Cafeteria Vision

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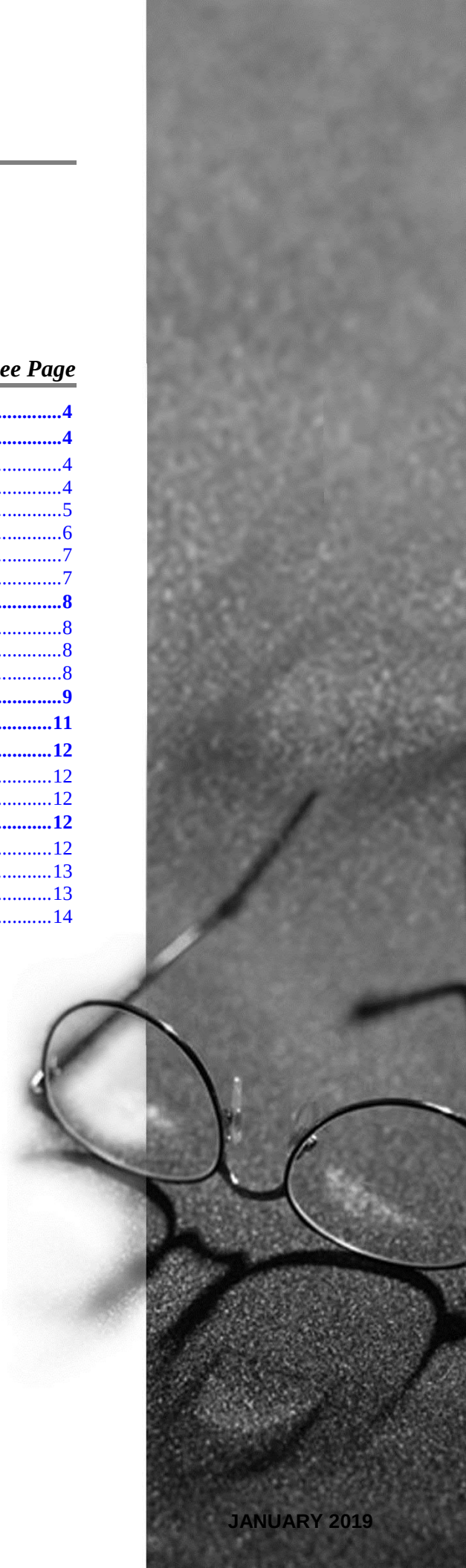

THE VISION PLAN

TERMS

Terms that are defined in the Glossary of this SPD are bolded and capitalized when they first appear in the text; thereafter, they will be capitalized wherever they are used in the text. See the Glossary section for more information.

The Vision Plan pays for periodic exams, eyeglass lenses and frames, or contact lenses, up to a designated dollar amount, after a Copayment. Vision Plan benefits are insured under a group vision care policy issued by Vision Service Plan Insurance of Illinois, NFP (VSP). VSP is the Third Party Administrator for the Vision Plan and vision claims.

The vision exam benefit provides coverage for a complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

The lenses and frames benefit provides coverage for necessary professional services including:

- prescribing and ordering proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustment to frames to maintain comfort and efficiency; and
- progress or follow-up as necessary.

BENEFITS

Choice Plan Benefits

You have two affordable vision plans to choose from. Select the Vision Plan, or upgrade your coverage to the Vision Plus Plan. With the Vision Plus Plan, you and each Covered Person on your plan can select the enhancement that's right for you and get glasses every plan year.

The Vision Plans provide two levels of benefits, In-Network care provided by a VSP Network Provider and Out-of-Network care provided by a Non-VSP Provider. You choose between these benefit levels each time you obtain vision care.

Services available under the Out-of-Network schedule of benefits:

- are subject to the same time limits as those described for In-Network services; and
- are obtained from a Non-VSP Provider in lieu of services rendered from a VSP Network Provider.

Access the VSP website at www.vsp.com to obtain a list of VSP Network Providers. VSP Member Services may also be reached at (800) 877-7195.

Frequency of Services

The following frequencies apply to services received from either a VSP Network Provider or Non-VSP Provider:

Service	Frequency	
	Vision Plan	**Vision Plus Plan**
Vision Exam	Once per Plan Year	Once per Plan Year
Lenses	Once per Plan Year*	Once per Plan Year*
Contact Lenses	Once per Plan Year*	Once per Plan Year*
Frames	Once every other Plan Year*	Once per Plan Year*

* When contact lenses are obtained, you are not eligible for lenses and frames again for one Plan Year.

