

## **Vision Insurance**

**THIS IS A LIMITED BENEFITS PLAN  
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO  
COVER ALL MEDICAL EXPENSES**

### **Outline of Coverage**

**Read Your Certificate Carefully--this outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!**

**This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Guide to Health Insurance for People With Medicare available from the company.**

**Vision coverage is designed to provide, to persons insured, vision and eye health, subject to any limitations set forth in the policy or certificate. Coverage is not provided for any benefits other than the specific Vision benefits described and any additional benefit described below:**

#### **Description of Covered Services**

Services covered by your Vision Plan includes a vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses. Your Plan may also include prescription eyewear such as Lenses (Glasses), Frames, and Contact Lenses.

There may be frequency and dollar limitations on certain services covered under your Cigna vision plan. For example you may be limited to one eye exam per year, or your plan may only provide coverage for certain vision expenses up to a specific dollar amount.

If your plan includes out-of-network benefits, your plan may base reimbursement on the Reasonable and Customary amount, which is a calculated amount based on the 50<sup>th</sup>-90<sup>th</sup> percentile of all charges in the geographic service area.

In addition, there are exclusions on services not covered under your plan. A list of services not covered under your vision plan is listed below.

Cigna Health and Life Insurance Company

**Cigna Vision Benefits**

Schedule of Vision Benefits

For Your and Your Dependents

Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information

All coverage outlined below is subject to applicable copayments, coinsurance or allowances. For a complete listing of copayments, coinsurance or allowances under Your Plan, please refer to your Plan documents

For a complete listing of covered services under Your Plan, please refer to Your Plan documents

There are frequency limitations on certain covered services covered under Your Cigna vision plan. In addition, the general exclusions on services not covered under Your plan are listed below.

<b>Benefit Highlights</b>	<b>In-Network Benefit</b>	<b>Out of Network Benefit</b>
	0-100%	0-100%
<b>Examinations</b>	0-100%	0-100%
<b>Retinal Screening</b>	0-100%	0-100%
<b>Eyeglass Lenses</b>	0-100%	0-100%
<b>Frame</b>	0-100%	0-100%
<b>Lenses and Frames and Contact Lenses</b>	0-100%	0-100%
<b>Contact Lenses</b>	0-100%	0-100%
<b>Contact Lens Professional Services</b>	0-100%	0-100%
<b>Low Vision</b>	0-100%	0-100%
<b>Safety Eyewear</b>	0-100%	0-100%

**Vision Plan General Exclusions and Limitations\*:**

\*This is a general list of all possible exclusions and limitations. For a list of exclusions and limitations that apply to your Plan, refer to your plan documents or call Customer Service

**at 1-800-CIGNA24 (1-800-244-6224), or login in to myCigna.com if you have questions or need more information.**

- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids
- Any non-prescription (minimum Rx required) eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment
- VDT (video display terminal)/computer eyeglass benefit.
- Charges in excess of the usual and customary fees for the Service or Materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- Lens treatments or “add-ons”, except rose tints (#1 & #2), and oversize lenses.[, not shown as covered in the Schedule]
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers’ Compensation or similar law, or which is work-related.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.

**Provisions regarding insurer’s right to change premium rates**

The initial premium rate is guaranteed for the first year. After this initial period, We may change the premium rates. We will send a written notice of any such change at least 60 days before the change becomes effective, Rates will not change more than once in any 12-month period.

**Provision regarding renewability or continuation of coverage**

Your insurance will cease on the earliest date below: the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance the last day for which you have made any required contribution for the insurance the date the policy is canceled;

Depending on your plan, either the date your Active Service ends, or the last day of the calendar month in which your Active Service ends.