

# Group Vision Care Policy



**Group Name:** LOYOLA UNIVERSITY MARYLAND  
**Group Number:** 12093416  
**Effective Date:** JULY 1, 2012

## Certificate of Coverage

Provided by:

MID-ATLANTIC VISION SERVICE PLAN, INC.  
3333 Quality Drive, Rancho Cordova, CA 95670  
(916) 851-5000 (800) 877-7195

This form is a summary of the Policy provisions and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Policy itself. A specimen copy of the Policy will be furnished upon request.

**DEFINITIONS:**

<b>ADDITIONAL BENEFIT RIDER</b>	The document attached to this Certificate of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Policy.
<b>BENEFIT AUTHORIZATION</b>	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
<b>COPAYMENTS</b>	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
<b>COVERED PERSON</b>	An Enrollee or eligible dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under the Policy.
<b>EMERGENCY CONDITION</b>	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
<b>ENROLLEE</b>	An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.
<b>EXPERIMENTAL NATURE</b>	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
<b>GROUP</b>	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.
<b>MEMBER DOCTOR</b>	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.
<b>NON-MEMBER PROVIDER</b>	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.
<b>PLAN BENEFITS</b>	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.
<b>PREMIUMS</b>	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which this plan shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this Policy.
<b>SCHEDULE OF PREMIUMS</b>	The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

## ELIGIBILITY FOR COVERAGE

**Enrollees:** To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

**Eligible Dependents:** If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any child of an Enrollee who has not obtained the limiting age as shown on the enclosed insert, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, grandchild, minor covered under guardianship or other child for whom a court or administrative agency holds the Enrollee responsible.

A dependent, unmarried child over the limiting age as shown on the enclosed insert may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical incapacities, and chiefly dependent upon the Enrollee for support and maintenance.

## PREMIUMS

Your Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by your Group.

## PROCEDURE FOR USING THE POLICY

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.
2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.
3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of your termination of coverage or the termination of the Policy. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Policy. VSP will pay the Member Doctor directly according to its agreement with the doctor.

**Note:** If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Non-Member Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

## **BENEFIT AUTHORIZATION PROCESS**

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Policy. When Covered Person requests services under this Policy, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Policy's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

## **BENEFITS AND COVERAGES**

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

**IMPORTANT: The benefits described below are typical services and materials available under most VSP Policies. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.**

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Policy in lieu of all other lens and frame benefits described herein for the current eligibility period.

Necessary contact lenses, together with professional services, will be provided as indicated on the enclosed insert.

When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown on the enclosed insert. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Policy includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. **THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS.** Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.
6. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

## **COPAYMENT**

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. **ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.**

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

**Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.**

**This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the option's extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Policy maintained by your Group Administrator.**

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

### **NOT COVERED**

**There is no benefit under this plan for professional services or materials connected with:**

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than  $\pm .50$  diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
6. Services/materials not indicated as covered Plan Benefits on the enclosed insert.

### **LIABILITY IN EVENT OF NON-PAYMENT**

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION PLAN OTHER THAN THOSE NOT COVERED BY THE Policy.

### **COMPLAINTS AND GRIEVANCES**

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

### **Claim Payments and Denials**

A. **Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. 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.

B. **Request for Appeals:** If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons

the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

**VSP  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670  
(800) 877-7195**

VSP's final review determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within sixty (60) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's final review determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring civil (court) action when all required reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

C. **Claim Appeals:** If a claim for benefits submitted by a Covered Person is denied by VSP in whole or in part, VSP will notify the Covered Person in writing, of the reason or reasons for the denial. Within one hundred eighty (180) after receipt of such notice, a Covered Person, or a health care provider acting on the Covered Person's behalf, may make a written request to VSP for a full review of such denial. The written request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied. This includes the name of VSP Enrollee, social security number of VSP Enrollee, and the Covered Person's name and date of birth. The Covered Person, or a health care provider acting on the Covered Person's behalf, may state the reasons the Covered Person, or the health care provider acting on the Covered Person's behalf, believes that the denial of the claim was in error and may provide any pertinent documents which the Covered Person, or the health care provider acting on the Covered Person's behalf, wishes to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. VSP's review determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person in writing within 30 days after receipt of a request for review concerning services not yet rendered, or within 45 working days after receipt if the review concerns services which have already been rendered unless special circumstances require an extension of time for processing. In cases where a resolution is not possible within 30 or 45 working days, such as those involving a vision examination, a letter will be sent to the Covered Person explaining the reason for delay. Written consent will be obtained from the Covered Person or health care provider acting on the Covered Person's behalf for an extension of not longer than an additional 30 working days.

