

Medical Plan Vision Care Benefit

Payless ShoeSource
EyeMed Vision Care Benefit
Summary

January 1, 2018

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EYEMED VISION CARE BENEFIT SUMMARY

This summary has been designed as a “plain talk” guide for the Vision Care Plan benefits underwritten by Combined Insurance Company of America and offered by EyeMed VisionCare, which is offered under the Payless ShoeSource, Inc. Medical Plan (the “Plan”). This summary describes the vision care benefits offered to you as a participant in the vision care health plan option, in a manner which is easier to understand than the legal documents which describe the full provisions of the Plans. Every effort has been made to include the important features and to be as accurate as possible, but if we have inadvertently not described a feature of the Plans related to the vision care benefit or in describing such benefits under the Plans stated something which conflicts with the text of the legal documents, the legal documents must, of course, govern.

Who’s Eligible?

All regular Island Full-time Employees of Payless ShoeSource, Inc., and its affiliates adopting the Plan as well as their eligible dependents, can enroll in this option provided by EyeMed Vision Care. As referred to in this summary, an eligible Dependent is an employee’s lawful spouse, Domestic Partner or an unmarried Dependent child of the employee who is:

- A natural child
- A stepchild residing with the employee
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the employee or the employee’s spouse
- A child of a domestic partner, provided that the Domestic Partner is enrolled in the Plan

The definition of an eligible Dependent is subject to the following conditions and limitations:

- A dependent includes an employee’s dependent child under the age of twenty-six (26) years who is not offered vision coverage by his/her own employer
- A dependent includes an employee’s dependent child who is not able to be self-supporting by reason of mental or physical handicap

Domestic Partner means a person of the same or opposite gender who:

- is your sole domestic partner and such relationship is intended to remain so indefinitely;
- has resided with you for no less than one year and intends to do so indefinitely;
- is no less than 18 years of age and mentally competent;
- is not related by blood to a degree of closeness that would prohibit legal marriage;
- is not legally married to anyone nor has had another domestic partner within the prior 12 months;
- shares a close personal relationship with you and is jointly responsible for your common welfare and financial obligations and likewise. (The Plan Administrator may, during any time period, in which domestic partnership is claimed, require evidence of such joint responsibility by requesting copies of three or more of the following types of documentation):
 - a. Domestic partnership agreement;
 - b. Joint mortgage, lease, or deed
 - c. Joint ownership of a vehicle
 - d. Joint checking account or credit account

- e. Designation of domestic partner as primary beneficiary on life insurance or retirement contract
- f. Durable property and health care powers of attorney
- g. Other legal or financial documentation evidencing joint responsibility
- h. Has signed jointly with you, a Declaration Statement of Domestic Partnership.

Eligibility Requirements

Under the Medicare Medicaid and SCHIP Extension Act of 2007, new mandatory reporting requirements that become effective for the 2009 Plan Year require that the Plan Administrator of the Plan obtain and report to the Centers for Medicare & Medicaid, social security numbers for participants in the Plan. To satisfy this reporting requirement, Employees may be required to provide social security numbers for themselves and each of their Dependents in order to participate or to continue to participate in the Plan.

Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, if you or your Dependent lose state CHIP coverage or you or your Dependent become eligible for premium assistance through a state CHIP program, you may request enrollment in the Plan within 60 days of losing the state CHIP coverage or becoming eligible for the premium assistance.

Michelle's Law

If your Dependent child is covered by this Plan as a student, as defined in the definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) The date that is one year after the first day of the medically necessary leave of absence; or
- b) The date on which coverage would otherwise terminate under the terms of the Plan.

The child must be a Dependent under the terms of the Plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence. The Plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the Dependent child at the institution that: (1) starts while the Dependent child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the Dependent child to lose student status under the terms of the plan.

The Plan will recognize any child of an Eligible Employee who is recognized as an alternate recipient under a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is an order that is typically issued in or after divorce proceedings, and may create or recognize the right of an eligible employee's child to be covered under this Plan. Such an order must be qualified and issued by a court of competent jurisdiction or authorized state agency in order for this Plan to be bound by it. You can obtain a copy of the Plan's Qualified Medical Child Support Order procedures from the Plan Sponsor. Please contact the Plan Sponsor, as listed in the "general information" section of this summary, for more information regarding whether or not a medical child support order is "qualified".