VSP Choice Plan Schedule of Benefits

Vision Plan Benefits (Maximum Limits Shown)		
Basic Plan Features	**In-Network VSP Network Provider***	**Out-of-Network Non-VSP Provider**
Comprehensive Vision		
Examination	100% after a $10 Copayment	$40 after a $10 Copayment
Retinal Screening	Copay not to exceed $39	Not covered
Frames	$175 after a $10 Copayment**	$45 after a $10 Copayment**
Lenses (Glass or Plastic)*		
Single Vision	100% after a $10 Copayment	$40 after a $10 Copayment
Bifocal	100% after a $10 Copayment	$60 after a $10 Copayment
Trifocal	100% after a $10 Copayment	$80 after a $10 Copayment
Lenticular	100% after a $10 Copayment	$100 after a $10 Copayment
Polycarbonate	100% for children****; average savings of 20-25% for adults	Not covered
Progressives	➢ $0 Copayment for standard progressive lenses ➢ $95-$105 Copayment for Premium progressive lenses ➢ $150-$175 Copayment for Custom progressive lenses	$80 after a $10 Copayment
Tints, Dyes and Coatings		
Plastic Dyes—Solid	100%	$10***
Plastic Dyes—Gradient	100%	$10***
Glass Tints	100%	$10***
Glass Color Coatings—Solid	100%	$10***
Glass Color Coatings—Gradient	100%	$10***
Photochromics—Glass	100%	$10***
Photochromics—Plastic	100%	$10***
UV Protection	100%	$10***
Anti-Reflective	100%	$10***
Mirror (Solid and Single Gradient)	100%	$10***
Scratch Resistant Coating	100%	$10***
Ski-type	100%	$10***
Contact Lenses (Materials, Evaluation Fee and Fitting Costs)		
Medically Necessary	100% after a $10 Copayment	$125 after a $10 Copayment
Elective	Contact lens exam (fitting and evaluation) maximum $60 copay; $175 allowance toward the contact lenses	$125

* Coverage with a participating Retail Chain may be different. Visit www.vsp.com for details.

** Frames and lenses purchased at the same time are subject to only one $10 materials Copayment.

*** VSP allows a $10 allowance for tints/dyes as well as a $10 allowance for each coating received on a pair of lenses.

**** Children are defined as any dependent child up to the end of the birth month at age 26.

VSP Choice Plan Schedule of Benefits

Vision Plus Plan Benefits with Personalized EasyOptions Upgrade (Maximum Limits Shown)		
Basic Plan Features	**In-Network VSP Network Provider***	**Out-of-Network Non-VSP Provider**
Comprehensive Vision		
Examination	100% after a $10 Copayment	$40 after a $10 Copayment
Retinal Screening	Copay not to exceed $39	Not covered
Frames	$175 after a $10 Copayment**	$45 after a $10 Copayment**
Lenses (Glass or Plastic) **		
Single Vision	100% after a $10 Copayment	$40 after a $10 Copayment
Bifocal	100% after a $10 Copayment	$60 after a $10 Copayment
Trifocal	100% after a $10 Copayment	$80 after a $10 Copayment
Lenticular	100% after a $10 Copayment	$100 after a $10 Copayment
Polycarbonate	100% for children***; average savings of 20-25% for adults	Not covered
Progressives	➢ $0 Copayment for standard progressive lenses ➢ $95-$105 Copayment for Premium progressive lenses ➢ $150-$175 Copayment for Custom progressive lenses	$80 after a $10 Copayment
Tints, Dyes and Coatings		
Plastic Dyes—Solid	Average savings of 20-25%	Not covered
Plastic Dyes—Gradient	Average savings of 20-25%	Not covered
Glass Tints	Average savings of 20-25%	Not covered
Glass Color Coatings—Solid	Average savings of 20-25%	Not covered
Glass Color Coatings—Gradient	Average savings of 20-25%	Not covered
Photochromics—Glass	Average savings of 20-25%	Not covered
Photochromics—Plastic	Average savings of 20-25%	Not covered
UV Protection	Average savings of 20-25%	Not covered
Anti-Reflective	Average savings of 20-25%	Not covered
Mirror (Solid and Single Gradient)	Average savings of 20-25%	Not covered
Scratch Resistant Coating	Average savings of 20-25%	Not covered
Ski-type	Average savings of 20-25%	Not covered
Contact Lenses (Materials, Evaluation Fee and Fitting Costs)		
Medically Necessary	100% after a $10 Copayment	$125 after a $10 Copayment
Elective	Contact lens exam (fitting and evaluation) maximum $60 copay; $175 allowance toward the contact lenses	$125

Vision Plus Plan Benefits with Personalized EasyOptions Upgrade (Maximum Limits Shown)		
EasyOptions		
Personalize your vision plan—after your eye exam. You and each Covered Person on your plan can choose one of these five enhanced eyewear options when purchasing your glasses or contacts	➢ An additional $50 frame allowance, or ➢ An additional $50 contact lens allowance, or ➢ Fully covered progressive lenses, or ➢ Fully covered photochromic adaptive lenses, or ➢ Fully covered anti-reflective coating.	Not covered

* Coverage with a participating Retail Chain may be different. Visit www.vsp.com for details.

