due. You are responsible to update your payment information by calling Member Services at 800-877-7195.

Renewal: This Policy is renewable at the option of the Policyholder and will automatically renew 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. VSP will not cancel coverage under the Policy because of a Covered Person's health status requirements for vision care services. You will be notified on or around sixty (60) days prior to your auto-renewal. To make changes to your current plan, call Member Services at 800-877-7195 prior to your policy renewal date. If payment is not received for any reason, VSP may cancel your plan after thirty (30) days from when your premium was due.

Right to Return the Policy: You are permitted to return the Policy within thirty (30) days of its delivery to you and have the premium paid refunded, less the processing fee, if after examination of the Policy you are not satisfied with it for any reason. If you return the Policy to 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.

Other Insurance Coverage: VSP cannot coordinate plan benefits payable under this Policy with any other private or government insurance plan, including any other plan underwritten by VSP.

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.

Limitations, Exclusions & Exceptions:

Some brands of spectacle frames and 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.

Copayments and other out-of-pocket expenses apply to the eye examination and/or to the purchase of most materials. Services or materials of a cosmetic nature are not covered under this policy. Medical services and supplies are not covered under this policy. Each person covered under this policy will have higher out of pocket expenses if they use a doctor who is not part of VSP's provider network.

VSP will not cancel coverage under this plan because of a covered person's health status or requirements for vision care service.

Covered persons shall report any complaints and/or grievances by selecting one of these options:

- In writing to VSP, 3333 Quality Drive Rancho Cordova CA 95670-7985;
- By calling VSP's Member Services at 800-877-7195;
- Online at VSP.com by completing a member grievance form; or
- Through your VSP doctor.

VISION SERVICE PLAN INSURANCE COMPANY

INDIVIDUAL VISION CARE POLICY

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INDIVIDUAL VISION CARE POLICY

Provided By

VISION SERVICE PLAN INSURANCE COMPANY

POLICY NUMBER:

POLICYHOLDER'S NAME:

COVERED DEPENDENTS:

POLICY EFFECTIVE DATE:

PREMIUM:

STATE OF DELIVERY: Colorado

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 Vision Service Plan Insurance Company ("VSP") at its home office, [or to the broker or agent from whom You purchased it] 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 Vision Service Plan Insurance Company ("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

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

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 reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. 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 action at law or in equity 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.

CHANGE OF BENEFICIARY

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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 Colorado.

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. |
| 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 this Policy. |
| Plan Year | 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 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 Plan Benefits on behalf of Covered Persons of VSP.

We, Us, Our, VSP

This refers to Vision Service Plan Insurance Company.

PLAN BENEFITS

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

Examination

Each Plan Year, 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 Network Doctor a Copayment of \$ []. You will not be responsible for any other charges relating to the examination.

Lenses*

Each Plan Year, You and each of Your Covered Dependents are entitled to receive one pair of prescription lenses. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Network Doctor 1), the following Copayment[†] 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".

[For Lenses, a Copayment of \$ [].]

[For single vision lenses, a Copayment of \$[].]

For bifocal lenses, a Copayment of \$[].

For trifocal lenses, a Copayment of \$[].

For Lenticular lenses, a Copayment of \$[].]

[For Lenses, no Copayment is required.]

[Insert if Member purchased Lens Option benefit: Additionally, You and each of Your Covered Dependents are entitled to include the following Lens Options with Your Lens benefit: [Insert Lens Options purchased by Member].

Frames*

Each Plan Year, You and each of Your Covered Dependents are entitled to an allowance of \$ [] 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 Network Doctor 1), a Copayment of \$ [][†] 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. 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 Year, the \$ [] Copayment will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Year, only one \$ [] Copayment will be required for the combined purchase.

Contact Lenses*

Each Plan Year You and each of Your Covered Dependents are entitled to an allowance of \$ [] 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. An additional discount of fifteen percent (15%) will apply to the VSP Network Doctor's professional fee. 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 Network Doctor 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 Year 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.

OTHER PLAN BENEFITS

You and each of Your Covered Dependents are also entitled to receive the additional vision care services as stated below.

Additional Discount

In addition to the specific Plan Benefits stated above, You and each of Your Covered Dependents are entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (frames, lenses and Lens Options) from VSP Network Doctors. Additional pairs are those purchased beyond the Plan Year benefit frequency allowed under this Policy.

Also, You and each of Your Covered Dependents are entitled to receive a discount of fifteen percent (15%) off of any VSP Network Doctor's professional fees for evaluation and fitting of contact lenses.

You will be responsible for paying the VSP Network Doctor the balance of any charges for materials and services after the applicable discount(s) are applied. To receive the discount(s), all services and/or materials must be purchased within twelve (12) months of an examination covered under this Policy and must be purchased from a VSP Network Doctor.