**EYEMED VISION CARE
SELECT BENEFITS¹**

In-Network Benefits:

Eye Examination \$10 copay

A complete examination, refraction and prescription for eyeglass lenses are covered. Standard contact lens examinations are covered in full. You will receive a 10% discount on premium contact lens examinations. These may require additional fees for fitting and follow-up. Dilation is a covered procedure and is available at no additional cost to you. Routine eye exams are covered once every 12 months.

Eyeglass Lenses \$25 copay

Benefit includes standard uncoated single vision, bifocal or trifocal plastic lenses regardless of size or power. Polycarbonate lenses are covered in full. Other lens options are available for a discounted additional cost. Eyeglass Lenses are available once every 12 months.

Frames² \$0 copay

You may choose a frame up to a regular retail value of \$150. If you choose a frame that retails for more than \$150, you will receive a discount of 20% off the remaining balance difference. Frames are available every 24 months.

Contact Lenses² \$25 copay

Benefit includes conventional or disposable contact lenses up to an allowance of \$150. If you choose conventional contact lenses that retail for more than \$150, you will receive a discount of 15% off the remaining balance difference. If you choose disposable contact lenses in excess of the \$150 allowance, you are responsible for 100% of the remaining balance difference. If you require medically necessary contact lenses, there is no additional cost to you once you have paid your copayment. Contacts can be obtained from a network provider or replacement orders through mail order. Simply visit www.eyemed.com for details and a link to the order site. Contact lenses are available once every 12 months.

NOTE: Contact Lenses are in lieu of eyeglass lenses.

Out of Network Benefits:

You are responsible to pay the provider in full at the time of services are rendered. You may Now file out of network claims electronically. Go to:

[https://www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/
/](https://www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/)

You may still complete an out of network claim form and mail copies of the OON claim form with a detailed copy of the receipt. For reimbursements, simply call the EyeMed Customer Service Center at (866) 723-0514 to verify eligibility and receive a claim form. You may also obtain a claim from at www.eyemed.com. Then just mail the completed claim form with a copy of your bill to :

Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

You will be reimbursed for eligible expenses incurred by you or your covered dependents in accordance with the following schedule for out-of-network benefits:

Eye Exam

Eyeglass Lens	Up to \$20
Contact Lens Fit & Follow Up	Up to \$40

Standard Plastic Lenses

Single Vision	Up to \$ 5/pair
Bifocal	Up to \$ 20/pair
Trifocal	Up to \$ 25/pair

Frames	Up to \$ 60
Contact Lenses	Up to \$75

¹ Benefits cannot be used in conjunction with other discounts, promotions or prior orders.

² The applicable allowance amount may only be used once per benefit period.

Online Contact Lenses with ContactsDirect.com - You can now apply your in-network contact lens benefit at contactsdirect.com. Simply complete the online transaction form and the contacts will be delivered directly to your home.

Online Eyewear with Glasses.com - To make sure you get easy, convenient access to vision choices that best fit your lifestyle, we've added Glasses.com to our roster of thousands of independent providers and top optical retailers. This is great news for you because EyeMed members can now apply in-network vision benefits from anywhere, anytime. For additional information visit www.glasses.com.

Laser Vision Correction

Your plan includes a discount for laser vision correction procedures. Members receive a 15% discount off the price of LASIK or PRK procedures, or 5% off any promotional price, whichever is lower. Services are provided through the U.S. Laser Network, owned and administered by LCA Vision. Simply call (877) 5LASER6 to begin the process of receiving your discount.

Additional Available Discounts

Once you have exhausted your available annual benefits as listed under the 'EYEMED VISION CARE SELECT BENEFITS' section of this summary, unlimited pairs of glasses and contacts are available to you and your covered dependents through a network location for purchase at the following costs:

Lens Options (Add to lens prices listed on the previous page)- your cost:

Standard Progressive (No-Line Bifocal)	\$90
Polycarbonate	\$0
Scratch Resistant Coating	\$15
Ultraviolet Coating	\$15
Solid or Gradient Tint	\$15
Anti-Reflective Coating	\$45
Other Add-Ons and Services	20% off retail price

Lenses & Frames

Members receive a 40% discount off a complete pair eyeglass purchase once the funded benefit has been used.

Contact Lenses

Members receive a 15% discount off conventional contacts once the funded benefit has been used.

Thousands of Locations (Locations are subject to change.)