#### **TERMINATION OF BENEFITS**

Terms and cancellation conditions of your vision care policy are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this Policy whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to you as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

#### **INDIVIDUAL CONTINUATION OF BENEFITS**

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

#### **THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

**MID-ATLANTIC VISION SERVICE PLAN, INC.**

**3333 Quality Drive  
Rancho Cordova, CA 95670**

Group Name: LOYOLA UNIVERSITY MARYLAND

Plan Number: 12093416

Effective Date: JULY 1, 2012

Plan Term: FORTY-EIGHT (48) MONTHS

**VISION CARE PLAN  
DISCLOSURE FORM AND EVIDENCE OF COVERAGE**

**PLAN ADMINISTRATOR:** Director of Benefits & Wellness  
(Name)  
4501 N Charles Street  
(Address)  
Baltimore, MD 21210-2699  
(City, State, Zip)

**MONTHLY PREMIUM:** YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

**ELIGIBILITY:** ENROLLEES ONLY ARE COVERED UNDER THIS POLICY. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **EXAM ONLY**

**EXAMINATION:** ONCE EVERY PLAN YEAR\*  
\*PLAN YEAR BEGINS JULY 1ST.

**TERM, TERMINATION AND RENEWAL:** AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

**TYPE OF ADMINISTRATION:** BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

**VSP'S ADDRESS IS:** VISION SERVICE PLAN  
3333 QUALITY DRIVE  
RANCHO CORDOVA, CA 95670

**MID-ATLANTIC VISION SERVICE PLAN, INC.**  
**SCHEDULE OF BENEFITS**  
**Exam Only – Members Only**

**GENERAL**

*This Schedule lists the vision care services to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as shown by the reimbursement provisions below, vision care services may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Policy to which it is attached.*

*When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement.*

**COPAYMENT**

*The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.*

*A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.*

**PLAN BENEFITS**

	<b>MEMBER DOCTOR BENEFIT</b>	<b>NON-MEMBER PROVIDER BENEFIT</b>
<b>VISION CARE SERVICES</b>		
<b><u>Eye Examination</u></b>	Covered in Full*	Up to \$ 52.00

*Complete initial vision analysis which includes a comprehensive examination of visual functions.*

*Subsequent regular eye examinations once every plan year beginning on July 1st.*

*\*Less any applicable Copayment.*

*Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.*

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

THIS PLAN/POLICY IS DESIGNED TO COVER AN EYE EXAMINATION ONLY.

There is no benefit for professional services or materials connected with:

- Costs associated with securing materials such as lenses and frames;
- Orthoptics or vision training and any associated supplemental testing;
- Medical or surgical treatment of the eyes;
- Costs above the Plan Benefit allowances as indicated on this Schedule;
- Services not indicated on this Schedule as covered Plan Benefits.

**THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.**



**MID-ATLANTIC VISION SERVICE PLAN, INC.**

**3333 Quality Drive  
Rancho Cordova, CA 95670**

Group Name: LOYOLA UNIVERSITY MARYLAND

Plan Number: 12093416

Effective Date: JULY 1, 2012

Plan Term: FORTY-EIGHT (48) MONTHS

**VISION CARE PLAN  
DISCLOSURE FORM AND EVIDENCE OF COVERAGE**

**PLAN ADMINISTRATOR:** Director of Benefits & Wellness  
(Name)  
4501 N Charles Street  
(Address)  
Baltimore, MD 21210-2699  
(City, State, Zip)

**MONTHLY PREMIUM:** YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

**ELIGIBILITY:** ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **SIGNATURE PLAN**

**EXAMINATION:** ONCE EVERY PLAN YEAR\*  
**LENSES:** ONCE EVERY PLAN YEAR\*  
**FRAMES:** ONCE EVERY PLAN YEAR\*  
\*PLAN YEAR BEGINS JULY 1ST.

