

# Group Vision Care Plan



Vision Care for Life

Group Name: LITTLETON PUBLIC SCHOOLS  
Group Number: 12056608  
Effective Date: JULY 1, 2016

## Evidence of Coverage

Provided by:

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

**To be filled in by employer in the event this document is used to develop a Summary Plan Description:**

NAME OF EMPLOYER:  
NAME OF PLAN:  
PRINCIPAL ADDRESS:

EMPLOYER I.D.#:

PLAN #:

PLAN ADMINISTRATOR:  
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

This form is a summary of the Plan provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Plan itself. A copy of the Plan will be furnished on request.

**DEFINITIONS:**

<b>ADDITIONAL BENEFIT RIDER</b>	The document attached to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
<b>ANISOMETROPIA</b>	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
<b>BENEFIT AUTHORIZATION</b>	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
<b>COPAYMENTS</b>	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits that are not fully covered.
<b>COVERED PERSON</b>	An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.
<b>ELIGIBLE DEPENDENT</b>	Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under the provisions of the Plan under which such Enrollee is covered.
<b>EMERGENCY CONDITION</b>	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
<b>ENROLLEE</b>	An employee or member of Group who meets the criteria for eligibility specified under the provisions of the Plan.
<b>EXPERIMENTAL NATURE</b>	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
<b>GROUP</b>	An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
<b>KERATOCONUS</b>	A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

<b>MEMBER DOCTOR</b>	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
<b>NON-MEMBER PROVIDER</b>	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.
<b>PLAN BENEFITS</b>	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.
<b>PREMIUMS</b>	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which the Plan shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.
<b>SCHEDULE OF PREMIUMS</b>	The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

**BENEFITS AND COVERAGES**

**IMPORTANT:** The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. 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 not required for Covered Person to be eligible for Necessary Contact Lenses..

Elective or Necessary contact lenses are available in lieu of spectacle lenses and frames for the current eligibility as indicated on the enclosed insert.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

Although a low vision benefit is available to Insureds diagnosed as having severe visual problems (i.e., partial sight), it is subject to limitations. Consult your Member Doctor or Benefits Representative for details. **There is no benefit for professional services or materials connected with:**

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than  $\pm .50$  diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
5. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.

## **ELIGIBILITY FOR COVERAGE**

**Enrollees:** To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

**Eligible Dependents:** If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, the civil union partner of any Enrollee, and any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible from the moment of birth who has not obtained the limiting age as shown on the enclosed insert page.

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 the enrollee for support and maintenance.

## **PREMIUMS**

The Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by the Group.

## **COPAYMENT**

The benefits described herein are available to you from any participating Member Doctor, provided you follow the proper procedures by obtaining Benefit Authorization. THERE MAY BE A COPAYMENT AMOUNT PAYABLE BY YOU TO THE MEMBER DOCTOR AT THE TIME OF THE EXAMINATION. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

## **CHOICE OF PROVIDERS**

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment).

When vision care services are received from a Non-Member Provider, you will be reimbursed for such benefits according to the schedule shown on the enclosed insert, less any applicable Copayment.

## **BENEFIT AUTHORIZATION PROCESS**

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Insured by Group under this Plan. When Covered Person requests services under this Plan, Covered Person prior utilization of Plan Benefits will be reviewed by VSP to determine if Insured is eligible for new services based upon Covered Person's Plan level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

## **PROCEDURE FOR USING THE PLAN**

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or the Member Doctor. If you are eligible, VSP will provide Benefit Authorization to you or the Member Doctor.
2. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
3. A list of Member Doctors in your geographic location can be obtained from your Group or Plan Administrator. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographic area in which you desire to seek services, you may call or write VSP office nearest you to obtain one that does.
4. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.
5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider - if the attached Schedule of Benefits indicates that Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

## **LIABILITY IN EVENT OF NON-PAYMENT**

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION PLAN OTHER THAN THOSE NOT COVERED BY THE PLAN.

## **INDIVIDUAL CONTINUATION OF BENEFITS**

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

## **TERMINATION OF BENEFITS**

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Plan.

## COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of Covered Person, the Covered Person may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Insured to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

### Claim Payments and Denials

**A. Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. 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.

**B. Request for Appeals:** If the Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Insured believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

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

VSP's determination, 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 appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

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

## OTHER FACTS YOU SHOULD KNOW ABOUT THE PLAN

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents such as detailed annual reports and Plan descriptions, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor or the Internal Revenue Service.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and your claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

The Plan Administrator and the employer are subject to numerous obligations in connection with continuation coverage, including an obligation to notify eligible participants and their dependents of the existence of said continuation coverage. In this regard, the U.S. Department of Labor has issued ERISA Technical Release No. 86-2 dated June 26, 1986, setting forth a Model Statement of the required notice. Providing said notice by first class mail to each covered employee and his or her spouse, if any, at their last known address will constitute a good faith effort at compliance of the notice requirement in the absence of promulgated COBRA regulations.