Important: Additional Discounts do not apply to vision care services and/or materials obtained from a Non-VSP Provider.

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 Network Doctor and make an appointment. Identify Yourself as a VSP insured and the VSP Network Doctor will contact VSP to verify Your eligibility and obtain a Benefit Authorization. You should refer to the VSP List of VSP Network Doctors provided to You with Your Policy for the names of the VSP Network Doctors in Your area. You may also find the locations of VSP Network Doctors 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 Network Doctor 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 Network Doctor 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.

Plan Benefits received from a Non-VSP Provider

You and Your Covered Dependents may receive Plan Benefits from any duly licensed optometrist or ophthalmologist. If You or Your Covered Dependents receive Plan Benefits from a Non-VSP Provider, You will be responsible for paying the provider's full fee and requesting reimbursement from VSP. The amount reimbursed to You by VSP may not be enough to cover the full amount of the Non-VSP Provider's fee. VSP Network Doctors have agreed to accept discounted fees for their services and to not bill You for Plan Benefits payable under this Policy. Non-VSP Providers do not have such an agreement with VSP and can charge You their full, non-discounted fees. Also, VSP is unable to require Non-VSP Providers to adhere to VSP's quality standards. Plan Benefits received from a Non-VSP Provider will exhaust Covered Persons' Plan Benefits under this Policy. Covered Persons may not receive similar Plan Benefits from both a VSP Network Doctor and a Non-VSP Provider. For example, if We pay for an exam from a VSP Network Doctor, no Plan Benefits will be available for an exam from a Non-VSP Provider.

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 7 AM to 8 PM, MST 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 Network Doctor, 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 Vision Service Plan Insurance Company, a Connecticut domiciled Accident and Health Insurer, and are subject to preferred provider arrangements.

A preferred provider, referred to in this Policy as a "VSP Network Doctor," is an optometrist or ophthalmologist that has signed a contract with VSP to provide Plan Benefits to Covered Persons under VSP policies. Each VSP Network Doctor 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.

Services from VSP Network Doctors

When You or Your Covered Dependents receive services or materials from a VSP Network Doctor, 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 Network Doctor, 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.

Services from Non-VSP Providers

When You or Your Covered Dependents receive services or materials from a Non-VSP Provider, You will usually be required by the provider to pay the charges in full. You would then need to submit a claim or other "proof of loss" to VSP for reimbursement. You do not need a special claim form in order to request reimbursement from VSP. At a minimum, with any request for reimbursement, You should include Your name, Your Member Identification Number, the name of the patient, the patient's date of birth, the date the services were rendered and/or materials provided, the amounts You paid for each service or material and the doctor's name. Also, include copies of any invoices or receipts You received from the doctor for the services or materials. Mail Your request for reimbursement to VSP at the following address:

VSP
P. O. Box 997105
Sacramento, CA 95899-7105

You will be reimbursed for the services or materials based on the following Non-VSP Provider Schedule of Allowances:

| Non-VSP Provider Schedule of Allowances | |
|---|-----------|
| Service or Material | Allowance |
| Examination | \$ [] |
| Single Vision Lens (pair) | \$ [] |
| Bifocal Lens (pair) | \$ [] |
| Trifocal Lens (pair) | \$ [] |
| Lenticular Lens (pair) | \$ [] |
| Frame | \$ [] |
| Contact Lens (pair) | \$ [] |

(This schedule is updated annually on January 1st of each year. When updated, allowances may change from those stated above.)

Notice of Claim

Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the Policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to VSP at 3333 Quality Dr., Rancho Cordova, CA 95670

Proof of loss

Written proof of loss must be furnished to VSP at the address stated above in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of legal incapacity.

Under the provisions of this Policy, "loss" means any amounts You paid for services or materials to a Non-VSP Provider. A "proof of loss" means a request for reimbursement as described in the "Services from Non-VSP providers" section, above. "Date of loss" means the date services were rendered or materials purchased.

Time of payment of claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death, may at the option VSP, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Physical examinations

VSP at its own expense shall have the right and opportunity to examine the person of the Policyholder when and as often as it may reasonably be necessary during the pendency of a claim hereunder.

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

[Insert if Member did not purchase Lens Options benefit:

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. If You or any of Your Covered Dependents obtain lens enhancements such as (but not limited to) blended lenses, tinted lenses, lens coatings, or any other "Lens Options" not related to the correction of refractive error, VSP will pay the amount stated in the Plan Benefits section for the lenses and You will be responsible for paying the VSP Network Doctor for the additional costs of the Lens Options.]

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 Preferred Provider or by calling VSP's Customer Care Division.

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 $\pm .50$ 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.
18. [A small number of frame brands may be excluded or limited to applicable maximums for Non-Member Provider benefits.]