

Client Vision Care Plan



CLIENT NAME: National Wellness and Fitness Association, Inc.

CLIENT NUMBER: 30096959

EFFECTIVE DATE: 2/1/2026

EVIDENCE OF COVERAGE

Provided by:

Vision Service Plan Insurance Company
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT: National Wellness and Fitness Association, Inc.

NAME OF PLAN: VSP Preferred Plan

PRIMARY ADDRESS OF CLIENT: 706 North 129 Street, Suite # 100, Omaha, NE 68154

PHONE NUMBER: (800) 992-8044

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Network Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Network Provider will obtain benefit verification from VSP. The VSP Network Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within 365 calendar days from the date services are rendered and/or materials provided. Claims received by VSP after 365 days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits for details.

URGENT VISION CARE

Services for conditions of a medical nature are not covered by under this Plan. Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Network Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Network Providers. More information is available under “Patient’s Rights and Responsibilities” on VSP’s web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP’s Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP’s receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. 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.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person’s authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to “Covered Person” include Covered Person’s authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP’s review. VSP’s response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP’s response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation. Covered Person may contact the State insurance regulatory agency for details.

Time of Action: No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) calendar days after written proof of loss has been filed with VSP. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

INDIVIDUAL CONTINUATION OF BENEFITS

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

DEFINITIONS:

CLIENT

An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.

COPAYMENTS

Those amounts 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 PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
OPEN ACCESS 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 the Policy, as defined in the attached Schedule of Benefits.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP NETWORK 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 Plan Benefits on behalf of Covered Persons of VSP.

EXHIBIT A

SCHEDULE OF BENEFITS VSP Preferred Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of Vision Service Plan Insurance Company. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD: A twelve-month period beginning on the effective date each year.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Dependent Parent
- Any unmarried child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

A dependent child is covered until the end of the calendar year in which the child reaches the age of 26.

A dependent unmarried 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 Enrollee for support and maintenance.

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Covered Person at the time services are rendered. If materials are provided, there shall be an additional \$25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Enhancements, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Covered in full* once every 12, months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to age 19.

LENS ENHANCEMENTS

Progressive Lenses: Covered in full after a \$ \$50 Copayment once every 12 months.**

FRAMES: Covered up to the Plan allowance of \$200* once every 24 months**

The VSP Network Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered in full up to \$ \$150.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein. When contact lenses are utilized in lieu of spectacle lens and frame benefits, the member becomes eligible for contact lenses or spectacle lenses after 12 months and eligible for a frame after 12 months**.

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period

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 and lens brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the LightCare enhancement, if purchased by Client.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lens insurance policies or service agreements.
8. Refitting of contact lenses after the initial (90-day) fitting period.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of \$20 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses or frames) are provided, there shall be an additional \$25 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Covered up to \$45* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Single vision covered up to \$30* once every 12 months**

Lined Bifocal or Progressive covered up to \$50* once every 12 months**

Lined Trifocal covered up to \$65* once every 12 months**

Lenticular covered up to \$100* once every 12 months**

FRAMES: Covered up to \$70* once every 24 months**

CONTACT LENSES

Elective Contact Lenses are covered up to \$105 once every 12 months.**

Contact Lenses are provided in lieu of spectacle lens and frame benefits within the benefit period**. When contact lenses are utilized in lieu of spectacle lens and frame benefits, the member becomes eligible for contact lenses or spectacle lenses after 12 months and eligible for a frame after 12 months**.

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period

*EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS*

1. Exclusions and limitations of benefits described above for VSP Network Providers shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Network Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.