Vision Benefit Summary Booklet

DeltaVision®

WEDGEWOOD VILLAGE PHARMACY, INC.

Group # 09718

Delta Dental of New Jersey, Inc.
P. O. Box 16354
Little Rock, AR 72231

Subject to the Laws of the State of New Jersey

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About This Booklet

This **Booklet** contains a general description of your **DeltaVision**® vision benefit program as a convenient reference. All **Benefits** are governed by the **Contract** provided to your employer.

*The words that appear in bold in this booklet are defined in the Glossary. In the event of a difference between the **Benefits** described in this Booklet and the **Contract**, the terms of the **Contract** shall prevail.*

*This **DeltaVision** vision benefit program does not provide essential pediatric vision benefits that satisfy the Affordable Care Act or similar state law requirements.*

About DeltaVision®

DeltaVision is underwritten by Delta Dental of New Jersey, Inc. ("Delta Dental®") and administered by Vision Service Plan Insurance Company ("VSP"). **VSP** has a network of independent providers and popular retailers. With **DeltaVision, Covered Persons** can choose to receive **Benefits** using **VSP Preferred Providers** or through other licensed vision care providers that are not part of the **VSP** network (Open Access Providers). **Benefits** are listed in the Schedule of Benefits and **Additional Benefit Riders**, if applicable, and are subject to limitations, **Exclusions**, or member responsibility, like. **Copayments**.

Eligibility Requirements

You are eligible for coverage under this plan when you have :

- Met the employer's eligibility requirements, and
- Complete enrollment in the employer's vision plan.

Your employer will inform you of your coverage effective date under the vision plan. An enrollment form is required unless eligibility is submitted electronically. You are considered a **Covered Person** once **Delta Dental** receives and approves a signed enrollment form or electronic file. Persons in military service are not eligible for **Benefits** under the **Contract.**

- All new employees and their dependents will be covered from the date stated on the enrollment form after completing any eligibility periods required by the employer.

- An eligible employee is any full-time employee or retiree, if applicable, eligible for coverage, as determined by the employer.

Eligible Dependents

- Your **Spouse** (if applicable).

- Dependent children (subject to age limitations):

    - Children include a biological child, stepchild, foster child, legally adopted child, child of the employee's **Spouse**, and children under a court appointed guardianship.
    - Children from birth to age 26.
    - Your legally adopted child includes a child for whom legal adoption proceedings have already been started.
    - Disabled children – in order for a mentally or physically disabled child to remain covered, you must show proof of the child's disability. This proof must be provided to Delta Dental.

When does coverage terminate/expire?

Coverage for employees and their eligible dependents shall cease upon the earliest of:

- Termination of employee's employment
- Death of employee
- Termination of the **Contract**
- You or your dependents are no longer eligible for **Benefits** based on the eligibility standards listed here or as selected by the employer

Coverage for dependent **Spouse** shall terminate on divorce from the covered employee unless otherwise stated by divorce decree.

Coverage for a dependent child shall terminate upon attaining the limiting contract age, except that coverage for a mentally or physically disabled child may continue upon proof of disability (see the Eligible Dependent section above).

A **Covered Person** who is totally disabled, as determined by the **Covered Person's** physician as of the date on which termination of the **Contract** takes effect (the "**Contract Termination Date**") shall be entitled to continued coverage as if the **Contract** had not been terminated for ninety (90) days following the **Contract Termination Date** without payment. To receive this continued coverage, the **Covered Person** must submit evidence of the total disability to **Delta Dental.**

For **Coordination of Benefits**, your group follows the birthday rule.

How to Use Your Program

We provide **Benefits** to **Covered Persons** based on the level of coverage purchased by your employer. Refer to the Schedule of Benefits and **Additional Benefit Rider**, if applicable, for specific **Benefits. Benefits** are subject to certain limitations**, Exclusions,** and member payment responsibilities, such as **Copayments,** as listed for your plan, as listed in this Booklet.

You can choose any vision provider for services. However, the provider you choose will affect the Benefits you receive under this plan.

Obtaining Services from VSP Preferred Providers:

VSP Preferred Providers have agreed to accept payment for **Covered Services** or materials with no additional billing to you except for **Copayments**, applicable tax, and any amounts for services or materials that are not covered **Benefits**. It is also important to remember that the **VSP Preferred Provider** can also bill you for the full amount of the service or material if you chose to get a service or material that is not a **Covered Service** that is listed in the Schedule of Benefits or any **Additional Benefit Rider.**

1. Contact **VSP** to obtain a list of **VSP Preferred Providers** and/or to view available **Benefits** (see below for contact information).

