

Client Vision Care Plan



Vision Care for Life

Client Name: THE STATE TEACHERS RETIREMENT SYSTEM OF OHIO
Client Number: 12098166
Effective Date: JANUARY 1, 2019

EVIDENCE OF COVERAGE

OUT OF NETWORK BENEFITS PROVIDED BY VISION SERVICE PLAN INSURANCE COMPANY

3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
(916) 851-5000 (800) 877-7195

IN NETWORK BENEFITS PROVIDED BY VISION SERVICE PLAN

3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 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.



Welcome to VSP® Vision Care!

Your vision and wellness come first.

You're unique—and so is your VSP benefit. As a member, you'll experience quality vision care, personalized attention, and the best choices in eyewear—all at the lowest out-of-pocket costs.

It's easy to use your VSP benefit.

- **Create an account at vsp.com.** Review your vision benefit and access your eligibility and coverage information.
- **Find superior eye care near you.** The decision is yours—choose a conveniently located VSP doctor, participating retail chain, or any out-of-network provider. Visit **vsp.com** or call **800.877.7195** to find the best provider for you.
- **At your appointment, tell them you have VSP.** There's no ID card needed. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! There are no claim forms to complete when you see a VSP provider.

Maximize your savings.

Enjoy Exclusive Member Extras, including additional savings and special offers available only to VSP members. Plus, when you choose a featured frame brand, including bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, and Nine West—you'll get an extra \$20 to spend¹.

Get even more from your benefit when you visit a practice that participates in the Premier Program. You'll get a wide selection of featured frame brands, extra savings on contact lenses, advanced eye exams using the latest high-tech equipment, and access to exclusive bonus offers.



Check out more ways to save at **vsp.com**.

We're committed to delivering the eye care you deserve, the eyewear choices you want, and the savings you need. For details on your coverage, visit **vsp.com** or call **800.877.7195**.

Sincerely,

Kate Renwick-Espinosa
President, VSP Vision Care

¹Brands/Promotion subject to change.

Who Is Eligible for Coverage?

Benefit Recipient

A Defined Benefit Plan or Combined Plan member with 15 or more years of service credit who is granted service retirement or disability benefits with an effective date of Jan. 1, 2004, or later is eligible for coverage. In addition, a Defined Benefit Plan or Combined Plan member who is granted service retirement or disability benefits with an effective date before Jan. 1, 2004, is also eligible for coverage; however, they pay 100% of their health care premium if they have less than 15 years of service credit.

Benefit recipients do not need to be eligible for or enrolled in an STRS Ohio health care plan to enroll in the vision plan. However, the benefit recipient must be enrolled in the vision plan for any eligible dependents to participate in the plan.

If you experience a life event, such as death, divorce, marriage, birth of a child or the addition of a dependent child, please contact STRS Ohio for an explanation of how the change will affect your coverage.

Eligible Dependents

A spouse, child or disabled adult child may be eligible for coverage. You must notify STRS Ohio in writing when a dependent no longer meets eligibility requirements and indicate the day, month and year your dependent is no longer eligible. Premium deductions from your monthly STRS Ohio benefit payment do not guarantee coverage if your dependent no longer meets eligibility requirements.

Spouse

A spouse means a husband or wife of a primary service retirement benefit recipient, disability benefit recipient or active member at the time of the member's death.

Child

A child means a child of a primary service retirement benefit recipient, disability benefit recipient or active member at the time of the member's death. The child must be under age 26 with no access to employer-sponsored coverage (not including a parent's coverage) and be a:

- Biological child; or
- Lawfully adopted child or a stepchild; or
- A child for whom the benefit recipient or member is legally appointed as guardian.

Disabled Adult Child

A person age 26 or older who is permanently and totally disabled **and**:

- Is a biological child, child lawfully adopted before age 18 or stepchild of a service retirement benefit recipient, disability benefit recipient or active member at the time of the member's death; or a child for whom the service retirement benefit recipient, disability benefit recipient or deceased active member was legally appointed as guardian before the child attained age 18; **and**
- Meets the following requirements:
 - Person has never been married and has been adjudged physically or mentally incompetent by a court before age 18 or age 22 if attending school on at least two-thirds-of-a-full-time basis and has been continuously disabled; **or**
 - Person has never been married and has been unable to earn a living because of a mental or physical condition that was disabling before age 18 or age 22 if attending school on at least two-thirds-of-a-full-time basis and has been continuously disabled. (This means the person is incapable of earning 150% of the federal minimum wage multiplied by 2,080 hours and rounded to the nearest \$1,000 as of Jan. 1 of the prior year, as well as the current year and for each year thereafter. Currently this amount is \$23,000.)

