Supplemental Information Section

Plan Name:	WELLSPAN HEALTH-BUY UP PLAN
Type of Plan:	This plan provides vision care benefits to participating employees and their dependents (if dependent coverage was selected).
Employer/ Plan Administrator	WELLSPAN HEALTH-BUY UP PLAN
Insurance Carrier:	Vision Benefits of America 400 Lydia Street, Suite 300 Carnegie, PA 15106 Member Service: (800) 432-4966 VBA Group #: **5416**
Cost of Plan:	Plan is paid a portion by the Employer with the Employee paying the remaining portion.
Plan Continuation:	The Employer intends to continue this plan indefinitely. Since future changes and conditions cannot be foreseen, we do reserve the right to change, suspend, or terminate the plan at any time within the parameters of the agreement with the carrier. To the extent a claim has been incurred prior to the amendment or termination, the claim will be honored in accordance with the terms and conditions which were previously in effect.

The preceding pages set forth the eligibility requirements and benefits provided for you under this plan.

To the Employees of WELLSPAN HEALTH-BUY UP PLAN:

Vision Benefits of America is pleased to provide you and your dependents with a vision care plan, as part of your total Health and Welfare Program.

The purpose of the vision care plan is to provide you and your family with complete vision care services, to maintain visual efficiency, and to prevent the development of conditions which might result in serious loss of sight.

This booklet is written in layman's language for your convenience. It is not intended to interpret, extend, or change the rules and regulations of the plan. Should any differences arise in the interpretation between the plan and this booklet, the plan shall govern.

What Is Vision Benefits of America?

Professional services and materials are provided by contractual arrangement with VBA, a non-profit organization head quartered in Pittsburgh, Pennsylvania. VBA maintains a network of more than 16,000 Participating Doctors of Optometry and Ophthalmology nationwide to provide professional vision care for persons covered under this plan. All materials are provided through approved laboratories, thus assuring that only the finest quality professional care and materials are provided to you.

The plan is administered directly by the Plan Administrator with benefits provided in accordance with provision of the group insurance policies issued by Vision Benefits of America.

Who is Eligible?

EMPLOYEES: Eligibility under this vision care plan is the same as the eligibility under your Health and Welfare plan.

DEPENDENTS: The term "dependents" includes the employee's spouse and unmarried children up to the end of their 26th birthday month. Such children include (1) a blood descendant of the first degree, (2) a legally adopted child (including a child living with the adopting parents during a period of probation), (3) a stepchild residing in the employee's household, or (4) a child permanently residing in the household of which the employee is head and actually being supported solely by the employee, providing the employee is related to the child by blood or marriage or is the child's legal guardian.

An unmarried child over 26 years of age may continue to be eligible as a dependent if the child is:

> Twenty-six (26) years of age or older and is incapable of self-sustaining employment by reason of intellectual disability or mental disability, as defined by Pennsylvania's Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4101 *et seq.)* or a physical handicap, and who became so incapable prior to attainment of twenty-six (26) years of age.
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> PROVIDED HOWEVER, proof of such incapacity and dependency is furnished to the Subscriber or VBA by the participant within thirty-one (31) days of the request for such information by VBA to the Subscriber. Subsequently additional information may be required by VBA or Subscriber but not more frequently than annually after the two-year period following the child's attainment of the limiting age

What are the benefits?

VISION EXAMINATION - A complete analysis of the eyes and related structures to determine the presence of vision problems.

*LENSES - The VBA Participating Doctor will order the proper lenses. The program provides the finest quality lenses, with a basic scratch coating, fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses. In addition, the following options, if any, are covered:

UV 400, Solid or Gradient Tints, Basic and Premium Scratch coating

*FRAMES - The plan offers a wide selection of frames; however, if you select a frame which costs more than the amount allowed by your plan, there will be an additional charge. Allowance up to a $60 wholesale frame.

CONTACT LENS – LIMITATIONS

Subject to the terms and conditions contained herein, the beneficiary may opt to utilize the plan's Contact Lens Benefit to either (1) obtain Medically Necessary contact lenses; OR (2) utilize their allowance towards the cost of fittings and materials for Elective contact lenses as set forth below

MEDICALLY NECESSARY

Contact lenses are furnished under the VBA plan only when the examining doctor secures prior approval for any of the following conditions:

a. Following cataract surgery
b. To correct extreme visual acuity problems not correctable with spectacle lenses.
c. Certain conditions of Anisometropia
d. Keratoconus

When the VBA Participating Provider receives prior approval for such cases, medically necessary contacts are covered under VBA's UCR basis.

Contact lenses once furnished under this plan as described above can only be replaced with prior authorization by VBA, but in no event more frequently than every 12 months.

ELECTIVE

When the beneficiary chooses contact lenses for reasons other than those mentioned above, and after completion of the Vision Examination set forth above, the beneficiary shall receive an allowance of $150 towards the cost of fittings and contact lens materials, plus a fifteen percent (15%) discount off of the VBA Participating Provider's usual customary fee for contact lens fittings.

*Payment of the provider's discounted UCR shall entitle the beneficiary to no less than two (2) follow-up visits within ninety (90) days of the initial fitting when required.

Elective contact lenses will be provided once every 12 months.

LASIK SURGERY – All VBA covered members are eligible to receive a discount at hundreds of provider locations nationwide through TLC or QualSight. For more information regarding this benefit, please visit our website or call one of VBA's member services representatives at 1-800-432-4966/option 5.

How Often are these Services Available?

EXAMINATION - Once every 12 months

- AND -

LENSES - Once every 12 months, if needed

FRAMES - Once every 12 months, if needed

- AND -

CONTACT LENSES - Elective - Once every 12 months

- OR -

Medically Necessary - Once every 12 months

How do I use this plan?

