

Client Vision Care Plan



Vision Care for Life

Client Name:	LINCOLNWAY AREA AFFILIATION OF PARTICIPATING SCHOOL DISTRICTS
Client Number:	12019596
Effective Date:	JULY 1, 2021

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN OF ILLINOIS, NFP
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. 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.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to 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 Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

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 be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	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, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	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.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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 to the end of the month in which they turn age 26.

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.

PLAN BENEFITS VSP PREFERRED PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$175.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a \$60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY

Necessary Contact Lenses are covered up to \$210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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 to the end of the month in which they turn age 26.

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.

PLAN BENEFITS VSP PREFERRED PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$175.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a \$60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY

Necessary Contact Lenses are covered up to \$210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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.

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.

PLAN BENEFITS VSP PREFERRED PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$175.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a \$60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY

Necessary Contact Lenses are covered up to \$210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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 to the end of the month in which they turn age 26.

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.

PLAN BENEFITS VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$130.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a \$60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY

Necessary Contact Lenses are covered up to \$210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to \$1000.00*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

VISION SERVICE PLAN OF ILLINOIS, NFP ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("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 Plan or Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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 to the end of the month in which they turn age 26.

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 Program ("DEP") 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 |
| • tunnel vision | • visual distortion |

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

- diabetic retinopathy
- rubeosis
- diabetic macular edema

- age-related macular degeneration
- glaucoma

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then 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.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Preferred Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

REFERRALS

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

If the Covered Person requires services beyond the scope of DEP Plus, the VSP Preferred Provider 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 VSP Preferred Provider in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDER

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 covered Plan Benefits.
2. Frames, spectacle 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 and/or supplies.
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

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, “straight ahead” central vision necessary for reading, driving, identifying faces and performing other daily tasks.
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.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

PLAN BENEFITS

OPEN ACCESS PROVIDERS

An Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to \$ 100.00 after a \$20.00 Copayment.

Special Ophthalmological Services: Covered up to \$120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSPs quality standards.

EXHIBIT C

ADDITIONAL BENEFIT RIDER SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, 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 to the end of the month in which they turn age 26.

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.

Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

- | | |
|-----------------------------|--|
| • ocular discomfort or pain | • recent onset of eye muscle dysfunction |
| • transient loss of vision | • ocular foreign body sensation |
| • flashes or floaters | • pain in or around the eyes |
| • ocular trauma | • swollen lids |
| • diplopia | • red eyes |

CONDITIONS

Examples of conditions which may require management under the PEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then 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.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Preferred Provider and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Preferred Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Preferred Provider 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 VSP Preferred Provider in order to obtain Plan Benefits.

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of \$20.00.

Special Ophthalmological Services: Covered in Full

Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

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

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.

Transient Loss of Vision Temporary loss of vision.

PLAN BENEFITS

OPEN ACCESS PROVIDERS

An Eyecare Professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered up to \$100.00 less a Copayment amount of \$20.00.

Special Ophthalmological Services: Covered up to \$120.00 per individual service.

Eye and Ocular Adnexa Services: Covered up to \$120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: LINCOLNWAY AREA AFFILIATION OF PARTICIPATING SCHOOL DISTRICTS
Group ID: 12019596
Effective Date: JULY 1, 2021

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	\$0.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: \$25.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam	Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: LINCOLNWAY AREA AFFILIATION OF PARTICIPATING SCHOOL DISTRICTS
Group ID: 12019596
Effective Date: JULY 1, 2021

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	\$10.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: \$25.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam	Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.