2. Once a **Covered Person** selects a **VSP Preferred Provider,** contact the provider's office to schedule an appointment and let the office know that you are a **Covered Person** under a plan that uses the **VSP** network of providers. The **VSP Preferred Provider** will contact **VSP** to obtain a **Benefit Authorization**. Each **Benefit Authorization** has a benefit expiration date and must be used prior to that expiration date. As long as the **Covered Person** gets the service or materials prior to the expiration date on the **Benefit Authorization** and before the **Coverage Expiration Date,** payment will be made to the **VSP Preferred Provider** even if the **Covered Person** is no longer eligible for **Benefits**. Retail chains may not offer all **Benefits**. A **Covered Person** may contact a **VSP Preferred Provider** for information describing vision care services and vision care materials offered. If you have questions about your coverage or **Benefits**, please call 800-877-7195 or visit www.deltadentalnj.com**.**

3. Once an appointment is scheduled, the **VSP Preferred Provider** will get a **Benefit Authorization from VSP**. The **VSP Preferred Provider** will bill **VSP** directly and the **Covered Person** is responsible for payment of any applicable **Copayments**, non-covered services or materials, or amounts which exceed plan allowances and annual maximum **Benefits**. If a **Covered Person** receives **Benefits** from a **VSP Preferred Provider** without a **Benefit Authorization**, any services or materials received from the provider will be treated as **Benefits** from an **Open Access Provider**.

4. Except as otherwise provided herein, **VSP** may deny any **Claims** received after one hundred eighty (180) calendar days from the date services are rendered and/or materials provided. If it was not reasonably possible to submit a **Claim** in the required time period, the **Claim** must be filed as soon as reasonably possible.

Open Access Provider Benefits:

1. When services and /or materials are received from **Open Access Providers**, you 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 your behalf**, VSP** will reimburse the **Open Access 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.** You may be responsible for paying more than the applicable **Copayment**. Obtaining services from an **Open Access Provider** will typically result in higher out of pocket expenses for you**.** You are responsible for paying an **Open Access Provider** any amounts billed for services rendered. You may apply any reimbursement paid directly to you by **VSP** to such **Claim** for services you receive from an **Open Access Provider.**

2. All **Claims** must be submitted to **VSP** within one hundred eighty (180) calendar days from the date services are rendered and/or materials provided. Except as otherwise provided herein, **Claims** received after one hundred eighty (180) days will be denied unless prohibited by applicable state or federal law. If it was not reasonably possible to submit a **Claim** in the required time period, the **Claim** must be filed as soon as reasonably possible.

Schedule of Benefits

GENERAL

This Schedule of Benefits lists the vision care services and materials that are covered **Benefits** under this plan. **Covered Persons** are entitled to the **Benefits** listed in the Schedule of Benefits, and **Additional Benefit Riders**, if applicable, subject to any **Copayments** and other conditions, limitations and/or **Exclusions** stated herein. This Schedule of Benefits forms a part of this plan and the **Contract**.

	BENEFITS WITH VSP PREFERRED PROVIDERS	**BENEFITS WITH OPEN ACCESS PROVIDERS**
		• **Exclusions** and limitations of **Benefits** described for **VSP Preferred Providers** shall also apply to services rendered by **Open Access Providers**. • Services from an **Open Access Provider** are in lieu of services from a **VSP Preferred Provider** or **Retail Chain 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 meet or comply with **VSP**'s billing or quality standards.
COPAYMENT		
Eye Examination	There shall be a **Copayment** of $0 for the eye examination payable by the **Covered Person** at the time services are rendered. Retinal Screening – There shall be a maximum **Copayment** of $39 for retinal imaging as an enhancement to eye examination.	There shall be a **Copayment** of $0 for the examination payable by the **Covered Person**.

	BENEFITS WITH VSP PREFERRED PROVIDERS	BENEFITS WITH OPEN ACCESS PROVIDERS
Materials Lenses, frames or **Necessary Contact Lenses**	If materials are provided, there shall be a $0 **Copayment** payable at the time the materials are ordered. The **Copayment** shall not apply to **Elective Contact Lenses**. Lens Enhancements, if covered under this plan, may have a separate **Copayment**. Please refer to COVERED SERVICES AND MATERIALS, below.	If materials are provided, there shall be a $0 **Copayment**
COVERED SERVICES AND MATERIALS		
Eye Examination Comprehensive examination of visual functions and prescription for corrective eyewear		
	Covered in full less any applicable **Copayment** once every – 12 months beginning with the **First Date of Service.** Retinal Screening – Covered in full less any applicable **Copayment**. Coverage for retinal imaging as an enhancement to eye examination.	Covered up to $45 less any applicable **Copayment** once every – 12 months beginning with the **First Date of Service**
Lenses Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)		
	Covered in full less any applicable **Copayment** once every – 12 months beginning with the **First Date of Service.** Polycarbonate lenses are covered in full for **Dependent** children up to age 26. Standard progressive lenses covered in full.	Covered less any applicable **Copayment** once every – 12 months beginning with the **First Date of Service** Single Vision covered up to $30 Bifocal covered up to $50 Trifocal covered up to $65 Progressive covered up to $50 Lenticular covered up to $100