How to Enroll in a Plan

Benefit Recipient and Eligible Dependents

Termination of other coverage

You may enroll yourself and/or an eligible dependent if other vision coverage is terminating. Coverage becomes effective the first of the month following termination of other coverage if STRS Ohio receives and approves the request to enroll within 31 days of the date your other coverage ended. If you do not request enrollment within 31 days, you will need to wait until open enrollment to enroll.

Medicare enrollment

You may enroll yourself or an eligible dependent upon initial eligibility and enrollment in Medicare Parts A & B or Part B-only. If you do not request enrollment within 31 days of enrolling in Medicare, you will need to wait until open enrollment to enroll.

New Spouse

You may enroll a spouse upon marriage if the enrollment request is received within 31 days of marriage for coverage to be effective the first of the month following the marriage. If you do not request enrollment within 31 days, you will need to wait until open enrollment to enroll.

Child

You may enroll a child who is under age 26 upon birth, adoption or legal guardianship. The enrollment request must be received within 31 days of the birth, adoption, or legal guardianship for coverage to be effective the first of the month following the event. If you do not request enrollment within 31 days, you will need to wait until open enrollment to enroll.

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

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 Network 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 Network Provider will obtain benefit verification from VSP. The VSP Network 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. If an Open Access Provider agrees to submit a claim to VSP on behalf of Covered Person, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. 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.

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 Network 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 Network Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Network 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.
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 NETWORK 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 and 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.

VSP Network 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-Eligibility determined by Client's criteria.
- Legal Spouse of Enrollee-Eligibility determined by Client's criteria.
- Any child of Enrollee-Eligibility determined by Client's criteria.
- Dependent Parent-Eligibility determined by Client's criteria.
- Other Relation-Eligibility determined by Client's criteria.

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 permanently and totally disabled. Eligibility determined by Client's criteria.

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

A Copayment amount of \$ 10.00 shall be payable by the Covered Person at the time of the examination.

A Copayment amount of \$ 10.00 shall be payable by the Covered Person for Lenses.

A Copayment amount of \$ 10.00 shall be payable by the Covered Person for Frames.

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**

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

Polycarbonate lenses are covered in full for dependent children up to age 26.

LENS OPTIONS

Polycarbonate Lenses covered in full* once every 24 months**

Progressive lenses covered in full* once every 24 months**

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

The VSP Network 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 are covered up to \$125.00 once every 24 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 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 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.

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 under the SunCare enhancement, if purchased by Client.
- 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.
- 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

A Copayment amount of \$ 10.00 shall be payable by the Covered Person at the time of the examination.
A Copayment amount of \$ 10.00 shall be payable by the Covered Person for Lenses.
A Copayment amount of \$ 10.00 shall be payable by the Covered Person for Frames.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 50.00* once every 24 months**

Bifocal Up to \$ 75.00* once every 24 months**

Trifocal Up to \$100.00* once every 24 months**

Lenticular Up to \$125.00* once every 24 months**

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

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to \$125.00 once every 24 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 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 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 VSP Network 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 Network Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Network 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 Network 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

ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN and VISION SERVICE PLAN INSURANCE COMPANY (“VSP”) are entitled, subject to any applicable Copayment and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Diabetic Eyecare Program (“DEP”) are available to Covered Persons who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, and who are covered under the VSP Signature Plan®. The Diabetic Eyecare Program allows Covered Person’s VSP Network Providers to provide diagnostic services not available under the VSP Signature Plan. The Diabetic Eyecare Program does not cover medical treatment for Covered Persons with diabetic or any other medical conditions.

ELIGIBILITY

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

- Enrollee-Eligibility determined by Client’s criteria.
- Legal Spouse of Enrollee-Eligibility determined by Client’s criteria.
- Any child of Enrollee-Eligibility determined by Client’s criteria.
- Dependent Parent-Eligibility determined by Client’s criteria.
- Other Relation-Eligibility determined by Client’s criteria.

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 permanently and totally disabled. Eligibility determined by Client’s criteria.

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 may include, but are not limited to:

- blurry vision
- trouble focusing
- transient loss of vision
- “floating” spots

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

- diabetic retinopathy
- rubeosis
- diabetic macular edema

REFERRALS

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

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

**PLAN BENEFITS
VSP NETWORK DOCTORS**

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of \$5.00.

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.
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 due to leaking of fluid from blood vessels within the macula

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 \$5.00 Copayment.

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

- Exclusions and limitations of benefits described above for VSP Network 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 Network 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: THE STATE TEACHERS RETIREMENT SYSTEM OF OHIO
Group ID: 12098166
Effective Date: JANUARY 1, 2019

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 \$50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Lenses: \$10.00 Copay Frames: \$10.00 Copay	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 \$125.00	Frames covered every 24 months** Lenses covered every 24 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.