**VISION SERVICE PLAN INSURANCE COMPANY**

**3333 Quality Drive**

**Rancho Cordova, CA 95670**

Group Name: LITTLETON PUBLIC SCHOOLS

Plan Number: 12056608

Effective Date: JULY 1, 2016

Plan Term: TWENTY-FOUR (24) MONTHS

**VISION CARE PLAN  
DISCLOSURE FORM AND EVIDENCE OF COVERAGE**

**PLAN ADMINISTRATOR:** Janet Walworth  
(Name)  
5776 S Crocker St  
(Address)  
Littleton, CO 80120-2012  
(City, State, Zip)

**MONTHLY PREMIUM:** YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

**ELIGIBILITY:** ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** SIGNATURE PLAN

**EXAMINATION:** ONCE EVERY 12 MONTHS.

**LENSES:** ONCE EVERY 12 MONTHS.

**FRAMES:** ONCE EVERY 24 MONTHS.

**TERM, TERMINATION AND RENEWAL:** AFTER THE PLAN TERM, THIS PLAN WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

**TYPE OF ADMINISTRATION:** BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

**VSP'S ADDRESS IS:** VISION SERVICE PLAN  
3333 QUALITY DRIVE  
RANCHO CORDOVA, CA 95670

## SCHEDULE OF BENEFITS

### GENERAL

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

<u>PLAN BENEFITS</u>	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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### VISION CARE SERVICES

Vision Examination	Covered in Full*	Up to \$ 50.00*
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### VISION CARE MATERIALS

Lenses		
Single Vision	Covered in Full*	Up to \$ 50.00*
Bifocal	Covered in Full*	Up to \$ 75.00*
Trifocal	Covered in Full*	Up to \$ 100.00*
Lenticular	Covered in Full*	Up to \$ 125.00*
Frames	Covered up to Plan Allowance*	Up to \$ 70.00*

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

### CONTACT LENSES

Necessary		
Professional Fees and Materials	Covered in Full*	Up to \$ 210.00*
Elective	Materials	Professional Fees and Materials
	Up to \$ 130.00	Up to \$ 105.00
	Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum \$60.00 Copayment.	

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 not required for Covered Person to be eligible for Necessary Contact Lenses.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

LENS OPTIONS

UV (ultraviolet) protected

Covered in full

Not Covered

*\*Subject to Copayment, if any.*

*\*\*15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.*

**COPAYMENT**

*There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.*

**LOW VISION**

*Professional services for severe visual problems not corrected with regular lenses, including:*

<i>Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)</i>	<i>Covered in Full</i>	<i>Up to \$125.00</i>
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<i>Supplemental Aids</i>	<i>75% of cost</i>	<i>75% of cost</i>
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*Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) years.*

***THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.***

**PLAN BENEFITS  
AFFILIATE PROVIDERS**

**GENERAL**

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Person should discuss requested services with their provider or contact VSP Customer Care for details.

**COPAYMENT**

There shall be no Copayment payable by the Covered Person under this Plan.

**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, or Lined Trifocal )

**LENS OPTIONS**

**UV (ultraviolet) protected-Covered in full once every 12 months\*\***

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

**CONTACT LENSES**

**ELECTIVE**

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

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

**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.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

## **LOW VISION**

Professional services for severe visual problems not correctable with regular lenses, including:

**Supplemental Testing: Up to \$ 125.00†**

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

**Supplemental Aids: 75% of Affiliate 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 Doctor.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. The Company is unable to require Affiliate Providers to adhere to the Company's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

## ADDENDUM

### VISION SERVICE PLAN INSURANCE COMPANY ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM

#### GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY 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 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.
- The legal spouse of Enrollee.
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they attain the age of 26 years.

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 Plus Program ("DEP Plus") is intended to be a supplement to Covered Persons group medical plan. Providers will first submit a claim to Covered Persons 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
- transient loss of vision
- trouble focusing
- "floating" spots

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

- diabetic retinopathy
- diabetic macular edema
- rubeosis

## REFERRALS

If Covered Persons Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Person receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.



**PLAN BENEFITS  
MEMBER DOCTORS**

**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 Person 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 Plan Benefits.
2. Frames, 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.
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 PROGRAM DEFINITIONS**

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.

**Summary of Benefits and Coverage**  
**SIGNATURE PLAN**

Prepared for: LITTLETON PUBLIC SCHOOLS  
 Group ID: 12056608  
 Effective Date: JULY 1, 2016

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 \$50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: \$0.00 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 \$ 50.00 Bi-Focal Lenses reimbursed up to \$ 75.00 Tri-Focal Lenses reimbursed up to \$100.00 Lenticular Lenses reimbursed up to \$125.00 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.