** Frames and lenses purchased at the same time are subject to only one $10 materials Copayment.

*** Children are defined as any dependent child up to the end of the birth month at age 26.

NOTE

Maximize your benefits with an extra $50 to spend, on top of your allowance, on any frame from a wide selection of featured frame brands. Simply select a featured frame brand in any VSP provider's office and the $50 will automatically be applied to your purchase. See your VSP Network Provider for details, or visit the Special Offers section of www.vsp.com.

Contact Lens Benefit

Contact lenses are considered Medically Necessary if they are visually necessary:

- to correct extreme visual acuity problems that cannot be corrected with glasses;
- for Anisometropia (a condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other);
- for Keratoconus (a developmental or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area); or
- for other eye conditions that make contact lenses necessary.

The determination of whether contact lenses are Medically Necessary or elective, regardless of whether they are obtained from a VSP Network Provider or Non-VSP Provider, is subject to review and authorization from VSP's optometric consultants.

Employees can find information about contact lens rebates and other offers at www.vsp.com on the Special Offers tab.

Low Vision Benefit

The Low Vision Benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses. This benefit is subject to the following limitations:

- Prior Authorization-When a VSP Network Provider suspects a low vision condition, the doctor requests advance approval prior to beginning services. VSP consultants may authorize supplementary testing by the doctor to determine the nature of the problem and to allow the doctor to gather enough facts to propose a treatment plan. The supplementary testing is paid by the Vision Plan with no Copayment by the Covered Person.
- Benefit-After supplementary testing, the doctor submits the treatment plan to VSP consultants. The consultants will review the plan and, if the plan is approved, will authorize benefits on a Coinsurance basis with 75% of the cost being paid by the Vision Plan and 25% being paid by the Covered Person.
- Maximum Benefit-The Vision Plan will pay a maximum of $1,000 (excluding the portion paid by the Covered Person) every two years for approved low vision care. This maximum includes supplementary testing charges.

Low Vision Benefits secured from a Non-VSP Provider are subject to the same time limits and payment arrangements as described above for a VSP Network Provider, except that VSP will reimburse you for Non-VSP Provider fees in accordance with an amount not to exceed what VSP would pay a VSP Network Provider in similar circumstances. However, there is no assurance the amount billed to the Covered Person will equal 25% of the Non-VSP Provider fee.

DIABETIC EYECARE PLUS PROGRAM

General

Under the Diabetic Eyecare Plus Program ("DEP") Benefit, Covered Persons who have been diagnosed with diabetic eye disease, glaucoma and age-related macular degeneration (AMD), and who are covered under the VSP Choice Plan®, are entitled to additional vision care benefits. The Diabetic Eyecare Plus Program allows the Covered Person's VSP Network Doctor to provide diagnostic services not available under the VSP Choice Plan. The Diabetic Eyecare Plus Program does not cover medical treatment for Covered Persons with diabetic or any other medical conditions. The Diabetic Eyecare Plus Program does not replace coverage for diabetic eyecare, glaucoma or AMD services under a medical plan.

Procedures for Obtaining Diabetic Eyecare Plus Program Services

The Covered Person's VSP Network Doctor will provide services under the DEP Program as needed following the Covered Person's routine VSP Choice Plan eye examination. No referrals or authorizations are required for services provided under the DEP Program.

Copayment

A Copayment of $5.00 is required for each Ophthalmological Service and Office Visit under the DEP Program, and is paid to the VSP Network Doctor at the time of service. Other Copayments may apply to services under Covered Person's VSP Choice Plan. Refer to the Schedule of Benefits below.

VSP Diabetic Eyecare Plus Program® Schedule of Benefits

Service*	VSP Network Doctor Benefit	Benefit Frequency†	Non-VSP Provider Benefit**
Ophthalmological Services and Office Visits	Covered in full, less $5.00 Copayment	Once every 12 months	Up to current Non-VSP Provider Schedule of Allowances
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	

Covered Services
(The following list is current and is subject to change without notice.)

