VISION EXPENSE BENEFITS

This section outlines the **fully insured Vision Plan** coverage; however, where the text in this chapter deviates from the certificate of coverage and summary of benefits produced by the vision plan insurance company, the insurance company documents will prevail. Contact the Vision Plan insurance company (whose name is listed on the Quick Reference chart in the front of this document) for a copy of vision plan insurance benefit information.

All medical plan participants are eligible for this Vision Plan. This Vision Plan offers services from network or non-network providers.

NETWORK PROVIDERS

The Vision Plan is a network of preferred vision providers (licensed ophthalmologist, optometrist or dispensing optician) who have a contract to provide discounted fees to you for services covered under this Vision Plan. By using the services of an In-Network provider, both you and the Plan pay less (see the Network column of the Schedule of Vision Benefits).

A current list of network service providers is available free of charge when you call the Vision Plan whose name, address and telephone number are noted on the Quick Reference Chart in the Introduction chapter of this document. To receive services, simply call a network vision provider and identify yourself as a member of the Vision plan.

NON-NETWORK PROVIDERS

Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, this plan will pay at the non-network benefit level as noted in the Schedule of Vision Benefits. The itemized bill reflecting the non-network provider's fees must be submitted to the Vision Plan Administrator for reimbursement. You will be reimbursed according to the Allowed Amount or the schedule below, whichever is less.

Non-network provider services may cost you more than if those same services were obtained from an In-Network provider. Non-Network Providers may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. <u>You can avoid balance billing by using In-Network providers.</u> (See the definitions of Allowed Amount and Balance Billing in the Definitions chapter of this document).

NOTE: Vision claims must be submitted to the Vision Plan Administrator <u>within 6 months of the date of service</u> or payment cannot be considered.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- A **vision exam** includes a professional eye examination and an eye refraction. The exam typically includes:
  - an assessment of your health history particularly as it is relevant to your vision,
  - external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens and lashes/eyelids,
  - internal exam including but not limited to an assessment of the lens and retina along with tononometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes' ability to focus light rays on the retina from a distance and close-up).
- **Contact Lens Exam** means a special examination of the eye and the surface of the eye (the cornea) for the purpose of helping you receive a proper fitting contact lens. This exam can include

a measurement of the curvature of the eye, assessment of the moisture/tear content of the eye, evaluation of the alignment of the lens on the surface of the eye, etc.

- **Dispensing Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.
- **Gonioscopy** is a special contact lens to look at the eye's aqueous area.
- **Fundus Photography** is a photo of the inside of the eye showing the optic nerve and retinal vessels.

SCHEDULE OF VISION BENEFITS

Covered Vision Benefits	Explanation See also the Vision Exclusions.	Plan Pays	
		Network Provider (Doctor)	Non-Network Provider
Vision Exam and analysis of visual function.	Payable once every 12 months.	100% after a $10 copay	Up to $35 per exam
Eyeglasses (frames and lenses)	• A single vision, lined bifocal, lined trifocal lenses or lenticular lenses every 12 months if needed; **and/or** • A frame not to exceed the frame allowance, every 24 months, if needed. This program provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a limit (determined by the Vision Plan Administrator) on the reimbursement for frames. Covered persons who select frames that exceed the frame allowance will pay the additional cost.	100% after a $15 copay for lenses and/or frames. Frame of your choice is covered/allowed up to $120, plus 20% discount off any Out-of-Pocket costs for frames. Scratch coating and polycarbonate lenses are payable with the copay.	Single vision (pair)*= Up to $25 Lined bifocal lenses (pair)*= Up to $40 Lined trifocal lenses (pair)*= Up to $55 Lenticular lenses (pair)* = Up to $80 Frame = Up to $45. *If only one lens is needed, the allowance will be one-half the pair allowance. Scratch coating and polycarbonate lenses are not payable.
Contact Lenses	• Once every 12 months in lieu of all other lens and frame benefits. When you choose contacts instead of glasses your $105 allowance applies to the cost of your contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.	Contacts that are medically necessary (as determined by the Vision Plan Administrator) because no less expensive professionally acceptable alternative is available: Covered in full Cosmetic (elective) contact lenses: 100%, the Plan pays up to $105.	Contacts required for vision correction (medically necessary as determined by the Vision Plan Administrator) = Up to $210 Cosmetic (elective) contact lenses (as determined by the Vision Plan Administrator) = Up to $105.
Low Vision Benefit	• The low vision benefit is available to covered persons who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by the Vision Plan Administrator. Maximum benefit available is $1,000 (excluding copayment) every two years. • Supplemental Testing: includes complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions including the prescription of corrective eyewear or vision aids where indicated. • Supplemental Care Aids: subsequent low vision aids as visually necessary or appropriate.	Supplemental Testing: Covered in full Supplemental Care Aids: You pay 25% of cost	Supplemental testing: up to $125 Supplemental Care Aids: You pay 25% of cost Reimbursement will be determined by the Vision Plan Administrator. There is no assurance that the reimbursement will be within 25% of the cost.
Diabetic Eyecare Program (DEP)	• This is an additional service for Type I diabetics to help preserve vision and prevent vision complications. DEP includes an eye exam and gonioscopy every 12 months, and extended ophthalmoscopy and fundus photography every 6 months	100% after a $20 copay for each service	No coverage.

NOTE: The lens allowance described in this Vision Plan is for a pair of lenses. If only one lens is needed, the allowance will be one-half of the pair allowance.

EXTRA DISCOUNTS AND SAVINGS: When visiting a network doctor you will receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
- 20% off additional prescription glasses and sunglasses.
- 15% discount off the cost of contact lens exam (fitting and evaluation).
- Exclusive pricing on annual supplies of popular brands of contacts.

VISION PLAN EXCLUSIONS

The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the basic cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras such as:

1. Oversized lenses (61mm or greater, except with prior authorization).
2. Progressive multi-focal lenses.
3. Blended lenses and Laminated lenses.
4. Contact lenses, except as otherwise stated in the Schedule of Vision Benefits.
5. Photochromic lenses; Tinted lenses, except pink #1 and #2.
6. Optional cosmetic processes.
7. Antireflective coating; Color coating and Mirror coating.
8. Cosmetic lenses; and UV (Ultraviolet) protected lenses.
9. Certain limitations on low vision care.
10. A frame that costs more than the Plan's allowance as noted in the Schedule of Vision Benefits.
11. Orthoptics or vision training, and any associated supplemental testing.
12. Plano (non-prescription) lenses (less than a $\pm$ diopter power) or two pair of glasses in lieu of bifocals.
13. Replacement of lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
14. Medical or surgical treatment of the eyes.
15. Corrective vision treatment of an experimental nature.
16. Costs for services and/or materials above the Plan Benefit allowances.
17. Services and/or material not indicated on the Schedule of Vision Benefits.
18. Insulin or any medication or supplies of any type.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

When you use the services of an In-Network vision provider, you should pay the provider for your appropriate copay along with any services you purchased that are not covered by the Vision Plan. The provider will typically send the remainder of their bill directly to the Vision Plan for reimbursement.

If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but within six (6) months of the date of service, submit the bill to the Vision Plan whose name and address are listed on the Quick Reference Chart in the front of this document. You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits. Vision claims submitted beyond six months of the date of service may not be considered for reimbursement.