VISION SERVICE PLAN INSURANCE COMPANY

INDIVIDUAL VISION CARE POLICY

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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, has not made an intentional misrepresentation of material fact and VSP continues to offer this plan in the state of Florida. This Policy shall be automatically renewed at the end of each Plan Year unless the Policyholder gives VSP written notice of termination prior to the renewal date.

Kate Renwick-Espinosa, President
Vision Service Plan Insurance Company

INDIVIDUAL VISION CARE POLICY

Provided By

Vision Service Plan Insurance Company

POLICY NUMBER:

POLICYHOLDER'S NAME:

COVERED DEPENDENTS:

POLICY EFFECTIVE DATE:

POLICY TERMINATION DATE:

POLICY TERM: One year

PREMIUM: $ [ ] per Plan Year

STATE OF DELIVERY: Florida

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 Administrator through whom it was purchased, 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, Vision Service Plan Insurance Company, Inc. will not be liable for payment of any Plan Benefits utilized by any Covered Person under this Policy.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with VSP by consulting VSP's website or contacting VSP or your agent directly.

The benefits available under this Contract are provided by Vision Service Plan Insurance Company. For any questions or problems please contact VSP at (800) 877-7195 or in writing to 3333 Quality Drive, Rancho Cordova, CA 95670.

REQUIRED PROVISIONS

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, has not made an intentional misrepresentation of material fact and VSP continues to offer this plan in the state of Florida. This Policy shall be automatically renewed at the end of each Plan Year unless the Policyholder gives VSP written notice of termination prior to the renewal date.

ENTIRE CONTRACT; CHANGES

This Policy, including the application and the Schedule of Benefits, 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 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

This Policy has a thirty-one (31) day grace period. This provision means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the policy will stay in force.

REINSTATEMENT

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the insurer, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this policy. If the insurer or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless the insurer has previously written the insured of its disapproval. The rights of the insured and the insurer will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums the insurer accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

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 the applicable statute of limitations from the time written proof of loss is required to be furnished.

TERMINATION OF DEPENDENT COVERAGE

As to a spouse, coverage shall terminate upon legal separation or termination of marriage by divorce or annulment. As to a domestic partner, coverage shall terminate upon legal separation or termination of partnership. As to a child, coverage shall terminate upon cessation of dependency or at the end of the calendar year in which the child reaches the limiting age. If VSP accepts premium for coverage extending beyond the date, age or event specified for termination as to the insured family member, then coverage as to such person shall continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age.

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CANCELLATION

VSP will give You at least forty-five (45) days' advance written notice of cancellation, nonrenewal, or a change in rates. Such notice shall be mailed to Your last address as shown by VSP's records. If We fail to provide the 45 days' notice required by this section, coverage under this Policy shall remain in effect at the existing premium until 45 days after the notice is given or until the effective date of replacement coverage obtained by the You, whichever occurs first. However, if We cancel this Policy for nonpayment of premium, We will give You at least ten (10) days' written notice accompanied by the reason for the cancellation. If VSP discontinues offering this Policy in the state of Florida, VSP shall provide You ninety (90) days advance notice of nonrenewal. If VSP discontinues offering all health insurance coverage in the individual market in the state of Florida, VSP shall provide You with one hundred eighty (180) days advance notice of nonrenewal.

If this Policy is cancelled by either Party, it shall be without prejudice to claims originating prior to the effective date of cancellation. You may cancel this Policy at any time. In the event of cancellation, VSP will promptly return any unearned portion of any premium paid.

CONVERSION PRIVILEGE

If a person's eligibility for coverage under this Policy ceases, then such person shall be entitled to have issued to him or her, without evidence of insurability, an Individual Vision Care Policy provided application for the policy is made and the first premium paid to VSP.

SCHEDULE OF BENEFITS

PLAN BENEFITS

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

Examination

You and each of Your Covered Dependents are entitled to one complete initial vision analysis each Plan Year 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 $15.00. You will not be responsible for any other charges relating to the examination.

Lenses*

You and each of Your Covered Dependents are entitled to receive one pair of corrective lenses each Plan Year. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Network Doctor 1), a Copayment† of $25.00 and 2), any charges for Lens Options or other materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limitations".

Frames*

You and each of Your Covered Dependents are entitled to an allowance of $150.00 toward the purchase of one set of frames each Plan Year. For each set of frames You and Your dependents receive, You will be responsible for paying the VSP Network Doctor 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. 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 $ 25.00 Copayment will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Year, only one $ 25.00 Copayment will be required for the combined purchase.

Contact Lenses*

You and each of Your Covered Dependents are entitled to an allowance of $150.00 toward the cost of professional services and the purchase price of one pair of contact lenses each Plan Year. For each set of Contact Lenses You and Your dependents receive, You will be responsible for paying the VSP Network Doctor 1), any amounts which exceed the VSP Network Doctor's discounted professional fee, 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".

*Important: Under this Policy, You and each of your Covered Dependents may purchase either 1), one pair of frames each Plan Year and one pair of lenses each Plan Year or 2), one pair of contact lenses per Plan Year.

OTHER PLAN BENEFITS

You and each of Your Covered Dependents are also entitled to receive the additional discounts on 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 or non-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.

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 months from the date of an examination covered under this Policy and must be purchased from a VSP Network Doctor. Important: 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 may find the locations of VSP Network Doctors by visiting VSP's web site at www.vsp.com or by calling VSP Customer Service 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 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 has 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.

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 problems, 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 or complaints You may have regarding Your coverage under this Policy, please contact VSP's Customer Service Department at (800) 877-7195, Monday through Friday, from 9 AM to 10 PM, Eastern Standard 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 similar reason, Your first step should be to contact VSP's Customer Service Department. 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. At any time You may designate another person to act as Your authorized representative for matters involving VSP. For additional information on this subject, please refer to the section of this Policy entitled "Denial of payment for claims" on page 8.