EyeMed Vision Care's nationwide locations include such familiar names as LensCrafters, most Pearle Vision Centers, Sears Optical, Target Optical, JC Penney Optical and thousands of independent doctors. For the location nearest you, call (866) 723-0514 Monday-Saturday 7:30 am to 11 pm and Sundays 11 am to pm Eastern Standard Time. Automated location information is available 24 hours. You can also visit the EyeMed Vision Care website at www.eyemed.com, for the Select Network of providers. Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Claims and Appeal Procedures

Vision Benefit

Before visiting a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that members call ahead for an appointment, although some retail locations may have walk-in appointments available. Upon arrival, the EyeMed Identification Card, if applicable, should be shown to the receptionist or sales associate, or if the ID card is not available, it should be stated that the member is participating in the Payless ShoeSource, Inc. vision care plan so that eligibility can be verified.

EyeMed Customer Service can be reached seven days a week Monday through Saturday 8:00 am to 11:00 pm and Sunday 11:00 am to 8:00 pm Eastern Time at (866) 723-0514.

Most EyeMed plans allow members to select the provider of their choice, in or out of the network. EyeMed has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through our in-network services. Members may have the flexibility to visit an out-of-network provider, with a reduction in benefits.

In-Network Vision Benefit

When vision services are received at a participating EyeMed Provider location, members are only responsible for the designated plan copays and any services or eyewear that exceed any allowances, as well as state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training). Providers verify eligibility and submit claims for reimbursement. The following steps outline how to access the in-network plan benefit.

1. Locate the nearest EyeMed Provider. Members may locate EyeMed providers nearest them by calling the Customer Care Center and utilizing the Interactive Voice Response (IVR) system, or by speaking with a Customer Service Representative, by referring to their member brochure or by accessing the Provider Locator Service through the website at www.eyemed.com.
2. Schedule an appointment. Members should identify themselves as having EyeMed benefits at this time.
3. Receive services. Members should present their ID card at the time of service to help expedite the process. Once eligibility is verified, members may access their benefits.

Out-of-Network Vision Benefit

EyeMed members who choose to use their vision benefits at a non-participating provider location will need to pay for all services and materials at the point of purchase. You may now submit your OON claim electronically. Please go to <https://www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/> and follow the instructions. You may still mail or fax an out-of-network claim form to EyeMed for reimbursement. Claims are managed by First American Administrators (“FAA”), a wholly-owned subsidiary of EyeMed Vision Care, LLC.

The following steps should be completed prior to submitting the out-of-network claim form.

1. Request an out-of-network claim form. Members may obtain the form through EyeMed’s website or by calling our Customer Care Center. The claim form will be mailed directly to the member within 24 hours. Forms can also be e-mailed or faxed.
2. Schedule an appointment. Members may make an appointment with the out-of-network provider of their choice.

3. Pay for all services. Members must pay for all services at the point of care and ask their provider for an itemized receipt.
4. Complete the Patient Information portion of your claim form.
5. Complete the Plan Information Portion of the claim form. This information can be found on your benefit card or by contacting your Human Resources Department.
6. Complete the Request for Reimbursement portion of the form.
7. Sign the claim form. If the patient is a minor, the parent or legal guardian is required to sign the claim form.

Attach itemized receipts from your provider to the claim form, and mail to: F A A / EyeMed Vision Care, Attn: OON Claims Processing, P.O. Box 8504, Mason, Ohio 45040-7111 or fax all the information to (866) 293-7373.

Filing Claims

Out-of-Network claim forms can be obtained from (866) 723-0514 or www.eyemed.com. All information on the claim form should be filled out completely, and submitted within 1 year from the date the services were provided. Claim forms should be mailed to the above address.

Timeframes for Processing Claims

Activity	Time Frame
Plan – Determination of Initial Claim <ul style="list-style-type: none"> • Initial Review Decision • Extension Period 	30 calendar days 15 calendar days
Plan – Notice of Incomplete Claim	Within time for initial determination, including extension period.
Claimant – Time to Complete Claim	45 calendar days
Plan – Determination of Claim after Receipt of Complete Information	Within time for initial determination, including extension period

All of the vision care services under this Plan are considered post service claims. If a claim for benefits is denied (in whole or in part), EyeMed will notify the member in writing of the specific reasons for the denial, and of the process for requesting a review of the denial.

Appeal of Denied Claims

A denied claim may be requested to be reviewed. To make this request, the member must send EyeMed a written letter of appeal no more than 180 calendar days after the date of the denied claim. The written letter of appeal should include the following:

- The claim number, a copy of the EyeMed denial information, or a copy of the EyeMed Explanation of Benefits.
- The item of vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the eye care provider that will assist EyeMed in completing its review of the appeal, such as documents, medical and/or financial records, questions or comments.

