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## *Superior Vision Plan*

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**Effective Date: January 1, 2009**

**Outline of Benefits - Gold Preferred Plan With Materials Discount**

**Vision Plan - Preferred Provider (PPO / Indemnity)**

**Exam Copayment Amount - \$15.00**

**Materials Copayment - None**

**Contact Lens Fitting Copay - \$35.00**

<b>BENEFITS</b>	<b>FREQUENCY</b>	<b>IN-NETWORK</b>	<b>NON-NETWORK</b>
<b>Comprehensive Exam</b> <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$34.00
<b>Comprehensive Exam</b> <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$26.00
<b>Lenses (Standard) per Pair:</b>			
Single Vision	12 Months	Covered in Full	Up to \$32.00
Bifocal	12 Months	Covered in Full	Up to \$46.00
Trifocal	12 Months	Covered in Full	Up to \$57.00
Lenticular	12 Months	Covered in Full	Up to \$90.00
<b>Contact Lenses (Per Pair)*:</b>			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
<b>Frames (Standard)**</b>	24 Months	Up to \$100.00	Up to \$47.00

*\*Contact lenses are in lieu of eyeglass lenses and frames benefit.*

*\*\*The insured is responsible for paying any charges in excess of this allowance.*

*\*\*\*Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.*

### **DEFINITIONS OF CONTACT LENSES**

#### **Contact Lenses, Elective/Cosmetic**

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

#### **Contact Lenses, Medically Necessary**

These lenses must be specifically prescribed by the eye doctor to be used for the following reason or reasons. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens)

A pair of prescription single vision or multifocal eye glass lenses and an eye frame can be provided along with contact lenses prescribed for this reason.

- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

**Contact Lens Examining Fee:**

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the eye examination and will vary depending on the provider's fee structure policies. It will also vary due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription, and the type of lenses used. The contact lens exam/fitting fee may be included in the contact lens allowance.

**EXCLUSIONS (products & services not covered):**

There is no benefit coverage for the following products and services.

- Professional Services and/or Materials in conjunction with:
  - blended bifocals, no line, or progressive lenses
  - compensated or special multi-focal lenses
  - plain (non-prescription) lenses
  - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
  - subnormal vision aids
  - tints, other than solid
  - orthoptics, vision training and developmental vision procedures
  - polycarbonate lenses
  - Medical or surgical treatment of the eyes
- Any eye examination or any corrective eye wear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eye wear
- Spectacle lens styles, materials, treatments, or "add-ons" not shown in the Benefits Summary
- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his, or her license
- Any additional service required outside basic vision analysis for contact lenses except fitting fees

- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured within 31 days from the date of such order
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently delivered, and the services rendered to the Insured within 31 days from the than that which is specified in the Benefits Summary

## **HOW TO USE YOUR BENEFIT**

### **Procedure when using a Superior Vision Plan in-network provider:**

- Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.
- After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate copayments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

### **Procedure when using a Superior Vision Plan non-network provider:**

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on page 38.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

## DISCOUNTS ON ADDITIONAL PURCHASES

- Prescription eyeglass lenses 30% off retail prices
- Eye frames 30% off retail prices
- Add-on charges to basic lenses 20% off retail prices
- Everyday “frame and lens package” pricing 20% off retail prices
- Contact lenses, standard hard or soft 20% off retail prices
- Disposable contact lenses 10% off retail prices
- All other prescription materials 20% off retail prices

## DISCOUNT SVP8-20

- Frames 20% off the difference between the covered frame allowance and the retail price of the selected frame

## Add-on charges to the covered pair of lenses

## Member pays 20% off retail up to:

- Factory Scratch Coat \$13 (Single Vision & Standard Multifocal lenses)
- Ultraviolet Coat \$15 (Single Vision & Standard Multifocal lenses)
- Standard Anti-Reflective coat\* \$50 (Single Vision & Standard Multifocal lenses)
- High Index 1.6\* \$55 (Single Vision lenses only)
- Polycarbonate \$40 (Single Vision lenses only)
- Standard Photochromic \$80 (Single Vision lenses only)
- Glass coloring \$35 (Any Type lenses)
- Plastic Tints solid or gradient \$25 (Any Type lenses)

## Member pays:

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00 Prism 20% off retail prices (any type lenses)
- Cosmetic finishing, Beveling, Edging, and Mounting 20% off retail prices (any type lenses)
- Miscellaneous Options 20% off retail prices (any type lenses)

\* Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward upgraded lens retail cost and member is responsible for the difference less 20%.

## REFRACTIVE SURGERY DISCOUNTS

Superior Vision Services has contracted a network of over 500 refractive surgeons nationwide who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy, (PRK), and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Master Policy and Certificate of Coverage by contacting your Human Resources/Employee Benefits Office.

**RATES (BASED ON 10 PAY PERIODS)**

Employee Only	\$12.34
Employee + 1	\$23.90
Employee + 2 or more	\$35.11

**Member Services, Provider Listings and Claims Services:**

(800) 507-3800

**Member Services Fax:**

(916) 852-2277

**Provider Nominations:**

(800) 923-6766

**Web Site:**

[www.superiorvision.com](http://www.superiorvision.com)

**Address:**

Superior Vision Services, Inc  
11101 White Rock Road, Ste. 150  
Rancho Cordova, CA 95670

**Non-network Claims Submission:**

Superior Vision Services, Inc.  
P.O. Box 967  
Rancho Cordova, CA 95741

*This plan is underwritten by National Guardian Life Insurance Company  
P.O. Box 1191 Madison, WI 53701-1191*