HOW VSP HANDLES PAYMENT OF CLAIMS

Plan Benefits under this Policy are underwritten by Vision Service Plan Insurance Company, a Missouri non-profit corporation, 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 Service Department 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 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; Proof of loss

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 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, you must include copies of any invoices or receipts You received from the doctor for the services or materials. Mail Your request for reimbursement to:

VSP
Attn: Claims Processing
P.O. Box 495918
Cincinnati, OH 45249-5918

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	$ 45.00
Single Vision Lens (pair)	$ 30.00
Bifocal Lens (pair)	$ 50.00
Trifocal Lens (pair)	$ 65.00
Progressive Lens (pair)	$ 50.00
Lenticular Lens (pair)	$ 100.00
Frame	$ 70.00
Contact Lens (pair)	$ 105.00

(*The allowances shown remain in effect during the duration of this Policy.)

For reimbursement of services obtained under this Policy, a claim ("proof of loss") must be provided to VSP at the address stated above no more than one hundred and eighty (180) days after the date of the services. 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.

Time of payment of claims

Requests for reimbursement payable under this Policy will be paid or denied within thirty (30) days of receipt of a request for reimbursement as described in the section entitled "Services from Non-VSP Providers", above. Requests for reimbursement received by VSP which are not complete may result in a delay in payment. If VSP requires additional information in order to process Your claim, we will contact You by telephone or in writing within fifteen (15) days after receipt of Your request for reimbursement. Once all requested information has been received, we will pay or deny Your claim within 15 days.

Payment of claims

Benefits for services from Non-VSP Providers will be paid to the insured. In the event of the death of the Policyholder, benefits unpaid at death may be paid, at VSP's option, either to the insured's beneficiary or estate.

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 submitted, 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 Service Department at (800) 877-7195.

PLAN LIMITATIONS

This Policy is designed to cover visual needs rather than cosmetic materials. If You or any of Your Covered Dependents obtain lens enhancements or "Lens Options" not related to the correction of refractive error, VSP will pay according to the coverage 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.

The following vision care services and/or materials are Not Covered under this Policy.

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

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 provided.
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.
Elective Contact Lenses	A corrective lens used to restore a patient's visual acuity and for which less expensive alternative corrective lenses are available.
Eligible Dependent	A Policyholder's spouse or domestic partner. Any dependent child of the Policyholder including natural child from the date of birth, legally adopted child from the date of placement of adoption with the Policyholder, or other child for whom a court or administrative agency holds the Policyholder responsible. This includes an adopted child from the date of birth when a written agreement to adopt such child has been entered into prior to the birth of the child. A dependent child is covered until the end of the calendar year in which the child reaches the age of 26. A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the Policyholder for support. A dependent child over the limiting age may continue to be eligible as a dependent until the end of the calendar year in which the child reaches the age of 30 if the child a) is unmarried and does not have a dependent of his or her own; b) is a resident of the state of Florida or a full-time or part-time student; and c) is not provided coverage under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
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 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 and each subsequent anniversary thereof.
Policy	This document and all of its attachments, if any.
Policyholder	The person who applied for and agreed to the provisions of this Policy and who is responsible for payment of premiums for this Policy.
You, Your	The person insured under this Policy, as shown on page 1. 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 vision care services and/or vision care materials on behalf of Covered Persons of VSP.
We, Us, Our, VSP	This refers to Vision Service Plan Insurance Company

VISION SERVICE PLAN INSURANCE COMPANY (VSP)
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

Vision Care Expense
Outline of Coverage (Policy No. VSP IND FL 0118)

This policy provides vision benefits only. Review your policy carefully.

(1) READ YOUR POLICY CAREFULLY. This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Vision Service Plan Insurance Company.

(2) Vision care expense coverage is designed to provide you with coverage for the expenses which you incur for the routine services of an optometrist or ophthalmologist for correction of vision deficiencies. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) Benefits

Each person covered under the policy will be entitled to

- an eye examination every 12 months
- one pair of prescription eyeglass lenses every 12 months and one pair of eyeglass frames every 12 months, or one pair of prescription contact lenses every 12 months; and
- discounts toward the purchase of additional pairs of eyeglasses

(4) Exclusions, Limitations, and Reductions

- Copayments and other out-of-pocket expenses apply to the eye examination and/or to the purchase of most materials.
- If You or any of Your Covered Dependents obtain lens enhancements or"Lens Options" not related to the correction of refractive error, VSP will pay according to the coverage 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.

- The following vision care services and/or materials are not covered:

    - Orthoptics or vision training and any associated supplemental testing.
    - Corneal Refractive Therapy (CRT)
    - Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
    - Refitting of contact lenses after the initial (90-day) fitting period.
    - Plano lenses (lenses with refractive correction equal to or less than ± .50 diopter).
    - Two pair of glasses in lieu of bifocals.
    - Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available.
    - Medical or surgical treatment of the eyes.
    - Plano contact lenses to change eye color cosmetically.
    - Artistically-painted contact lenses.
    - Contact lens insurance policies or service contracts.
    - Additional office visits associated with contact lens pathology.
    - Contact lens modification, polishing or cleaning.
    - Costs for services and/or materials exceeding Plan Benefit allowances.
    - Services or materials of a cosmetic nature.
    - Services and/or materials not included as Plan Benefits in 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.

(5) 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, has not made an intentional misrepresentation of material fact and VSP continues to offer this plan in the state of Florida

(6) The Premium due under this Policy is $134. 40, $253.68, or $347.76 (Based on Coverage Level) per Plan Year.