Description	Procedure Code
Ophthalmological Services	92002, 92004, 92012, 92014
Office Visits	99201–99205, 99211–99215
Gonioscopy	92020
Extended Ophthalmoscopy	92225, 92226
Fundus Photography	92250
SCODI-P	92133, 92134

* Service and/or diagnosis limitations apply, or certain procedures require special handling. VSP Network Providers must consult the VSP Provider Reference Manual for details before rendering services.

† Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.

** Non-VSP Provider Benefits are available only to Covered Persons whose Group has purchased this option, or where such benefits are required by the laws of Covered Person's state of residence. Covered Persons should contact their Group, or VSP Customer Service at (800) 877-7195 before obtaining services from Non-VSP Providers.

Exclusions and Limitations of Benefits

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an Employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered by Plan Benefits.

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
- **Type 2 Diabetes** A Disease in which the pancreas makes insufficient insulin or can't efficiently use it.
- **Fundus Photography** Taking photos of the inside of the eye that show the optic nerve and retinal vessels.
- **Extended Ophthalmoscopy** A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.
- **Gonioscopy** Use of special contact lens to look at the eye's aqueous drainage area.
- **Glaucoma** A Disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
- **AMD** Age-related macular degeneration (AMD) is a disease that destroys the clear, "straight ahead" central vision necessary for reading, driving, identifying faces and performing other daily tasks.

HOW THE VISION PLAN WORKS

In-Network VSP Network Provider	Out-of-Network Non-VSP Provider
Step one: Select your provider	
To find a VSP Network Provider location, visit the VSP website at www.vsp.com or call VSP at (800) 877-7195.	You may select the Non-VSP Provider of your choice.

In-Network VSP Network Provider	Out-of-Network Non-VSP Provider
Step two: Schedule your eye appointment	
➢ Call a VSP Network Provider and make an appointment. ➢ When making your appointment, you must identify yourself as a VSP participant. ➢ The VSP Network Provider will also need to know the covered Employee's name and last four digits of the Social Security Number. ➢ After the appointment has been scheduled, the VSP Network Provider will contact VSP to verify your eligibility and plan coverage. The doctor will also obtain authorization to provide services and materials. If you are not eligible, the VSP Network Provider should notify you. ➢ At the time of your appointment, the VSP Network Provider will provide you with an eye examination and, if necessary, order eye wear from a VSP contract laboratory.	➢ Call and make an appointment with the Non-VSP Provider of your choice.
Step three: Payment for services	
➢ VSP will pay the VSP Network Provider directly for covered services and materials. Any additional costs including Copayments, cosmetic options, or non-covered services and materials are your responsibility.	➢ You will be required to pay the full cost of your exam as well as any eyeglasses or contacts you select. ➢ Obtain an itemized bill. • The bill must show the charges for the eye examination, lens type (i.e., single vision, bifocal) and frame or contact lenses separately. ➢ Send a copy of the itemized bill to VSP. • The Employee's name, mailing address, and the last four digits of the Social Security Number, the Employer's name, as well as the Covered Person's name, relationship to the Employee, and date of birth, must also accompany the bill. • This information may be submitted on a reimbursement form obtained from VSP or any generic insurance claim form. These forms may be available from a Non-VSP Provider upon request.

In-Network VSP Network Provider	Out-of-Network Non-VSP Provider
	• Claims should be mailed to:
	Vision Service Plan Attention : Claim Services PO Box 385018 Birmingham, AL 35238-5018
	• You may also submit the reimbursement form on www.vsp.com. You may be eligible to upload your itemized bill (up to three attachments) and complete your claim submission online. ➢ Claims for reimbursement must be filed within one year (365) days of the date services were completed. VSP will reimburse you directly, up to the amount(s) shown in the Out-of-Network schedule of benefits. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.

EXCLUSIONS

The Vision Plan does not cover the following:

- Accidental injury or illness that affects your eyesight, which may be covered under your medical plan.
- Additional cost for the following options:
  - blended lenses (lenses that are bifocal or multifocal lenses which do not have a visible dividing line);
  - progressive multifocal lenses;
  - certain limitations on Low Vision Benefits;
  - contact lens modification, polishing or cleaning;
  - contact lens insurance policies or service agreements;
  - refitting of contact lenses after the initial (90-day) fitting period;
  - cosmetic lenses;
  - a frame that costs more than the Vision Plan allowance;
  - optional cosmetic processes; or
  - oversize lenses.
- Any eye examination or eye wear required by an Employer as a condition of employment.
- Corrective vision treatment of an experimental nature such as, but not limited to, Refractive Keratectomy (RK) and PRK Surgery.
- Laser vision correction services, including but not limited to Photorefractive Keratectomy (PRK), and Laser In-Situ Keratomileusis (LASIK).
- Medical or surgical treatment of the eyes.
- Orthoptics (the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision) and any associated supplemental testing.
- Plano lenses (lenses with less than +/- 0.50 diopter power).