<table>
<tr><td colspan="4">Lens Enhancements</td></tr>
<tr><td></td><td colspan="2">Covered in full once every 12 months beginning with the First Date of Service</td><td rowspan="8">Lens Enhancements are included with the Lens Copayment</td></tr>
<tr><td></td><td colspan="2">Copayment:</td></tr>
<tr><td></td><td>Single Vision</td><td>Multifocal</td></tr>
<tr><td>Anti-glare coating</td><td>$41</td><td>Anti-glare coating</td></tr>
<tr><td>Impact-resistant lenses– Children up to age 26</td><td>Covered</td><td>Impact-resistant lenses– Children up to age 26</td></tr>
<tr><td>Impact-resistant lenses- Adult</td><td>$31</td><td>Impact-resistant lenses- Adult</td></tr>
<tr><td>Progressive</td><td>Covered</td><td>Progressive</td></tr>
<tr><td>Light-reactive lenses</td><td>$75</td><td>Light-reactive lenses</td></tr>
<tr><td>Scratch-resistant coating</td><td>$17</td><td>Scratch-resistant coating</td></tr>
<tr><td colspan="4">Frames</td></tr>
<tr><td></td><td colspan="2">Covered up to the plan allowance less any applicable Copayment once every – 12 months beginning with the First Date of Service.

Frames are covered in full up to the retail allowance of $200.

The VSP Preferred Provider will prescribe and order Covered Person’s lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.</td><td>Covered less any applicable Copayment once every – 12 months beginning with the First Date of Service.

Covered up to $70.</td></tr>
<tr><td colspan="4">Contact Lenses – Contact lenses are provided in addition to spectacle lens and frame Benefits available herein.</td></tr>
<tr><td>Elective
Elective Contact Lenses not required for the visual welfare of the patient.</td><td colspan="2">Elective Contact Lenses (materials only) are covered up to the retail allowance of $200 once every – 12 months beginning with the First Date of Service (in lieu of frame and lenses).</td><td>Elective Contact Lenses are covered up to $105 once every – 12 months beginning with the First Date of Service.

The Elective Contact Lens allowance applies to both the provider's fitting and evaluation fees</td></tr>
</table>

	The **Elective Contact Lens** fitting and evaluation services are covered in full once every – 12 months beginning with the **First Date of Service**, after a maximum $60 **Copayment**.	and to materials.
Necessary **Necessary Contact Lenses** are a **Benefit** when specific benefit criteria are satisfied and when prescribed by Covered Person's provider.	**Necessary Contact Lenses** are covered in full less any applicable **Copayment** once every – 12 months beginning with the **First Date of Service**.	**Necessary Contact Lenses** are covered up to $210 once every – 12 months beginning with the **First Date of Service**.
LOW VISION Professional services for severe visual problems not correctable with regular lenses. In order to receive **Benefits** under the **Contract** for Low Vision services, the **Covered Person, VSP Preferred Provider**, or the **Open Access Provider** must receive a **Benefit Authorization** from **VSP**. Please note that Low Vision services are subject to a Maximum Benefit as listed in this schedule.		
Supplemental Testing - Includes evaluation, diagnosis and prescription of vision aids where indicated	Covered in full subject to the Maximum Benefit.	Covered up to $1,000 subject to the Maximum Benefit.
Supplemental Aids	75% of **VSP Preferred Provider's** fee, up to $1,000, subject to the Maximum Benefit.	75% of **Open Access Provider's** fee, up to $1,000, subject to the Maximum Benefit.
Maximum Benefit	Maximum Benefit for all Low Vision services and materials is $1,000 every two (2) years and a maximum of one (1) supplemental tests within a two (2)-year period.	

Additional Benefit Riders

When purchased by the employer**,** the attached vision care service riders become a part of this plan:

Supplemental Essential Medical Eye Care

Limitation of Benefits

Some brands of spectacle frames may be unavailable for purchase as **Benefits** or may be subject to additional limitations. **You** may obtain details regarding frame brand availability from the **VSP Preferred Provider** or by calling 800-877-7195.

General Exclusion:

No **Benefit** payment shall be provided for:

- Service and/or material not specifically included as a covered **Benefit** in the Schedule of Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), if included in this plan.
- Two pairs of eyeglasses instead of bifocals.
- Replacement or repair of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when **Benefits** are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or material service agreements.
- 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 required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology
- Missed appointments
- Travel arrangements to or from appointments

If You Have Coverage Through Another Plan--Coordination of Benefits

1. APPLICABILITY

A **Covered Person** may be covered for **Vision Services** by more than one Plan. For instance, he or she may be covered by the Contract as an **Employee** and by another Plan as a **Dependent** of his or her **Spouse**. If he or she is covered by more than one Plan, this provision allows **Delta Dental** to coordinate what it pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary Plan and which is the secondary Plan. Coordination of Benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the **Covered Person** is covered.

2. DEFINITIONS

The words shown below have special meanings when used in this Article V. Please read these definitions carefully.

(a) "Allowable Expense" means the charge for any **Vision Service** for which the **Covered Person** is liable when the **Vision Service** is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

Since the **Contract** provides benefits for **Vision Services**, it will coordinate benefits only with a Plan that also provides benefits for **Vision Services**.

When the **Contract** is Coordinating Benefits with a Plan that restricts Coordination of Benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which Coordination of Benefits applies as an Allowable Expense.

