



IV. Vision Care Program

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About This Section

In addition to the Medical and Dental benefits, the Plan also provides Vision Care benefits. Under the Vision Care program, you can use network or non-network providers, so you have choice and flexibility in obtaining the vision care you need. This section describes your benefits and options under the Vision Care program.

Some of the terms and phrases used in this benefits document have a specific meaning. Please refer to the *Important Terms* section of this document for further information.

You should also refer to the *Benefits Highlights* and the *Additional Information About Your Benefits* sections of this document for more important information regarding eligibility, how contributions are made, how elections can be changed, how to file claims, your right to continue health care coverage when coverage is lost and your rights under ERISA.

An Overview of the Vision Care Program

The Vision Care program, administered by Vision Service Plan (VSP), helps pay for the cost of visually necessary and appropriate vision expenses such as exams, lenses and frames, or contact lenses.

VSP has contracted with an extensive network of optometrists and ophthalmologists across the country to provide professional vision care. You can use VSP network providers, or providers outside the VSP network.

Below is a comparison of the network and non-network benefits available to you under the Vision Care program.

| | <i>VSP Provider</i> | <i>Non-VSP Provider</i> |
|--|--|-------------------------|
| <i>Annual deductible</i> | \$25 per individual (network and non-network combined) | |
| <i>Vision exam (once every 12 months)</i> | 100% | up to \$40 |
| <i>Prescribed lenses (once every 12 months)</i> | | |
| <i>Single vision</i> | 100% | up to \$40 |
| <i>Lined bifocal</i> | 100% | up to \$60 |
| <i>Lined trifocal</i> | 100% | up to \$80 |
| <i>Tints</i> | 100% | up to \$5 |
| <i>Contacts (once every 12 months)</i> | Up to \$150 | up to \$150 |
| <i>Frames (once every 12 months; not all frames are covered)</i> | 100% up to \$150 plan allowance, plus 20% off any out-of-pocket costs. | up to \$45 |

How the Vision Care Program Works

When you receive care, you can choose to use providers in the vision care network or obtain services from non-network providers. Whether you choose in-network or non-network providers, you must pay a \$25 deductible per individual when you receive care. Your \$25 deductible is applied to either the cost of your exam or eyewear covered under the plan.

Benefits under the Vision Care program are separate from benefits under the medical program. Your out-of-pocket vision care expenses do not count toward any out-of-pocket limit in the medical program.

Network Benefits

Your benefits are greater when you use VSP network providers. Once you have paid your deductible, most services are covered at 100%.

Your vision benefits will also cover in full the choice of one of the following lens enhancements for you and each covered dependent when you use an in-network provider.

- Additional \$100 frame allowance or \$50 contact lens allowance
- Progressive lenses – Plastic (Standard, Premium & Custom)
- Tints/Photochromic adaptive lenses
- Anti-reflective coating
- Polycarbonate lenses for children

For all other lens enhancements you will enjoy a 35-40% discount off the usual and customary charge.

The VSP provider network consists of a large network of optometrists, ophthalmologists and opticians nationwide. To obtain a list of current network providers near you, call 1-800-877-7195 or visit the website at www.vsp.com.

When making an appointment with a network provider, identify yourself as a VSP member. The VSP provider will contact VSP directly to verify your eligibility and plan coverage and to obtain authorization for services and eyewear. There are no claim forms to complete when using a network provider. Your provider will submit the necessary paperwork directly to VSP for reimbursement.

Non-Network Benefits

If you use non-network providers, you can choose any optometrist, ophthalmologist or optician you wish. However, you'll receive a lesser benefit and typically pay more in out-of-pocket expenses. You must pay the provider in full for vision care services and submit a claim for reimbursement. Once you have met the deductible, the plan will pay up to the scheduled amounts as described in the previous chart. You are responsible for any charges in excess of the amount paid by the Plan.

Claiming Benefits

If you use a VSP network provider, the provider will file for reimbursement from VSP. If you choose a non-network provider, you must file the claim with VSP within six months after receiving the care or service. You can obtain an out-of-network claim form at www.vsp.com or you can call VSP at 1-800-877-7195.

If a claim is denied by VSP, you may request a review of the denial. See the *Benefits Highlights* section of this document for more information on reviewing denied claims.

Covered Expenses and Services

The Vision Care program provides benefits for the following up to once every 12 months (not every calendar year) based on your last date of service:

- Eye examination
- Medically necessary lenses
- Frames
- Contact lenses in lieu of lenses and a frame.

If you use a VSP network provider, you are also eligible for certain discounts, including discounts on the purchase of additional prescription glasses and sunglasses, scratch resistant and anti-reflective coatings, and discounts for laser vision correction.

These discounts are available only from a VSP network doctor within 12 months of the last examination by that VSP doctor.

Low Vision Benefit

Members who have severe visual problems that are not correctable with regular lenses may be eligible for the Low Vision Benefit. If the patient uses a VSP network doctor, supplementary testing is covered in full and supplemental care is covered at 75% of the cost, to a maximum of \$1,000 every two years. The network doctor is responsible for gaining prior approval from VSP. For Low Vision Benefits obtained from a non-network doctor, the patient pays the non-network doctor his full fee. VSP will reimburse the patient the amount VSP would have paid a network doctor.

Expenses and Services Not Covered

The following list is intended to give you a general description of the services and eyewear not covered by the vision plan. There may be services and supplies in addition to these that are not covered by the plan. Some expenses not covered by the vision plan may be eligible for reimbursement through the health care flexible spending account. See the *Flexible Spending Accounts* section of this document for more information.

The following types of services are not covered under the Vision Care program:

- Treatment for medically-related eye conditions
- Costs beyond the basic cost allowed for services and supplies, including frames over the plan allowance, oversize lenses, progressive multifocal lenses, coating, laminating or UV protection of lens or lenses, and blended or cosmetic lenses
- Services or eyewear from the company's medical department

- Orthoptics, vision training or aniseikonia
- Expenses for services or eyewear incurred for fashion reasons
- Non-prescription sunglasses, safety lenses or goggles
- Replacement of lenses or frames that are lost or broken
- Eye exam or corrective eyewear required as a condition of employment
- Corrective vision treatment of an experimental nature, such as radial kerotomy
- Injury or sickness compensable under Workers' Compensation or the Occupational Disease Act
- Injury from declared or undeclared war
- Intentionally self-inflicted injury or sickness.