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MID-ATLANTIC VISION SERVICE PLAN, INC.

3333 Quality Drive

Rancho Cordova, CA 95670

Group Name: LOYOLA UNIVERSITY MARYLAND

Plan Number: 12093416

Effective Date: JULY 1, 2012

Plan Term: FORTY-EIGHT (48) MONTHS

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

MID-ATLANTIC VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
Exam Only – Members Only

GENERAL

This Schedule lists the vision care services to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Pla

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VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

**MID-ATLANTIC VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
Signature Plan**

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Policy to which it is attached.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional \$20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	Covered in Full*	Up to \$ 52.00*
Complete initial vision analysis which includes an appropriate exam		

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every plan year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

Necessary-

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

**MEMBER DOCTOR
BENEFIT**

**NON-MEMBER
PROVIDER BENEFIT**

Professional Fees and Materials
Covered in full*

Professional Fees and Materials
Up to \$210.00*

Elective -

**MEMBER DOCTOR
BENEFIT**

**NON-MEMBER
PROVIDER BENEFIT**

Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum \$60.00 Copayment.

Materials
Up to \$130.00

Professional Fees and Materials
Up to \$105.00

*Subject to Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

**MEMBER DOCTOR
BENEFIT**

**NON-MEMBER
PROVIDER BENEFIT**

Supplementary Testing

Covered in Full

Up to \$125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids

75% of Cost

75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is \$1000.00 (excluding Copayment) every two years.

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