Vision Examination Rider

Your *Certificate of Coverage* is amended as described in this document. This Rider becomes a part of your Contract and is subject to all its provisions . Please refer to all sections of your Contract, including your *Outline of Coverage* for guidelines on coverage and Cost-Sharing details.

1. Vision Care

The chapter in your Certificate entitled "Covered Services" is hereby amended.

The following covered language is *ADDED*:

Vision Care

We cover one routine vision examination each calendar year. This exam assesses your visual functions to:

- determine if you have any visual problems and/or abnormalities; and
- prescribe any necessary corrective eyewear.

We do not cover the evaluation and fitting of contact lenses, medical related services, or additional supplemental tests as part of this examination.

2. General Provisions

Your vision benefits are administered by Vision Service Plan (VSP). To receive the best benefits for vision care, you must obtain services and materials through a VSP Network Provider. For a list of providers, visit **www.vsp.com** or call VSP at (800) 877-7195.

There is a different Allowed Amount for Out-of-Network Providers than there is for Network Providers. If you decide not to see a VSP Network Provider, you may pay a larger share of the cost. You must pay for your services at the time of your appointment. Follow the instructions below to be reimbursed for Out-of-Network services.

3. Claim Filing

Your VSP Network Provider will file your claim on your behalf. VSP will reimburse your Provider directly.

To receive reimbursement when you visit an Out-of-Network Provider, you must pay for your services up front. Services are reimbursed only up to the Allowed Amount for Covered Services. Services are reimbursed based on the VSP Out-of-Network reimbursement schedule, minus any applicable Cost-Sharing. To receive reimbursement when you visit an Out-of-Network Provider, sign on to **www.vsp.com**, select the *Out-of-Network Reimbursement Form* and follow the instructions. You will need to submit with the Reimbursement Form, an itemized receipt listing the services received along with the patient's name and the covered subscriber's name and ID number. Out-of-Network claims must be submitted to VSP within six months of service. Mail the original claims reimbursement request and receipts to the address included on the form.

4. Exclusions

We do not cover services or supplies for:

- costs associated with securing materials such as lenses and frames;
- vision training or orthoptics and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- replacement of lenses and frames furnished under this Plan 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 Allowed Amount;
- services and/or materials not indicated as a covered Plan Benefit;
- vision materials (lenses, frames, etc.) for refractive purposes unless you need them to replace the lens of the eye and the lens was not replaced at the time of Surgery (unless your Group has purchased a vision materials rider); and
- any eye examination or corrective eyewear required by an employer as a condition of employment.

General Exclusions in your Certificate of Coverage also apply.

Don C. George
President and CEO