

# Group Vision Care Policy



Vision Care for Life

Group Name: THE TRUSTEES OF THE STEVENS INSTITUTE OF TECHNOLOGY  
Group Number: 30053079  
Effective Date: JANUARY 1, 2015

## Certificate of Coverage

Provided by:

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

Subject to the Laws of the State of New Jersey

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NAME OF EMPLOYER: The Trustees of the Stevens Institute of Technology  
NAME OF PLAN: The Trustees of the Stevens Institute of Technology Health and Welfare Benefit Plan  
PRINCIPAL ADDRESS: Castle Point on Hudson  
Hoboken, NJ 07030  
201-216-5000

EMPLOYER I.D.#: 22-1487354

POLICY #: 30053079

PLAN ADMINISTRATOR: The Trustees of the Stevens Institute of Technology  
ADDRESS: Castle Point on Hudson  
Hoboken, NJ 07030

PHONE NUMBER: 201-216-5000

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:  
The Trustees of the Stevens Institute of Technology

ADDRESS: Castle Point on Hudson  
Hoboken, NJ 07030  
201-216-5000

This form is a summary of the Policy provisions and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Policy itself. A specimen copy of the Policy will be furnished on request.

**DEFINITIONS:**

**ADDITIONAL BENEFIT RIDER** The document attached to this Certificate 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 Policy.

**BENEFIT AUTHORIZATION** Authorization issued by the Company identifying the individual named as a Covered Person of the Company, and identifying those Plan Benefits to which a Covered Person is entitled.

**COPAYMENTS** Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

**COVERED PERSON** An Enrollee or Eligible Dependent who meets the Company's eligibility criteria and on whose behalf Premiums have been paid to the Company, and who is covered under the Policy.

**EMERGENCY CONDITION** 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.

**ENROLLEE** An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.

**EXPERIMENTAL NATURE** Procedure or lens that is not used universally or accepted by the vision care profession, as determined by the Company.

**GROUP** An employer or other entity which contracts with the Company for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

**MEMBER DOCTOR** An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Covered Persons of the Company.

<b>NON-MEMBER PROVIDER</b>	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Company to provide vision care services and/or vision care materials to Covered Persons of the Company.
<b>PREMIUMS</b>	The payments made to the Company 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 Policy document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which the Policy shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document, attached as Exhibit A to the Group Policy document maintained by your Group Administrator, which lists the vision care services and vision care materials coverage purchased by Group for Enrollees and Eligible Dependents.
<b>SCHEDULE OF PREMIUMS</b>	The document, attached as Exhibit B to the Group Policy document maintained by your Group Administrator, which states the payments to be made to the Company by Group on behalf of a Covered Person to entitle him/her to Plan Benefits.

## 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 the Company.

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

A dependent, unmarried child over the limiting age as shown on the enclosed insert 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

Your Group is responsible for payments to the Company of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group.

## PROCEDURE FOR USING THE POLICY

1. When you desire to receive Plan Benefits from a Member Doctor, contact the Company or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Plan Administrator, or Company. If this list does not cover the geographic area in which you desire to seek services, you may call or write the Company office nearest you to obtain one which does.
2. You must contact the Member Doctor directly and identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from the Company. If you are eligible for Plan Benefits, the Company will provide Benefit Authorization directly to the Member Doctor.
3. When such Benefit Authorization is provided by the Company and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of your termination of coverage or the termination of the Policy. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
4. You pay only the Copayment (if any) to the Member Doctor for the services covered by the Policy. The Company will pay the Member Doctor directly according to its agreement with the doctor.

**Note:** If you obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by the Company in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

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 Covered Person's Plan includes such coverage). No prior approval from the Company 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 the Company 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 the Company 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 the Company'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 the Company.

6. In the event of termination of a Member Doctor's membership in the Company, the Company will remain liable to the Member Doctor for services rendered to you at the time of termination and permit Member Doctor to continue to provide you with Plan Benefits until the services are completed or until the Company makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

## **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 Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's 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.

## **BENEFITS AND COVERAGES**

Through its Member Doctors, the Company provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, the Company will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

**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: Unless otherwise indicated on the enclosed insert, contact lenses are available under the Policy in lieu of all other lens and frame benefits described herein for the current eligibility period.
5. Necessary contact lenses, together with necessary professional services, will be provided as indicated on the enclosed insert.

