

# Client Vision Care Plan



Client Name: BELLMAWR BOARD OF EDUCATION  
Client Number: 04110226  
Effective Date: JULY 1, 2026

## EVIDENCE OF COVERAGE

Provided by:

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

The insurance policy under which this Evidence of Coverage is issued is not a policy of worker's compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the worker's compensation system.

**PLEASE READ CAREFULLY. THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE PLAN. THE PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE PLAN WILL BE FURNISHED UPON REQUEST. ALL APPLICANTS HAVE A RIGHT TO REVIEW THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT. 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.**

**A STATEMENT DESCRIBING VISION SERVICE PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.**

Subject to the Laws of the State of New Jersey

**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: Bellmawr Board of Education

NAME OF PLAN: Vision Plan

PRIMARY ADDRESS OF CLIENT: 256 Anderson Avenue Bellmawr NJ 08031

PLAN ADMINISTRATOR: Bellmawr Board of Education

ADDRESS: 256 Anderson Avenue Bellmawr NJ 08031

PHONE NUMBER: (856) 931-3620

**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**

This Evidence of Coverage which sets forth in summary form a statement of the essential features of coverage shall be issued to the employer, the policyholder, or other person or association in whose name such policy is issued, for delivery to each employee or member.

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. 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](http://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**

In the event of a Covered Person seeks Emergency Care from an Open Access Provider, the Covered Person is liable only for the applicable in-network copayment and the in-network percentage of allowable expense for out-of-network services. 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](http://www.vsp.com). Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted by Covered Persons to VSP in writing, by telephone at (800) 877-7195, online or through Covered Persons' VSP Preferred Providers. VSP will fully investigate and resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. VSP will provide timely notification to Covered Person as to the progress of an investigation. Where such extension is required, VSP will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the results of VSP's investigation and final resolution of all complaints and grievances. Covered Person has the right to have their grievance reviewed by a managerial level person or group. VSP shall provide for copies of all grievances and responses to be available at the principal office of VSP for inspection by the commissioner for two (2) years following the year the grievance was filed.

A determination will be made by VSP not later than seventy-two (72) hours after receipt of an expedited grievance. An expedited grievance applies to Covered Person if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function. If the determination by VSP is made orally, VSP shall provide a written confirmation of the determination to the Covered Person not later than two (2) business days after the oral determination. Within 10 days after receipt of a determination of an expedited grievance, Covered Person may request a determination of the matter by the director or his or her designee or by an independent review organization.

## **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. If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative 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: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business 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 communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

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. A request for a second level appeal must be submitted to VSP must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state and federal laws and regulations. VSP's communication to the Covered Person 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. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. 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. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

Legal 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. A Covered Person must not bring an action at law or in equity after the expiration of 3 years after the time written proof of loss is required to be furnished.

## **INDIVIDUAL CONTINUATION OF BENEFITS**

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online [www.vsp.com](http://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:

<b>ADDITIONAL BENEFIT RIDER</b>	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.
<b>ASSIGNMENT OF BENEFITS</b>	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.
<b>CLIENT</b>	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.
<b>COORDINATION OF BENEFITS</b>	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
<b>COPAYMENTS</b>	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.
<b>COVERED PERSON</b>	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.
<b>ENROLLEE</b>	An employee or member of Client who meets the criteria for eligibility established by Client.
<b>PLAN OR 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 Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
<b>OPEN ACCESS 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 ADMINISTRATOR</b>	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.
<b>POLICY</b>	The contract between VSP and Client upon which this Plan is based.
<b>SCHEDULE OF BENEFITS</b>	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.
<b>VSP PREFERRED PROVIDER</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 Plan Benefits on behalf of Covered Persons of VSP.
<b>URGENT CARE</b>	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 Signature Plan®

#### GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("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.

#### ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Civil Union Partner\*
- Any unmarried or unpartnered child or dependent of Enrollee, including natural child from date of birth, a child acquired through 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.

Unmarried or unpartnered dependent children are covered up to age 19 or to age 23 if full time students.

A dependent unmarried or unpartnered 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.

\*Pursuant to N.J.S.A. 37:1-32

\*\*Pursuant to N.J.S.A. 26:8A-4(b)

**PLAN BENEFITS  
VSP PREFERRED PROVIDERS**

**COPAYMENT**

A Copayment amount of \$25.00 shall be payable by the Covered Person at the time services are rendered.

Lens Options, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

**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 24 months\*\***

**Spectacle** Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)  
Polycarbonate lenses are covered in full for dependent children up to age 19.

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**

**The Elective Contact Lens fitting and evaluation services are covered in full once every 24 months, after a \$60.00 Copayment.**

Elective Contact Lenses (materials only) are covered up to \$130.00 once every 24 months\*\*

### **NECESSARY**

**Necessary Contact Lenses are covered in full\* once every 24 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 not correctable 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**

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

**PLAN BENEFITS  
OPEN ACCESS PROVIDERS**

**COPAYMENT**

A Copayment amount of \$25.00 shall be payable by the Covered Person at the time services are rendered.

**COVERED SERVICES AND MATERIALS**

**EYE EXAMINATION: Up to \$ 50.00\* once every 12 months\*\***

Comprehensive examination of visual functions and prescription of corrective eyewear.

**LENSES - Up to \$50.00 - 125.00 \* once every 12 months\*\***

**Spectacle** Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Options.

**LENSES - Up to \$ 50.00 - 125.00 once every 24 months\*\***

**Spectacle** Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

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

**CONTACT LENSES**

**ELECTIVE**

**Elective Contact Lenses are covered up to \$105.00 once every 24 months\*\***

**NECESSARY**

**Necessary Contact Lenses are covered up to \$210.00\* once every 24 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 Doctor.

## **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.

## EXHIBIT C

### VISION SERVICE PLAN INSURANCE COMPANY

#### ADDITIONAL BENEFIT RIDER SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

#### GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY (“VSP”) are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eyecare professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. 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 of Enrollee
- Civil Union Partner\*
- Any unmarried or unpartnered child or dependent of Enrollee, including natural child from date of birth, a child acquired through 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.

Unmarried or unpartnered dependent children are covered up to age 19 or to age 23 if full time students.

A dependent unmarried or unpartnered 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.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

**PLAN BENEFITS**  
**VSP PREFERRED PROVIDERS**

**COVERED SERVICES**

**Medical Eye Examinations:** Covered in full after a Copayment of \$20.00.

**Urgent/Emergency Care\* and Special Ophthalmological Services\*\*:** Covered in full

\*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

\*\*Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services. A current list of the covered procedures will be made available to the Client upon request.

**NOT COVERED**

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

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

**Prepared for:** BELLMAWR BOARD OF EDUCATION  
**Group ID:** 04110226  
**Effective Date:** JULY 1, 2026

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	*	Reimbursed up to \$50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* 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 24 months**
	Fees	\$25.00 Copay		

\* Fees copay applies to first service used.

\*\* 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.