The written letter of appeal should be mailed to the following address:

EyeMed Vision Care
 Attn: Quality Assurance Dept.
 4000 Luxottica Place
 Mason, OH 45040

Timeframes for Appealed Claims

Activity	Time Frame
Claimant – Appeal of Adverse Determination	180 calendar days after the denial
Plan – Decision on Appeal	60 calendar days

EyeMed will review the appeal for benefits and notify the member in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure

If a member is dissatisfied with the services provided by an EyeMed Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Member Services toll free telephone number at (866) 723-0514. The EyeMed Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution is not able to be reached during the telephone call, the EyeMed Member Services representative will document all of the issues or questions raised. EyeMed will use its best efforts to contact the member within 4 business days with an acknowledgement to the issues or questions raised, and will resolve the issue within 30 calendar days. If the member is not satisfied with the resolution, they may appeal the grievance by using the appeal procedures set forth above.

For more information on member rights and how to obtain further review under the Employee Retirement Income Security Act of 1974, as amended (ERISA), please refer to the appropriate section of this Summary Plan Description.

COBRA CONTINUATION COVERAGE

Eligible employees and eligible dependents (except Domestic Partners) have the opportunity to continue their coverage in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as “COBRA Continuation Coverage.” This notice is intended as a summary of an eligible person’s rights and obligations under the provisions of that law.

ENTITLEMENT AND QUALIFYING EVENTS

Qualifying Events

Under COBRA, an eligible employee or eligible dependent, participating in the Plan (referred to herein as a “Covered Employee or a Covered Dependent”) may elect to continue health coverage if that coverage would otherwise terminate due to a “qualifying event.” Qualifying events are:

- a. A Covered Employee’s termination of employment, for reasons other than gross misconduct, or a reduction in work hours may constitute a qualifying event;
- b. Death of the Covered Employee;
- c. Divorce or legal separation of the Covered Employee and his spouse;
- d. A Covered Dependent child ceasing to satisfy the Plan’s definition of an Eligible Dependent child; or
- e. A Covered Employee’s entitlement to Medicare.

COBRA Qualified Beneficiaries

A COBRA Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former Covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee's period of COBRA Continuation Coverage, is also a COBRA Qualified Beneficiary.

MAXIMUM COVERAGE CONTINUATION PERIODS

General Rules

Coverage under COBRA may continue for up to:

- a. Eighteen (18) months if you are a Covered Employee or a Covered Dependent whose coverage would cease because of a termination of employment or reduction in work hours; or
- b. Twenty-nine (29) months (i.e. 18 plus 11) if you are a disabled individual who:
 - becomes entitled to the 18 months of continued coverage available after a Covered Employee’s termination of employment or reduction in work hours;
 - is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and
 - notifies the Plan of that disability determination within 60 days after you receive it and while you are still purchasing your first 18 months of COBRA.Please note that you are eligible for this additional 11 months of coverage, even if you are not disabled, if you are entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.
- c. Thirty-six (36) months, if you are a divorced or widowed spouse, or a child who has ceased to be a “dependent” under the terms of the Plan.

Multiple Qualifying Events

If a dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. *In no case will any period of COBRA Continuation Coverage exceed 36 months.*

Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the dependent spouse or dependent children may continue for up to 36 months from the date of the Medicare entitlement.

EARLY TERMINATION OF COBRA COVERAGE

Once you elect to continue your coverage, your coverage may continue for the period described above, unless:

- a. If you were entitled to 29 months of COBRA Continuation Coverage (due to your or another person's disability), the Social Security Administration determines that you (or such other person) are no longer disabled, in which case your extended COBRA Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;
- b. You become entitled to Medicare, after the date you elect COBRA Continuation Coverage;
- c. You fail to make a required monthly payment within the 30 day grace period pursuant to this provision;
- d. You become covered - after the date you elect COBRA Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;
- e. You become covered - *after the date you elect COBRA Continuation Coverage* - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or
- f. The Plan is terminated and the Employer maintains no group health plan for any of its active employees.

NOTIFICATION OF A QUALIFYING EVENT

To preserve your right to COBRA Continuation Coverage you must notify the Plan Sponsor within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of a "dependent", or of the Social Security Administration's determination of disability. In addition, if you were a disabled individual who obtained 29 months of COBRA Continuation Coverage, you must notify the COBRA Administrator of any determination by the Social Security Administration that you are no longer disabled. Notification to the COBRA Administrator must be made within 30 days of the date such determination is made. Contact the Plan Administrator if you have any questions.