(b) "Claim Determination Period" means a Calendar Year, or any portion of a Calendar Year, during which a **Covered Person** is covered by the **Contract** and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

"Plan" means coverage with which Coordination of Benefits is allowed.

i) Plan includes:
   1) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
   2) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
   3) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
   4) Group hospital indemnity benefit amounts that exceed $ 150.00 per day;
   5) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

ii) Plan does not include:
   1) Individual or family insurance contracts or subscriber contracts;
   2) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
   3) Group or group-type coverage where the cost of coverage is paid solely by the **Covered Person** except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
   4) Group hospital indemnity benefit amounts of $ 150.00 per day or less;
   5) School accident-type coverage;
   6) A State plan under Medicaid.

(c) "Primary Plan" means a Plan whose benefits for a **Covered Person's Vision Services** must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "i" or "ii" below exist:

i) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or

ii) All Plans which cover the **Covered Person** use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

(d) "Reasonable and Customary" means an amount that is not more than the usual or customary charge for the service or supply as determined by a Plan, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

(e) "Secondary Plan" means a Plan which is not a Primary Plan. If a **Covered Person** is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

3. PRIMARY AND SECONDARY PLAN

Delta Dental considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for necessary **Vision Services** and appropriate services on the basis that Prior Authorization was not obtained.

4. RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the **Covered Person** as a **Dependent**. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the **Covered Person** as an employee who is neither laid off nor retired, or as a **Dependent** of such person, shall be determined before those for the Plan that covers the **Covered Person** as a laid off or retired employee, or as such a person's **Dependent**. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree, or **Dependent** of such person, shall be determined before those of the Plan that covers the **Covered Person** under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

i) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
ii) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.
iii) "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
iv) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are separated or divorced, the following rules apply:

i) The benefits of the Plan of the parent with custody of the child shall be determined first.
ii) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
iii) The benefits of the Plan of the parent without custody shall be determined last.

iv) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

5. PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

i) The basis on which the Primary Plan and the Secondary Plan pay benefits; and

ii) Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the **Covered Person** may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R & C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the **Covered Person** may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the **Covered Person** uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per **Covered Person**. The **Covered Person** is liable only for the applicable deductible, coinsurance or copayment. If the **Covered Person** uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

i) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the **Covered Person** shall not exceed the fee schedule of the Primary Plan. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the **Covered Person** receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is R & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

i) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The **Covered Person** shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the **Covered Person** has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan

If the **Covered Person** receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

i) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

A. OTHER PROVISIONS REGARDING PAYMENT

1. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. **Delta Dental** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Delta Dental** need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give **Delta Dental** any facts it needs to pay the claim.

2. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, **Delta Dental** may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this Plan. **Delta Dental** will not have to pay that amount again. The term, "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

3. RIGHT OF RECOVERY

If the amount of the payments made by **Delta Dental** is more than it should have paid under the COB provision, it may recover the excess from one or more of:

(a) The person it has paid or for whom it has paid;

(b) Insurance companies; or

(c) Other organizations.

The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

How do I contact Delta Dental or VSP for Information?

Online

We encourage you to visit **VSP** at www.vsp.com. As a new member you should register to use the secured information center. Once registered, you can review **Benefits** and eligibility information, specifics on any **Claims** filed and remaining **Benefit** balances for all the individuals covered under your plan. You can also print additional copies of your ID card. You may also contact Delta Dental at www.deltadentalnj.com.

By Phone

Call whenever you have a question about your vision plan. You can reach **VSP** at 800-877-7195 or the toll-free number on the bottom of your ID card. Individuals with special hearing requirements may call 800-428-4833 to reach the TTY/TDD member care line. Representatives are available Monday through Saturday 9:00 a.m. to 8:00 p.m. (EST) to help with:

- General questions
- **Claims** questions
- Information about network providers
- Complaints and problem resolution

By Mail

Correspondence for Delta Dental should be addressed to:

Delta Dental of New Jersey, Inc
Attn: Correspondence Department
P.O. Box 15132
Little Rock, AR 72231

Correspondence for VSP should be addressed to:

VSP Customer Service:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Vision Claims:
Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5020

Vision Grievance and Appeals:
Vision Service Plan Insurance Company
Attention: Complaints and Grievances Unit
3333 Quality Drive
Rancho Cordova, CA 95670-7985

Notice of Nondiscrimination and Accessibility Rights
Delta Dental complies with applicable Federal civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, sex, age, or disability.

We offer free aids and services to provide access to information. This includes information provided in other formats and languages.

If you need a qualified interpreter, information in another language, or information in another format, contact our Customer Service department at 1-800-452-9310 or by email at service@deltadentalnj.com.

TDD Line - a hearing-impaired member can call 1-800-246-1020, Monday through Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST and be connected with a TDD machine to also access our Customer Service agents.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you may file a grievance with Delta Dental's Compliance Office by mail to: Delta Dental of New Jersey, Inc., Compliance Office, 1639 Route 10, Parsippany, NJ 07054 by phone at (866) 861-4716, or by email to: compliance@deltadentalnj.com.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Information on how to file a civil rights complaint is available at: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html .

