Your Vision Care benefits are designed to provide you and your family with coverage for routine eye care.

For more information on ...

- How Vision Service Plan Works  4—3
- Summary of Benefits  4—4
- Other Important Information  4—5
## Highlights

### Your Benefits …

**… Provide Vision Care Regardless of the Medical Plan You Select**

Vision Care benefits provided by Vision Service Plan (VSP) are the same under each Medical Plan option. You are covered automatically for vision benefits when you enroll in a Medical Plan.

**… Offer Coverage for Both You and Your Eligible Dependents**

You may enroll your eligible dependents for coverage under the same plan in which you are enrolled.
How Vision Service Plan Works

VSP offers increased benefits when you see an in-network provider. A list of VSP in-network providers is available on the provider directories at [www.vsp.com](http://www.vsp.com) or by calling VSP at 1-800-877-7195.

You do not need a referral from a primary care physician to see an optometrist for a routine eye exam. You use your vision benefit, not your medical benefit, for routine eye care.

See the Summary of Benefits for a summary of the co-payments, deductibles, coinsurance, and related limits under the plan.

Administrative Information

Information about the administration of your Vision Care benefits can be found in the chapter titled “Administrative Information.”

What happens to your benefits when ...

For more information about what happens to your Vision Care benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the “About Your Benefits” chapter.
# Summary of Benefits

Provided by VSP through the VSP Choice Network

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Services</strong></td>
<td>No charge for yearly exam</td>
<td>Allowance of up to:</td>
</tr>
<tr>
<td></td>
<td>No charge for lenses every 12 months: single vision,</td>
<td>• Exam: $45</td>
</tr>
<tr>
<td></td>
<td>bifocal, trifocal, or polycarbonate (for dependent children)</td>
<td>• Single vision: $30</td>
</tr>
<tr>
<td></td>
<td>Frames allowance of up to $120 plus 20% off excess of $120 every 24 months;</td>
<td>• Bifocals: $50</td>
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<tr>
<td></td>
<td><strong>OR</strong></td>
<td>• Trifocals: $65</td>
</tr>
<tr>
<td></td>
<td>Contact lens every 12 months covered up to $120 allowance; allowance</td>
<td>• Frames: $70</td>
</tr>
<tr>
<td></td>
<td>applies to cost of contacts. Contact lens exam (evaluation and fitting fee)</td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>(evaluation and fitting fee) subject to no more than $60 patient copay.</td>
<td>• Elective contacts: $105</td>
</tr>
<tr>
<td><strong>Lens Enhancements</strong></td>
<td>20–25% discount on lens enhancements and upgrades</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Discounts</strong></td>
<td>20% discount on additional prescription glasses and sunglasses including</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lens enhancements from any VSP provider within 12 months of your last eye</td>
<td>Laser vision correction services at reduced cost through VSP network doctors and</td>
</tr>
<tr>
<td></td>
<td>exam.</td>
<td>contracted laser surgery centers</td>
</tr>
<tr>
<td></td>
<td>In-Network Provider Benefit—Supplemental care aids covered 75% of cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Provider Benefit—Supplemental care aids covered 75% of cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit maximum available is $1,000 every two years.</td>
<td></td>
</tr>
</tbody>
</table>

### Necessary Contact Lenses

Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by Covered Person’s Member Doctor or Non-Member Provider. Prior review and approval by VSP are required for Covered Person to be eligible for necessary contact lenses.

- In-Network Provider Benefit—Professional fees and materials covered in full
- Out-of-Network Provider Benefit—Professional fees and materials covered up to $210

### Low Vision Benefit

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

- In-Network Provider Benefit—Supplementary testing covered in full
- Out-of-Network Provider Benefit—Supplementary testing covered up to $125

### Out-of-Network Provider Benefit

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and co-payment 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% co-payment feature.
Summary of Benefits (cont.)

Diabetic Eyecare Benefit
The VSP Diabetic Eyecare Program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration including medical follow-up exams, visual fields and acuity tests, specialized screenings and diagnostic tests, diagnostic imaging of the retina and optic nerve, and retinal screening for eligible members with diabetes. The program provides secondary coverage to your medical plan’s primary coverage for non-surgical medical eye conditions at participating VSP Providers. Members can self-refer, visit their VSP Provider as often as needed, and pay a $20 copay for services.

TruHearing Hearing Aid Discount Program
VSP members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too. Contact TruHearing at 877-396-7194 and mention that you are a VSP member. They will schedule an appointment with a local provider. For more information, contact TruHearing or visit their website at truhearing.com/vsp.

Other Important Information

Vision Services Claims Review and Appeal Procedures

Your Provider Submits a Claim
You pay your provider any applicable co-pays, taxes, and any amount over the coverage allotment. Your provider then submits a claim to VSP, and VSP pays the provider directly for your services and eyewear. Not all providers will submit a claim to VSP; ask the provider before you receive services.

Out-of-Network Claims Procedures
When you see a provider other than a VSP doctor, you must submit a claim to VSP for reimbursement. You have 6 months from the date of service to submit a claim for reimbursement. There are two ways to submit a claim to VSP.

Submitting a Claim
You can submit a claim online by logging on to www.vsp.com and clicking on “file a claim to request reimbursement” on the home page. Complete the form, scan receipts, and submit the claim.

Pay the provider in full for services and eyewear received, including taxes. Submit your receipt with an itemized list of services and eyewear using the VSP Member Reimbursement Form. VSP then reimburses you the allotted amount based on your coverage. Log on to www.vsp.com to access the form. For questions about submitting a claim, contact Member Services or call VSP at 800-877-7195.

Mail the completed claim, including form and receipts, to:

VSP
PO Box 385018
Birmingham, AL 35238-5018

Claim Denial Appeals
If, under the terms of this plan, a claim is denied in whole or in part, a request may be submitted to VSP by the Covered Person or Covered Person’s authorized representative for a full review of the denial. The Covered Person may designate any person, including his/her provider, as the authorized representative. References in this section to “Covered Person” include the Covered Person’s authorized representative, where applicable.
Other Important Information (cont.)

Initial Appeal
The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP enrollee’s name, the VSP enrollee’s Member Identification Number, the Covered Person’s name and date of birth, the provider of services, and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person also may submit written comments or supporting documentation concerning the claim to assist in VSP’s review. Mail the appeal to:

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

VSP’s response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within 30 calendar days after receipt of a request for an appeal from the Covered Person.

Second-Level Appeal
If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second-level appeal. Within 60 calendar days after receipt of VSP’s response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies
When the Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise the Covered Person to contact the US Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of the Employee Retirement Income Security Act of 1974 [Section 502(a)(1)(B)] [29 U.S.C. 1132(a)(1)(B)], the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

Time of Action
No action in law or in equity shall be brought to recover on the plan prior to the Covered Person exhausting his grievance rights as described above and/or prior to the expiration of 60 days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of 6 years from the last date that the claim and any applicable invoices may be submitted to VSP, in accordance with the terms of this plan.