BENEFITS THAT MAY CONTINUE

If you elect COBRA Continuation Coverage, it will be identical to the health coverage then being provided under the Plan to active Employees or, if you are a dependent, to covered dependents of active employees. You do not have to prove insurability to choose Continuation Coverage, but you do have to pay for it.

APPLICATION AND PAYMENT PROCEDURES

After you experience a COBRA qualifying event (and provide any notice required by the preceding “Notification of a Qualifying Event” section of this Plan), you will be sent a more detailed notice and an Application for Continued Coverage. To continue coverage under COBRA, you must complete and return the Application to the COBRA Administrator within 60 days from the later of the date the Application is sent to you or the date your coverage would otherwise terminate.

Your payment for the period from the date your coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if you elect COBRA Continuation Coverage on the 30th day of the 60-day election period, you must make your first payment by the 75th day after you elected COBRA Continuation Coverage, and the payment must be for the period of COBRA Continuation Coverage from the date you would otherwise lose coverage to that 75th day. Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods by the Plan Sponsor, and will not exceed 102% of the cost of coverage under the Plan for similarly situated covered persons. However, if you qualify for periods of extended coverage due to a disability (whether yours or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated covered persons, depending on whether the disabled person continued coverage during the extended coverage period.

SPECIAL TRADE ACT EXTENSION

Special COBRA rights apply to Eligible Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under a federal law called the Trade Act of 1974. These Eligible Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee’s group health plan coverage ended.

OTHER METHODS OF CONTINUING COVERAGE Family and Medical Leave Act

Regardless of the established leave policies of the Employer, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as outlined in the regulations issued by the Department of Labor, to the extent that Act applies. During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same basis as

coverage would have been provided if you had been continuously employed during the entire leave period.

Uniformed Services Employment and Reemployment Rights Act

You may have certain rights to continue or reacquire coverage if you engage in periods of uniformed service, and satisfy certain requirements upon the completion of that service. Your Plan Sponsor has additional information about these special rules.

ERISA RIGHTS STATEMENT

PARTICIPANTS' RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is normally required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can

take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

ERISA COMPLIANCE INFORMATION

Plan Name and Number

The Payless ShoeSource, Inc. Medical Plan (vision care benefit) PN 551

Employer/Plan Sponsor

Payless ShoeSource, Inc. and its affiliates adopting the Plan.

Identification Number

Employer Tax ID No.: 48-0674097

Address

Payless ShoeSource, Inc.
3231 S.E. Sixth Avenue
Topeka, KS 66607-2207

Type of plan

This is an Employee Welfare Benefit Plan providing vision care benefits.

Type of Administration

Employer and Insurer Administration. The Employer administers the Medical Plan except insofar as authority to administer the Medical Plan has been delegated to others. EyeMed Vision Care interprets the terms and provisions of the Medical Plan as they relate to the vision care benefit and makes all determinations as to when benefits are payable for particular claims.

Plan Administrator

Payless ShoeSource, Inc.
Corporate Benefits Department
3231 SE Sixth Avenue Topeka,
KS 66607-2207
(785) 233-5171

Vision Care Benefit Administrator

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

COBRA Administrator

COBRAGuard, Inc.
P.O. Box 504216
St. Louis, MO 63150

Agent for Service of Legal Process

The Plan Administrator

Plan Year

January 1st to December 31st

Plan Records

The Plan's records are kept on a Plan Year basis.

Plan Funding

The benefits provided under the Plan are fully insured and underwritten by Combined Insurance Company of America. Participating employees pay the full cost of membership in the Plan. Participating employee contributions, which are generally made by payroll deduction, are paid to EyeMed Vision Care. Benefits are paid by EyeMed Vision Care.

Fiduciary Discretion

Decisions, determinations or interpretations with respect to the Plan by a person or entity acting as a fiduciary (as that term is defined by ERISA) under the Plan shall be in that fiduciary's sole and absolute discretion. All such discretionary decisions, determinations and interpretations made by that fiduciary will be final and conclusive for any and all purposes.

Termination or Amendment of Plan

While the Plan Sponsor intends to maintain the Plan for an indefinite period of time, the Plan Sponsor reserves the right to terminate the Plan at will or amend the Plan at any time with respect to any or all Plan members, including without limitation, retirees, survivors and those participating through them. This right is subject to the provisions of the Plan document and applicable law and the provision that no termination or amendment shall impair any claim incurred as of the date of the amendment or termination.

The Plan may be amended either by written amendment, or by other written record of corporate action signed by the Plan Sponsor's Secretary or by any other person so authorized by or pursuant to authority of the Plan Sponsor's Board of Directors.