Complaints can be filed electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone to the following:

U.S. Department of Health and Human Services 200
Independence Avenue SW.
Room 509F, HHH Building
Washington, DC, 20201
1-800-368-1019 or 800-537-7697 (TDD).

Complaint forms are available at https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf .

If a Member has a complaint with respect to the resolution of an appeal of an Adverse Benefit Determination, including denials based on the nature of the **Benefits** that are described in the Master Group Contract, such as procedures that are covered or not covered, frequency limits, timely premium payments, and eligibility, the employee/member may contact the Department of Banking and Insurance (DOBI) at:

New Jersey Department of Banking and Insurance Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

OR

Office of Insurance
Claims Ombudsman
20 West State Street
P.O. Box 472
Trenton, NJ 08625-0472

Phone: 800-446-7467 (outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431 Email: ombudsman@dobi.state.nj.us

Benefit Changes

Your vision benefits may be changed on any Anniversary Date of the **Contract** or as agreed to by **Delta Dental** and your employer. If you have questions regarding your vision benefits, please see section **How do I contact Delta Dental or VSP for Information?** for contact information.

Examination, Information and Records

Before approving a claim for payment and to the extent necessary to process a **Claim, Delta Dental** and **VSP** have the right to ask **VSP Preferred Providers, Open Access Providers**, labs**, Retail Chain Providers**, online providers, physicians, hospitals or other sources, for information and records as permitted by law relating to **Vision Services**, examination of or treatment, or materials or products provided to fabricated for a **Covered Person**. Any such information in the possession of **Delta Dental** or **VSP** shall be available to the **Covered Person** or his or her authorized representative upon written consent of the attending **VSP Preferred Provider, Open Access Provider,** lab, **Retail Chain Provider**, online provider, physician, hospital or other authorized source and the **Covered Person**.

Exculpation

VSP arranges for the provision of vision care services and materials through agreements with **VSP Preferred Providers**. **VSP Preferred Providers** are independently licensed or independent contractors and responsible for exercising independent judgment. **Delta Dental** does not-directly furnish vision care services or vision-related supplies or materials. Under no circumstances shall **Delta Dental, VSP** or the employer be liable under the terms of the **Contract** to any **Covered Person** or to each other for the

negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with the **Contract**. **VSP** shall be responsible and liable for vision-related supplies or materials provided by **VSP**-owned labs to the extent permitted by law. **Delta Dental** shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee or on the part of any person or entity or others engaged by them in the course of rendering vision care services or providing vision-related supplies or materials to any **Covered Person**. In no instance shall any service provider be deemed an employee or agent of **Delta Dental**.

Limitation on Actions

No action shall be maintainable against **Delta Dental** or **VSP** for any claims by or on behalf of any **Covered Person** unless brought within three (3) years from expiration of the time within which proof of loss must be provided.

Right of Recovery

If any person not entitled to payment obtains payment from **Delta Dental**, **Delta Dental** shall have the right to recover such payment from the payee or other person who obtained or received the payment or **Benefit.**

Benefit Payment Limitations

Indemnity in the form of cash will not be paid by or on behalf of **Delta Dental** to any **Covered Person** except in payment for services for which **Delta Dental** is liable under the **Contract** at the time vision services are provided. If a **Covered Member** entitled to payment is no longer liming or is a minor, such payment may be made to such person as may, in **Delta Dental's** sole discretion, be deemed entitled to the payment and **Delta Dental's** liability shall be discharged to the extent of such payment.

No Assignment Unless Required by Law

Except as otherwise provided by law, the **Benefits** and payments under the **Contract** are personal and not assignable.

Confidentiality

Delta Dental and **VSP** agree to keep confidential and not release confidential information regarding a **Covered Person** except to provide the services, to process **Claims,** as authorized or required by law, and in accordance with the applicable Notice of Privacy Practices.

Laws of the State of New Jersey

The **Delta Dental DeltaVision Contract** is deemed to be issued and delivered in the State of New Jersey and shall be construed according to the laws of the State of New Jersey.

How to Submit a Claim

The following is a description of how a **Claim** is processed. If you use a **VSP Preferred Provider**, the **VSP Preferred Provider** will send a **Claim** on your behalf. If you visit an **Open Access Provider**, the **Open Access Provider** is responsible for submitting the **Claim** or, alternatively you may elect to submit the **Claim**. You or the **Open Access Provider** should obtain a **Claim** form from **VSP**. If you do not receive the **Claim** form within 15 days of **VSP's** receipt of your request, the proof requirements will be met by you upon submitting, within the time required below for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which the **Claim** is made.

Proof of loss: For reimbursement of any loss under the **Contract**, proof of loss must be provided to **VSP** at the address included in section **How do I contact Delta Dental or VSP for Information?** Proof must be provided no more than one hundred eighty (180) calendar days after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any **Claim** if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible.

"Loss" means any amounts you paid for services or materials to an **Open Access Provider**. A "proof of loss" means a request for reimbursement. "Date of loss" means the date services were rendered or materials purchased.