**TERM, TERMINATION AND RENEWAL:** AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

**TYPE OF ADMINISTRATION:** BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

**VSP'S ADDRESS IS:** VISION SERVICE PLAN  
3333 QUALITY DRIVE  
RANCHO CORDOVA, CA 95670

**MID-ATLANTIC VISION SERVICE PLAN, INC.  
SCHEDULE OF BENEFITS  
Signature Plan**

**GENERAL**

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Policy to which it is attached.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

**COPAYMENT**

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional \$20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

**PLAN BENEFITS**

<b><u>VISION CARE SERVICES</u></b>	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
<b><u>Eye Examination</u></b>	Covered in Full*	Up to \$ 52.00*
Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.		
Subsequent regular eye examinations once every plan year beginning on July 1st.		
*Less any applicable Copayment.		

**VISION CARE MATERIALS**

<b><u>Lenses</u></b>	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
Single Vision	Covered in full*	Up to \$ 55.00*
Bifocal	Covered in full*	Up to \$ 75.00*
Trifocal	Covered in full*	Up to \$ 100.00*
Lenticular	Covered in full*	Up to \$ 125.00*
Available once every plan year beginning on July 1st.		
<b><u>Frames</u></b>	Covered up to Plan Allowance*	Up to \$ 70.00*
Available once every plan year beginning on July 1st.		

\*Less any applicable Copayment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

**CONTACT LENSES**

Contact lenses are available once every plan year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

**Necessary-**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

**Professional Fees and Materials**

**Professional Fees and Materials**

Covered in full\*

Up to \$210.00\*

**Elective -**

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

Elective Contact Lens fitting and evaluation\*\* services are covered in full once every plan year, after a maximum \$60.00 Copayment.

**Materials**

**Professional Fees and Materials**

Up to \$130.00

Up to \$105.00

\*Subject to Copayment

\*\*15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

**LOW VISION BENEFIT**

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

**Supplementary Testing**

Covered in Full

Up to \$125.00

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**

75% of Cost

75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

**Benefit Maximum**

The maximum benefit available is \$1000.00 (excluding Copayment) every two years.

## **NON-MEMBER PROVIDER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

## **PATIENT OPTIONS**

This Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

## **NOT COVERED**

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a  $\pm .50$  diopter power); or 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;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF VSP'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

**THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.**

**MID-ATLANTIC VISION SERVICE PLAN, INC.  
ADDITIONAL BENEFIT RIDER  
DIABETIC EYECARE PLUS PROGRAM**

**GENERAL**

This Rider lists additional vision care benefits to which Covered Persons of MID-ATLANTIC VISION SERVICE PLAN, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

**ELIGIBILITY**

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner: The domestic partner of the same gender as Enrollee, or the opposite gender of Enrollee if one partner is over age 62, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits. The domestic partner's dependent children are also covered provided they depend upon the Enrollee for support and maintenance.
- Dependent Parent
- Any child of Enrollee, including 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.

Dependent children are covered up until the end of the month in which they attain the age of 26 years.

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.

**PROGRAM DESCRIPTION**

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- trouble focusing
- transient loss of vision
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema

**REFERRALS**

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

**PLAN BENEFITS  
MEMBER DOCTORS**

**COVERED SERVICES**

**Eye Examination:** Covered in full after a Copayment of \$20.00.

**Special Ophthalmological Services:** Covered in Full.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

**NOT COVERED**

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

**DIABETIC EYECARE PLUS PROGRAM DEFINITIONS**

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula

**DIABETIC EYECARE PROGRAM DEFINITIONS**

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas makes insufficient insulin or can't efficiently use it.
Fundus Photography	Taking photos of the inside of the eye that show the optic nerve and retinal vessels.
Extended Ophthalmoscopy	A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.
Gonioscopy	Use of a special contact lens to look at the eye's aqueous drainage area.

## **ADDENDUM**

### **EVIDENCE OF COVERAGE & DISCLOSURE FORM**

Please note the following revisions to your Evidence of Coverage and Disclosure Form. Keep this document with your Evidence of Coverage and Disclosure Form for a complete and accurate description of your benefits.

1. The following provision is added to the section titled **DEPENDENT ELIGIBILITY**:
  - (1) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and
  - (2) The dependent parent of the Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits.