Vision Materials Benefit 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 Materials

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

The following covered language is *ADDED*:

Vision Materials

We cover the following supplies and services:

- one pair of frames and lenses for prescription glasses and related Professional services each calendar year; or
- contact lenses and related Professional services each calendar year (in lieu of frames and lenses); and
- Professional services for low vision.

Frames and lenses are subject to the Cost-Sharing (Co-payment, Deductibles, Co-insurance, and amounts over an Allowed Amount) as shown on your *Outline of Coverage* and explained in your Certificate. Cost-Sharing for vision materials is separate from the Cost-Sharing for your vision exam.

Please note that we do not cover "Cosmetic" (those which we do not consider "necessary") frames and lenses as described below.

Frames for Prescription Glasses

We cover a frame of your choice up to a $120 Allowed Amount. A Vision Service Plan (VSP) Network Provider will give you a 20 percent discount on any amount over the Allowed Amount.

Lenses for Prescription Glasses

We cover single vision, lined bifocal, and lined trifocal lenses when purchased from a VSP Network Provider. When you select non-Covered Lens Enhancements you will be responsible for the full cost of the Lens Enhancements after the VSP discount has been applied. Some example of non-Covered Lens Enhancements are:

- progressive lenses;
- oversize lenses;
- polycarbonate lenses;
- scratch-resistant coating; or
- anti-reflective lenses.

Contact Lenses

When you choose contact lenses instead of glasses, we cover costs associated with contact lenses up to $105. The Allowed Amount applies to the cost of your contact lenses, and the fitting and an evaluation exam.

We do not cover contact lenses that are solely for cosmetic purposes (for example, to change your eye color).

Necessary Contact Lenses

When contact lenses are necessary because of eye conditions such as aphakia, anisometropia, high ametropia, nystagmus, keratoconus or other medical conditions, you pay only your Co-Payment for vision materials if you use a VSP Network Provider. Your Provider must get Prior Approval from VSP.

If you choose an Out-of-Network Provider for necessary contact lenses, you must pay for your services up front. Follow the instructions in Section Three of this document to file your claim. VSP will review your claim for medical necessity and decide if the necessary contact lenses will be covered. If your services are approved, you will be reimbursed up to the Allowed Amount.

Related Professional Services

When your annual vision exam (as described in your Contract) indicates that prescription glasses or contact lenses are necessary for your proper vision, we cover Professional services necessary to:

- prescribe and order proper lenses;
- assist you in the selection of a frame;
- verify the accuracy of the finished lenses;
- adjust and fit your prescription glasses properly;
- perform necessary follow-up work; and/or
- adjust your frames to maintain comfort and efficiency at a later date, if necessary.

Low Vision

If your vision cannot be corrected to 20/70 with the use of spectacle lenses, but your acuity is not worse than 20/200, we cover supplemental testing and a therapy program which can include:

- low vision prescription services;
- supplemental testing for low vision evaluation; and

- visual aids.

Your Network Provider must get Prior Approval from VSP for low vision services or aids. VSP provides a $1,000 maximum benefit every two years (includes one supplemental exam/evaluation and materials). If supplemental testing is approved, it will be covered at 100 percent of the Allowed Amount by VSP every two years. If aids are approved, VSP will pay 75 percent of the approved amount up to a maximum of $1,000 (less any amount paid for supplemental testing) per member every two years. The member is responsible for the remaining 25 percent of the approved amount plus any amount over the maximum.

If you choose an Out-of-Network Provider for low vision services or aids, you must pay for your services up front. Follow the instructions in Section 3 of this rider to file your claim. VSP will review your services and decide if they are covered. If your services are approved, you will be reimbursed up to our Allowed Amount.

2. General Provisions

Requirements

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;
- lenses and frames furnished under this program which are lost, broken or scratched (these will only be replaced at the normal intervals when benefits are otherwise available);
- medical or surgical treatment of the eyes (refer to your Certificate); and
- any eye exam 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