Time of Payment of Claims: Requests for reimbursement payable under the **Contract** will be paid or denied immediately upon receipt of due written proof of loss. Requests for reimbursement received by **VSP** which are not complete may result in a delay in payment. If **VSP** requires additional information in order to process **Your** claim, **VSP** will contact **You** by telephone or in writing. Once all requested information has been received, **VSP** will pay or deny **Your** claim immediately upon receipt of due written proof of such loss.

Benefit Determination and Appeal Process Summary

Introduction: The United States Department of Labor has adopted regulations governing **Claim** adjudication and appeals for group health plans governed by ERISA. The **Claims** and appeals procedures apply to all ERISA plans, whether insured ("risk") or self-funded ("ASO" or "ASC").

Below is the **Delta Dental's** Benefit Determination and Appeal Process. The procedures apply to ERISA plans. **Delta Dental** is currently voluntarily applying these procedures to non-ERISA plans whenever feasible.

Applicability: This process applies to all ERISA plans for which **Delta Dental** provides coverage or administration.

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 **Contract**, the **Covered Person** or the **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 **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, **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. Such arbitration shall be non-binding. 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, 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.

For the full version of the appeals process, please contact **VSP.

Health Care Fraud

It is insurance fraud to submit false information to a plan in order to obtain a larger payment than you are entitled to receive. False **Claims** include submitting a **Claim** for a service not actually rendered, misdescribing a service which was rendered, misrepresenting the amount of the fee the provider charged and intended to collect (including failing to disclose that the provider will waive all or part of the patient's copayment or coinsurance), or using an incorrect date for the actual rendering of the vision service.

Insurance fraud hurts everyone because it reduces the funds available to pay **bona fide Claims** and can result in the termination of benefit plans due to increased costs. It has severe criminal and civil consequences to those who participate in the preparation or submission of such **Claims**. We urge all plan participants to refrain from submitting or participating in the submission of false **Claims** and to contact us at 800-877-7195 if you suspect that a false **Claim** has been submitted.

Frequently Asked Questions

- Do I need to have an assigned provider?

  No. This plan allows you to be treated by any licensed vision provider of your choice. Generally, the least out-of-pocket expense can be achieved by using a **VSP Preferred Provider**.

- Do I need an ID card as proof of coverage when I visit a provider?

  If your employer has issued an identification card, you should show it to your provider. However, it is not required that a provider see an ID card before rendering treatment. An ID card does not verify active coverage. You or your vision provider may obtain your group number, current eligibility and benefit information by contacting VSP at 800-877-7195 and 24 hours a day, 7 days a week or at www.deltadentalnj.com.

- What if I have questions about my **Benefits**?

  You can call our Customer Service Department at 800-452-9310 and speak to a representative Monday through Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST. Also, our interactive voice response system can provide eligibility and benefit information, and information on your recent claims 24 hours a day, 7 days a week. Benefit and claim information is also available through our member benefit portal at www.deltadentalnj.com.

- When will **VSP** communicate its benefit determination?

  VSP will notify you of its benefit determination for post-service **Claims** within a reasonable period of time, but not later than 30 days after receipt of the electronic **Claim**. If **VSP** needs to extend its decision another 15 days, it will notify you of the reason for the extension and estimated determination date prior to the initial 30-day period.

- What will **VSP** do if there is an Adverse Benefit Determination?

  If the benefit determination is adverse, **VSP** will notify you in writing. The notice will specify the reason(s), refer to the specific plan provision, guideline or protocol upon which the determination was based, describe any additional material or information needed for you to complete the **Claim** and explain why such documentation is necessary, and describe the initial appeal process and time limits. In addition, if the Adverse Benefit Determination was based on medical necessity or **Exclusion** for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- Is there a time limit for submitting vision **Claims**?

  Yes. In most cases, you have 365 days from the date of service to submit your vision **Claims**. If there is **Coordination of Benefits** involved and **VSP** is not the primary plan, you have 365 days from the date on which the primary carrier(s) issues a statement of benefits to submit the **Claim** to **VSP**. If the **Claim** is submitted after these time frames, then the services are not covered. However, failure to provide the proof within the required time does not invalidate or reduce any **Claim** if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible.

- What can I do if I am dissatisfied with the initial Adverse Benefit Determination?

  You can file a request for informal review within 60 days of the Adverse Benefit Determination. You would send it to:

  VSP
  Attn: Correspondence Department
  P.O. Box 15132
  Little Rock, AR 72231

  Your request must include the **Claim** number, name and address of the employee, name of the employer, date of service and description of service, your signature and date of signature, date you received an Adverse Benefit Determination, reason(s) why you think the determination was incorrect and any relevant documents and information.

  The person making the decision at **VSP** will be a person who did not make the initial determination and who is not the subordinate of the initial reviewer. The decision-maker for a determination based in whole or in part on medical judgment will consult with a health care professional who has training and experience involved in medical judgment and who was not consulted in the earlier determination(s).

