VISION COVERAGE SUMMARY

Meadows Health's **Vision Plan** is also a self-insured plan. This Plan does not restrict participants to utilizing any specific vision facilities; you may choose your own vision providers.

The Comprehensive Vision Expense Benefit provides coverage for the following types of vision expenses:

1. Eye exams by an optometrist
2. Lenses, contacts, or disposable contacts
3. Frames Benefits are payable in accordance with any applicable co-payment amounts, deductible amounts, and benefits percentages listed in the Vision Schedule of Benefits or Plan Payment Provisions.

Eye examinations must be performed by a doctor. An optometrist or optician must furnish lenses and frames. An optician is a person whose services include:

- Preparing and ordering ophthalmic lenses based on a prescription
- Furnishing eyeglass frames

An optometrist is a doctor who is licensed to practice optometry. An optician is a person whose services include the preparation or ordering of ophthalmic lenses based on a prescription. The optician must be legally qualified to perform these services in the jurisdiction in which the services are rendered. Neither the optician nor the optometrist may be related to the participant by blood or marriage.

The following Services will be covered up to the maximum allowance when obtained from a licensed optometrist or optician. When obtaining these Services, you will be required to pay a Co-payment at the time of service. The amount of Co-payment is as noted in the chart below.

COVERED SERVICE	FREQUENCY OF SERVICE	CO-PAYMENT	MAXIMUM ALLOWANCE
Routine Vision Examination	Once every 12 months	$10	Up to $65
Eyeglass Frames	Once every 24 months †	$25	Up to $100
Eyeglass Lenses	Once every 12 months †		
• Single Vision		$25 ‡	Up to $40
• Bifocal		$25 ‡	Up to $60
• Trifocal		$25 ‡	Up to $80
• Progressive		$25 ‡	Up to $90
Contact Lenses	Once every 12 months †		
• Elective		$25 ‡	Up to $140 §
• Necessary		$25 ‡	Up to $210 §

Benefits are available every twelve (12) or twenty-four (24) months (depending on the benefit frequency), based on the last date of service)

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered up to the maximum allowance of the lens:
    - ♦ Standard scratch-resistant coating

Medically necessary contact lenses require pre-certification with Core Health Services (CHS).

[†] You are eligible to select only one of either eyeglasses (Eyeglass Lenses and or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

[‡] If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from your Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[§] The Contact Lens allowance includes the contact lens evaluation and fitting, two (2) follow-up visits (after copay), and the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $110 towards the purchase of contact lenses. If you choose disposable contacts, you may receive up to four (4) boxes of disposable contacts.

Plan Payment Provisions – Vision

The following is a complete list of Covered Vision Procedures under this Vision Expense Benefit. Any procedure not listed is excluded.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) - objective refraction to determine lens power of corrective Subjective refraction – to determine lens power of corrective lenses;
9. Photometry/Binocular testing - far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);

11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopy examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis;
17. Specific recommendations; and
18. Form completion – school, motor vehicle, etc.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems.

Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photo chromatic coating.

Contact Lenses – Elective

Elective contact lenses refer to contact lenses members choose to wear instead of eyeglasses for reasons of comfort or appearance. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency.

Contact Lenses – Medically Necessary

Medically necessary (non-elective) contact lenses are those prescribed by a doctor solely for purposes of correcting a specific medical condition.

Contact lenses are medically necessary if the Covered Person has:

1. Keratoconus or irregular astigmatism;
2. An isometropia of 4.0 diopters or more; provided visual acuity improves to 20/60 or better in the weak eye;
3. Post-cataract surgery without intraocular lens;
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses;
5. Any other condition the Plan designates as a medical necessity.

Prior Authorization is <u>REQUIRED</u>.

See also *Pre-Certification* and *Concurrent Review Requirements*.

General Limitations and Exclusions - Vision

The Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and Eyeglass Frame Benefit. An Insured shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

The Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit is payable in lieu of the Contact Lenses Benefit. An Insured shall be eligible to receive benefits under the Contact Lenses Benefit only after the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit Frequency has ended.

In no event will coverage exceed the lesser of:

- the actual cost of insured Services or Materials; or
- the limits of coverage shown in the Vision Schedule of Benefits.

Materials paid for under the Policy that are lost or broken will only be replaced at normal intervals when other Services are available.

Vision – Late Enrollee Benefit: Coverage for a Late Enrollee or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first twelve (12) months after the Late Entrant's or Re-Enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents if enrolled.

Except as specifically stated, no benefits will be payable under this Plan for:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.
4. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Services or supplies furnished before the effective date of the plan or after your coverage ends.
6. Services and supplies in connection with medical or surgical treatment of the eye.
7. Services and supplies that are in connection with special procedures such as:
    a. orthotics,
    b. vision training,
    c. subnormal vision aids,
    d. tomography, and
    e. any associated supplemental testing
8. Services supplies rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
9. Replacement or repair of lenses and/or frames that have been lost, stolen, or broken, except at normal intervals when services are otherwise available.

10. Spectacle lens styles, materials, treatments or optional lens extras not shown in the *Schedule of Benefits*.
11. Safety eyewear.
12. Missed appointment charges.
13. Charges incurred as a result of an intentionally self-inflicted injury.
14. Charges for the treatment of injury or illness incurred in the commission of a crime. However, this exclusion does not apply to otherwise eligible charges for the treatment of injury or illness incurred by victims of domestic violence.
15. Expenses covered by:
    a. Any other group insurance.
    b. A health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.
16. Applicable sales tax charged on Services.
17. Services that are not specifically covered by the Policy.
18. Charges for the treatment of injury or illness incurred as a result of declared or undeclared war or an act of war.
19. Charges for which the covered person otherwise would not have the responsibility to pay. For example, for coordination of benefit purposes, this Plan – as the secondary plan – will not cover charges that have been disallowed by the primary plan and for which the patient is not responsible.
20. Charges incurred for services described in this document that are rendered by yourself, your spouse, or a child, brother or sister, or parent of yourself or your spouse.
21. Medically necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Core Health Services (CHS).
22. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior notification was not sent to Core Health Services (CHS).
23. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
24. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the *Schedule of Benefits*.

The vision plan does not cover extra charges for the following eyewear. If you choose any of the following, you will be responsible for the charge(s):

1. Blended lenses
2. Oversize lenses
3. Photochromic or tinted lenses other than Pink 1 or 2
4. Coated or laminated lenses
5. Frames that cost more than the established plan allowance
6. Certain limitations on low vision care
7. High index or aspheric lenses
8. Cosmetic lenses
9. Optional cosmetic processes
10. UV protected lenses
11. No-line bifocals

Items not covered under the contact lens coverage include:

1. Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia);
2. Insurance policies or service agreements;
3. Non-prescription lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power);
4. Artistically painted lenses;
5. Additional office visits associated with contact lens pathology;
6. Contact lens modification, polishing or cleaning.