When Elective contact lenses are obtained from a Member Doctor, the Company will provide an allowance toward the cost of professional fees and materials as shown on the enclosed insert. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. The Company will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. **THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS.** Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

## **COPAYMENT**

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. **ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.**

## 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 options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Policy 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.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

## NOT COVERED

There is no benefit under this plan 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. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
6. Services/materials not indicated as covered Plan Benefits on the enclosed insert.

## CHANGES IN COVERAGE

In the event of subsequent changes to coverage under the Policy, Group shall distribute notice of such changes to Enrollees.

## 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 POLICY OTHER THAN THOSE NOT COVERED BY THE POLICY.

## CLAIMS

Member Doctors will submit claims on behalf of Covered Persons. If Plan Benefits are provided by Non-Member Doctors, the Covered Person shall pay for the services and submit a claim by submitting the receipt(s) to VSP for reimbursement for allowable expenses. Claims shall be furnished to VSP within three hundred and sixty five (365) days of the date Plan Benefits are received by a Covered Person. Failure to provide such proof within such time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

## COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call the Company'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 a Covered Person, the Covered Person may communicate a complaint or grievance to the Company 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 the Company's review. The Company 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 the Company's receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate the Company's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

The Covered Person may also contact the New Jersey Department of Health and Senior Services or the Department of Banking and Insurance:

**New Jersey Department of Banking and Insurance, Division of Insurance, Enforcement and Consumer Complaints**  
P.O. Box 329  
Trenton, NJ 08625-03299  
(609) 292-5316 (phone)  
(800) 446-7467 (in New Jersey)  
(609) 292-5865 (fax)

**New Jersey Department of Health and Senior Services, Office of Managed Care**  
P.O. Box 360, John Fitch Plaza  
Trenton, NJ 08625-0360  
(609) 292-7837  
(609) 292-0053 (fax)

### Claim Payments and Denials

**A. Initial Determination:** the Company 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 the Company may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

**B. Request for Appeals:** If a Covered Person's claim for benefits is denied by the Company in whole or in part, the Company 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 the Company 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 Company Enrollee, Member Identification Number of the Company 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 Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. The Company will review the claim and give the 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**

The Company'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 the Company's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. The Company 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.

**No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after a claim for benefits has been filed in accordance with the requirements of the Policy, and no such action shall be brought within six (6) years from the expiration of the time within which claims can be submitted as required by the Policy.**

#### **PHYSICAL EXAMINATION AND AUTOPSY**

The Company shall have the right and opportunity to examine the person for whom a claim is made when and as often as it may reasonably require during the pendency of claim under the Policy and to make an autopsy in case of death where it is not prohibited by law.

#### **TERMINATION OF BENEFITS**

Terms and cancellation conditions of the vision care policy are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of the Policy whether the cancellation is by Group or by the Company due to nonpayment of Premium.

If service is being rendered to you as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

Plan Benefits to Eligible Dependents shall continue for 180 days after the death of the Enrollee, subject to Continuation of Coverage provisions in the Policy with respect to Enrollees or Eligible Dependents for reasons other than the death of the Enrollee.

#### **CONTINUATION/EXTENSION 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. In the event of total disability of a Covered Person which exists as of the date of termination, the Covered Person shall have ninety days from said date to obtain Plan Benefits, subject only to the attached Schedule of Benefits.

#### **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 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.

**VISION SERVICE PLAN INSURANCE COMPANY**

**3333 Quality Drive**

**Rancho Cordova, CA 95670**

**Group Name:** THE TRUSTEES OF THE STEVENS INSTITUTE OF TECHNOLOGY

**Plan Number:** 30053079

**Effective Date:** JANUARY 1, 2015

**Plan Term:** TWENTY-FOUR (24) MONTHS

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

**PLAN ADMINISTRATOR:** The Trustees of the Stevens Institute of Technology  
Castle Point On Hudson  
Hoboken, NJ 07030

**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 YEAR IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **VSP CHOICE PLAN**

**EXAMINATION:** ONCE EVERY PLAN YEAR\*

**LENSES:** ONCE EVERY PLAN YEAR\*

**FRAMES:** ONCE EVERY TWO PLAN YEARS\*

\*PLAN YEAR BEGINS JANUARY 1ST.