  VSP will notify you in writing of its determination within 30 days for pre-service **Claims**. If the benefit determination is adverse, the notice will specify the reason(s), refer to the specific plan provision, guide or protocol upon which the determination was based, inform you of your right to receive free of charge, upon request, all relevant documentation, and describe any voluntary, external appeal procedures as well as your right to bring civil (court) action. In addition, if the Adverse Benefit Determination was based on medical necessity or **Exclusion** for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- What can I do if I am dissatisfied with the informal appeal decision?

  You or your provider must request a formal review in writing within 60 days of receipt of the original Adverse Benefit Determination (whether or not you requested an informal review) and send it to:

  VSP
  Attn: Correspondence Department
  P.O. Box 15132
  Little Rock, AR 72231

  The request for a formal review must include the provider's name, office name, address and license number, the employee's name, member ID number and date of birth, the patient's name, date of birth, the **Claim** number, the reason(s) why **VSP** should change its initial decision and the specific decision you are seeking, any relevant information or diagnostic materials, and/or a copy of the **Claim** for the determination you are appealing. You must also sign the request. **VSP** will notify you in writing of its determination within 30 days for pre- and post-service **Claims**.

- How do eligible children attending college away from home find a **VSP Preferred Provider**?

  A customized list of **VSP Preferred Providers** for a specific geographic location can be obtained by calling 800-877-7195. This list will be mailed or can be faxed in case of an emergency situation. Also, listings of **VSP Preferred Providers** throughout the country are available on our web site at www.vsp.com.

- If I am not located in the same state as my employer's headquarters, where do I call?

  800-877-7195 to reach our Customer Service Department, Monday to Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST. Our interactive voice response system is available 24 hours a day, 7 days a week.

- For more Frequently Asked Question please visit **Delta Dental**'s web site at www.deltadentalnj.com.

Continuation of Coverage (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (*COBRA*) or applicable state continuation of benefit law, you and/or your eligible dependents may have the right to elect to continue certain group health coverage which would otherwise end as a result of any of the following events:

- termination of employment for reasons other than gross misconduct;
- a reduction of your hours so that you or your dependents no longer meet the Eligibility Requirements for coverage;
- your death;
- your legal separation or divorce;
- your child no longer qualifies as a dependent.
- you or your spouse becomes entitled to Medicare.
- your becoming eligible under the Trade Adjustment Assistance Reform Act of 2002

If coverage is to continue, you and/or your eligible dependents will be responsible for paying the contributions and fees required for that coverage. Please see your employer / plan administrator for additional information about continuation of coverage or *COBRA.*

Statement of Participants and Beneficiaries' Rights Under ERISA

Plan Sponsor:
Wedgewood Village Pharmacy
405 Heron Dr, Suite 200
Swedesboro, NJ 08085-1749
Phone: (856) 832-1345

Plan Administrator:
Wedgewood Village Pharmacy
405 Heron Dr, Suite 200
Swedesboro, NJ 08085-1749
Phone: (856) 832-1345

Agent for Service of Legal Process:
Wedgewood Village Pharmacy
405 Heron Dr, Suite 200
Swedesboro, NJ 08085-1749
Phone: (856) 832-1345

Program Fiscal Year Ends: December 31st
Program Benefit Year Ends: December 31st
Source of Plan Contribution:
Plan Sponsor's Employer I.D. Number: 81-1186519
Plan Number: 501

As a participant in this Group Dental Health Program, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Receive a summary of the plan's annual financial report. Also, unless the plan has fewer than 100 participants, the plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have Delta Dental review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you requested materials from the plan and do not receive them within 30 days, you may file suit in state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA, you should contact the plan administrator (see above) or the nearest Area Office of the Pension and Welfare Benefits Administration.

Glossary

Term	Definition
ADDITIONAL BENEFIT RIDER	The document which lists selected vision care services and vision care materials which a **Covered Person** is entitled to receive under the **Contract**. Additional Benefits are only available when purchased by the employer in conjunction with a **Benefit** offered under the Schedule of Benefits
ASSIGNMENT OF BENEFITS	A written authorization including elements required by applicable state law and signed by a **Covered Person** eighteen (18) years of age or older and included with each **Claim**, directing **VSP** to pay available **Benefits** to a named **Open Access Provider.**
BENEFIT AUTHORIZATION	The process used to confirm eligibility of an individual named as a **Covered Person** and identifying those **Benefits** to which **Covered Person** is entitled.
BENEFITS	The vision care services and vision care materials which a **Covered Person** is entitled to receive by virtue of coverage under the **Contract**, as defined in the attached Schedule of Benefits and any applicable **Additional Benefit Riders**
BIRTHDAY RULE	**Coordination of Benefits** regulation whereby the primary payer of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the vision benefits program of the parent whose birthday falls first in a calendar year is considered primary.
BOOKLET	Means this document
CIVIL UNION	A **Civil Union** under the New Jersey Civil Union Act (L. 2006, c. 103) or a same sex relationship validly established under the law of another state that gives substantially all of the rights and obligations of married couples.
CIVIL UNION PARTNER	A person who is a party to a **Civil Union.**
CLAIM	A request to **Delta Dental** to pay a **Benefit** under the **Contract**
CONTRACT	The **Contract** between **Delta Dental** and Group upon which this plan is based.
CONTRACT CHARGES	The rate or dollar amount paid or payable on a for coverage under this plan.

COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care **Claims** for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a **Covered Person** for **Benefits** for services or materials which are not fully covered, and are payable at the time services are rendered or materials ordered.
COVERAGE EFFECTIVE DATE	The date, beginning at 12:01 a.m., that the **Covered Person** becomes eligible for **Benefits** under this plan.
COVERAGE EXPIRATION DATE	Midnight on the date that the **Covered Person** stop being eligible for the **Benefits** under this plan.
COVERAGE PERIOD	The term beginning on the **Coverage Effective Date** and ending on the **Coverage Expiration Date**. Services must be rendered or materials ordered prior to the end of the **Coverage Expiration Date** to be eligible for a **Benefit** under this plan.
COVERED PERSON	An employee and each eligible **Dependent** for whom **Contract Charges** are being paid under this plan. A **Covered Person** shall cease to be covered by the **Contract** at the point when such **Covered Person** ceases to meet the definition of an employee and/or **Dependent**. A **Covered Person** shall also cease to be covered if coverage is otherwise terminated under the provisions of the **Contract**.
COVERED SERVICES	**Vision Services** that are listed under the Schedule of Benefits. **Covered Services** are eligible for payment of **Benefits** under the **Contract** subject to applicable benefit limitations and **Exclusions**.
DEDUCTIBLE	The amount required to be paid by or on behalf of a **Covered Person** for **Benefits** which are not fully covered, and which are payable at the time services are rendered or materials ordered.
DELTA DENTAL	Means **Delta Dental** of New Jersey, Inc
DELTAVISION®	This vision plan underwritten by Delta Dental of New Jersey, Inc.
DOMESTIC PARTNER	A person who is a party to a domestic partnership under the New Jersey Domestic Partnership Act, N.J.S.A. 26:8A-1 et seq.
ELECTIVE CONTACT LENSES	Contact lenses that are not required for the visual welfare of the patient and vision correction could be treated with eyeglasses.
EXCLUDED	**Vision Services** and/or charges for which no **Benefit** is payable under the **Contract.**

FIRST DATE OF SERVICE	The first date on which a **Vision Service** is provided or materials are ordered.
NECESSARY CONTACT LENSES	Contact lenses that are medically necessary when the patient has an eye disease or prescription that has to be managed with contacts because glasses cannot provide sufficient correction. The conditions covered include aphakia, aniridia, anisometropia, corneal transplant, high ametropia, nystagmus, keratoconus, heredity corneal dystrophies and other eye conditions that make contact lenses necessary.
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.**
RETAIL CHAIN PROVIDER	A **Vision Services** provider who is not a **VSP Preferred Provider**. However, the providers are credentialed through **VSP** and meet National Committee for Quality Assurance (NCQA) standards.
SPOUSE	The employee's lawful **Spouse** or **Civil Union Partner**, or **Domestic Partner** (if applicable).
VISION SERVICES	Vision treatment and related procedures described in the Schedule of Benefits by persons duly licensed to render that treatment by the state in which they were rendered.
VSP	The plan administrator, Vision Service Plan Insurance Company.
VSP PREFERRED PROVIDER	Any optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with **VSP** to provide **Benefits** to Covered Persons.

Notes:

P. O. Box 16354
Little Rock, AR 72231

800-877-7195

www.deltadentalnj.com

ADDITIONAL BENEFIT RIDER

Supplemental Essential Medical Eye Care

GENERAL
This Rider lists additional vision care benefits to which **Covered Persons** are entitled, subject to any applicable **Copayments** and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the **Benefit**, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the **Contract** /Benefit Summary Booklet to which it is attached.

ELIGIBILITY

Covered Persons who meet the eligibility criteria established by **Employer** as indicated in the **Contract**/Benefit Summary to which it is attached, subject to the following:

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

PLAN BENEFITS - VSP PREFERRED PROVIDERS

COVERED SERVICES

Medical Eye Examinations: Covered in full after a **Copayment** of $20.00.
Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in full.

*Urgent/Emergency Care refers to **VSP** covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.
**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services. A current list of the covered procedures will be made available to the **Covered Person** upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the **Covered Person's** routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where **VSP** is required by law to pay.

8. Services and/or materials not specifically included in this Rider as covered **Benefits**.

PLAN BENEFITS - OPEN ACCESS PROVIDERS

An eye care professional that is an **Open Access Provider** may require a **Covered Person** to pay for all services in full at the time of the visit. **Covered Person** may then submit a claim to **VSP** for reimbursement.

COVERED SERVICES

Eye Examinations, Urgent/Emergency Care, and Special Ophthalmological Services: Covered up to $300.00 less any applicable **Copayment** amount; based on coverage limits for the specific medical eye care service and state service was received.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for **VSP Preferred Providers** shall also apply to services rendered by **Open Access Providers**.
2. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services in full.
3. **VSP** is unable to require **Open Access Providers** to adhere to **VSP's** quality standards.