- Replacement of lenses and frames furnished under the Vision Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Services and materials that are not medically or visually necessary to restore or maintain a Covered Person's visual activity and health.
- Services and/or materials not specifically included in this Summary Plan Description as covered plan benefits.
- Two pairs of single vision glasses instead of one pair of bifocals.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

IMPORTANT

Although the Vision Plan does not provide coverage for the services and materials listed in the Exclusions section, reduced fee arrangements may be available to Covered Persons on certain items, e.g., laser vision correction services, when the services and/or materials are obtained from VSP Network Providers at approved facilities. Covered Persons should contact their VSP Network Provider or VSP for additional information regarding reduced fees on these items.

At VSP's discretion, it may waive any of the Vision Plan limitations if, in the opinion of VSP's optometric consultants, this is necessary for the visual welfare of the Covered Person.

OTHER PLAN PROVISIONS

Assignment of Benefits

The benefits provided under the Vision Plan are assignable.

Payment of Benefits

Subject to the Coordination of Benefits as described in the General Provisions section, all benefits are payable immediately to the assignee, if any. Otherwise benefits are payable immediately to you or to an Alternate Recipient, or the Alternate Recipient's custodial parent or legal guardian, pursuant to a Qualified Medical Child Support Order. If benefits are payable after your death, the Vision Plan has the option to pay benefits to your estate or to any of the following of your surviving relatives: spouse, child(ren), parent(s), brother(s) and/or sister(s).

Payment of benefits will also be made in accordance with any assignment of rights made by or on behalf of a participant or beneficiary as required by a state's Medicaid program. Determination and payment of benefits under the Vision Plan will not take into account that a Vision Plan participant is eligible for or covered by Medicaid. Payment of benefits will be made in accordance with any state law which provides that the state has acquired the rights of the participant or beneficiary with respect to items or services the Vision Plan has a legal obligation to pay, but only to the extent the state has made payment for the benefits under the Medicaid program.

CLAIM PROCEDURES

The responsibility for initial claims determinations, and the full and fair review of denials (first and second level appeals and Urgent Care appeals, when applicable), pursuant to Section 503 ERISA has been delegated to the Third Party Administrator for the Vision Plan. For additional details, please refer to the section titled "How The Vision Plan Works."

Initial Benefit 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.

Urgent Care Claims

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans, such as the Diabetic Eyecare Plus Program. 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 Non-VSP Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature, but the Covered Person should contact medical plan to determine if prior approval is needed by the 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.")

For situations of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should call VSP for assistance. Reimbursement and eligibility are subject to the terms of the Policy.

Appeal of Initial Benefit Determination

If you disagree with an initial benefit determination made by VSP, you may request an appeal and have VSP reconsider the decision. You have the right to:

- Submit a written request to VSP for review of the claim no later than 180 calendar days after receipt of a denial determination;
- Review pertinent Plan documents; and
- Submit additional material or information in writing to VSP.

Send your initial benefit determination appeal to:

VSP
Attn: Appeals Dept.
P.O. Box 2350
Rancho Cordova, CA 95741

Manner and Content of Initial Appeal

A qualified individual who was not involved in the decision being appealed will be appointed to render a decision. If your appeal is related to clinical matters, the review will be conducted in consultation with a health care professional in the field who was not involved in the initial benefit determination. VSP may consult with medical experts as part of the appeal resolution process. If a claim is denied in whole or in part, under the terms of the Policy, the Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. The Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the 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 the Covered Person disagrees with the response to the initial appeal of the denied claim, the 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, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the 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 the Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. The 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)]), the 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 the Covered Person disagrees with the outcome.

Decisions of VSP are final.

Time Limits on Starting Lawsuits or Other Legal Action

No claimant (including Plan participants and their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action (under § 502 of ERISA or otherwise) to obtain any Vision Plan benefits under the Allstate Cafeteria Plan, without first having complied with and exhausted all levels of appeal required by the Vision Plan, and in any event not less than 60 calendar days or more than three years and 90 calendar days or any applicable statute of limitations in accordance with state or federal law after the final appeal is denied by VSP.

Failure to follow the claim procedures of the Vision Plan including timeframes and exhaustion of administrative remedies shall result in a loss of benefits, if otherwise available.