**TERM, TERMINATION AND RENEWAL:** AFTER THE POLICY TERM, THIS POLICY 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.*

*Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.*

*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.*

### **PLAN BENEFITS**

### **MEMBER DOCTOR BENEFIT**

### **NON-MEMBER PROVIDER BENEFIT**

#### **VISION CARE SERVICES**

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>45.00*</i>
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#### **VISION CARE MATERIALS**

##### *Lenses*

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>30.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>50.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>65.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>100.00*</i>

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$</i>	<i>70.00*</i>
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#### **CONTACT LENSES**

##### *Necessary*

<i>Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>210.00*</i>
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##### *Elective*

<i>Materials</i>	<i>Professional Fees and Materials</i>	<i>Up to \$</i>	<i>105.00</i>
<i>Up to \$ 150.00</i>			
<i>Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum \$60.00 Copayment.</i>			

*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 one plan year.*

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

**LOW VISION**

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

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Covered in Full	Up to \$125.00
Supplemental Aids	75% of cost	75% of cost

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.

**BENEFIT PERIOD**

A twelve-month period beginning on January 1st and ending on December 31st.

**COPAYMENT**

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

**COVERED SERVICES AND MATERIALS**

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

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

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

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

**CONTACT LENSES**

**ELECTIVE**

**Elective Contact Lenses (materials only) are covered up to \$150.00 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 day of the Benefit Period.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

## **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. VSP is unable to require Affiliate Providers to adhere to VSP'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.

## Exhibit C

### ADDITIONAL BENEFIT RIDER PRIMARY EYECARE PLAN

#### 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. This Rider forms a part of the Policy and Evidence of coverage to which it is attached.

The Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the Plan, Member Doctors provide treatment and management of urgent and follow-up services. Primary EyeCare also involves management of conditions that require monitoring to prevent future vision loss.

The Member Doctor is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Member Doctor as a Primary EyeCare professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS, below) will be covered for certain Primary EyeCare services in accordance with the optometric scope of licensure in the Member Doctor's state. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

#### SYMPTOMS

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

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

#### CONDITIONS

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

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

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

## **PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES**

To obtain Primary EyeCare Services, the Covered Person contacts a Member Doctor's office and makes an appointment. If necessary, the Covered Person may first call VSP's Customer Service Department to determine the location of the nearest Member Doctor's office.

If urgent care is necessary, the Covered Person may be seen by a Member Doctor immediately.

The Covered Person pays the applicable Copayment to the Member Doctor at the time of each Primary EyeCare office visit, and for any additional services not covered by the Plan.

Upon completion of the services, the Member Doctor will submit the required claim information to VSP. VSP will pay the Member Doctor directly in accordance with VSP's agreement with the doctor.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

## **COPAYMENT**

A Copayment amount of \$20.00 shall be payable by the Covered Person at the time of each Primary EyeCare office visit.

## **REFERRALS BY THE MEMBER DOCTOR**

The Member Doctor will refer the Covered Person to another doctor under the following circumstances:

If the Covered Person requires additional services which are covered by the Primary EyeCare Plan but can not be provided in the Member Doctor's office, the doctor will refer the Covered Person to another Member Doctor or to the Group's major medical physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the Primary EyeCare Plan, the Member Doctor will refer the Covered Person to the Group's major medical physician.

If the Covered Person requires emergency services beyond the scope of the Primary EyeCare Plan, the Member Doctor will make an urgent referral by calling either another Member Doctor or the Group's major medical physician.

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Primary EyeCare Plan is designed to cover Primary EyeCare services only. There is no coverage provided under the Policy for the following:

- Costs associated with securing materials such as lenses and frames.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical or pathological treatment.
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- Medication.
- Pre- and post-operative services.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.



## DEFINITIONS

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

**Summary of Benefits and Coverage**  
**VSP Choice Plan**

Prepared for: **THE TRUSTEES OF THE STEVENS INSTITUTE OF TECHNOLOGY**  
 Group ID: **30053079**  
 Effective Date: **JANUARY 1, 2015**

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

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

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

\*\* Beginning with the first day of the Benefit Period.

**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.