Select a VBA participating provider in your area. When scheduling an appointment, please notify the VBA participating provider that your vision coverage is administered by VBA. A list of participating providers is available on our website at vbaplans.com. The provider selected will contact VBA to verify eligibility via on-line system and will process services received electronically.

Please Note: The Participating Provider location will access benefits through VBA's secure web portal and download an electronic claim. This personalized electronic claim will contain an expiration date allowing 60 days to begin services. If services are not rendered with in the 60 day time period, the provider will need to secure a new authorization.

If You Choose To See An Optometrist, Ophthalmologist Or Dispensing Optician Who Is Not a VBA Participating Doctor

1. Make an appointment and receive the necessary services from the provider. Pay the doctor his full fee and obtain an itemized receipt which must contain the following information.
    a. Patient's Name
    b. Date service began
    c. The services and materials you received
    d. The type of lenses you received (Single vision, Bifocal, Trifocal, etc.)
2. Download/Print Out-of-Network Reimbursement Form from VBA's website at vbaplans.com
3. Mail your vision care reimbursement form and receipts to:

    VISION BENEFITS OF AMERICA

    400 Lydia Street, Suite 300

    Carnegie, PA 15106
4. You will then be reimbursed directly according to the "Non-Participating Reimbursement Schedule" (see schedule herein).

If You Choose To See A Non-Participating Doctor For An Examination And Have A VBA Participating Doctor Fill Your Prescription

1. After receiving an examination from the doctor, pay the doctor his exam fee. Obtain a receipt for the exam and prescription for your lenses.
2. Contact one of the VBA Participating Providers listed on our website who has an asterisk beside his/her name (this means the doctor is willing to fill another doctor's prescription) and make an appointment to have your prescription filled. You must inform the VBA Participating Provider office that VBA is your insurance carrier.
3. Take your prescription to the VBA Participating Provider. The VBA Provider will access the material benefits via web portal (electronically). He/She will fit you with your new glasses/contacts.
4. You will be paid directly according to the Non-Participating Reimbursement Schedule for exam, and the VBA Participating Provider will be paid for the dispensing of your glasses/contacts.

NOTE: If any problems arise with your glasses or contacts due to an inaccurate prescription written by a Non-Participating Doctor, VBA and the Participating Doctor assume no responsibility.

How much do I pay?

When you select a Doctor from our VBA list, your plan covers the visual care described at no cost to you other than a $10 copayment which applies to the routine vision examination and a $10 copayment which applies to the total cost of the lenses and/or frames. The copayments do not apply to the contacts. This care includes visual examination, fitting and dispensing services, clear lenses, and an allowance towards the wholesale cost of a frame. Any additional care, service and/or materials not covered by your plan must be arranged between you and the doctor at your expense.

NOTE: Charges for vision services or materials not covered under the service contract must be paid by the beneficiary when materials are delivered.

Extras

EXTRA COST - This plan is designed to cover your visual needs rather than cosmetic materials. There will be extra cost involved if you select:

1. Photochromic Lenses
2. Polycarbonate (Covered if under 19)
3. Hi-Index Lenses
4. Progressive (available starting at $29)
5. The coating of the lens or lenses (except as noted elsewhere herein)
6. A frame that costs more than the plan allowance
7. Contact lenses in excess of the plan allowance
8. Rimless frames

NOT COVERED ITEMS - There are no benefits for professional services or materials connected with:

a. Orthoptics or vision training

b. Plano lenses (non-prescription)
c. Two pair of glasses in lieu of bifocals
d. Medical or surgical treatment of the eyes
e. Any eye examination, or corrective eyewear, required by an employer as a condition of employment
f. Services or materials provided as a result of any Worker's Compensation Law or similar regulation

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

Reimbursement Schedule If I Visit A Non-Participating Doctor

Professional Fees	
Vision Examination, up to	$35.00
-AND-	
Materials	
Single Vision Lenses, up to	$30.00
Bifocal Lenses, up to	$40.00
Blended Bifocal Lenses, up to	$40.00
Trifocal Lenses, up to	$60.00
Progressives, up to	$60.00
Lenticular Lenses, up to	$100.00
Frames, up to	$40.00
-AND-	
Contact Lenses	
Elective -OR-	$150.00
Medically Necessary	$250.00

There is no assurance the non-participating reimbursement schedule will cover the entire cost of the examination, glasses or contacts.

What is the claims appeal process?

If a request for benefits is denied, claimants will be notified in writing as to specific reasons for the denial. This notice will include the name and address of the person to whom written request, including additional information, documents, data, etc., may be submitted for review of the denial. This appeal must be made within 180 days of the denial. VBA and the client will review all the facts of the case and provide you with a final decision in writing within 45 days of receipt of your appeal. None of these steps precludes you from taking your case to court if not satisfied.

Complaints Regarding Professional Services

The patient's complaint must be in writing and referred to VBA for action. The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted. If the complaint can be resolved within 15 days, the disposition of the complaint will be forwarded to the complainant. Otherwise, a notice of receipt of the complaint will be forwarded to the complainant advising of the time for resolution, which in any event should not be more than 45 days.

Grievance procedures and complaint forms will be maintained in VBA's Corporate Offices and all complaints will be retained by VBA for one year after the expiration of this agreement.

When may the plan terminate?

The Plan Administrator may change or eliminate benefits under the plan and may terminate the entire plan or any portion of it within the parameters of the agreement with the carrier. Your individual coverage terminates on the day you leave active service, when you are no longer in an eligible class or when the Plan Administrator terminates the plan, whichever occurs first. If different, the Employer's / Plan Administrator's termination criteria will override the above. Claim forms issued and received by the employee prior to the termination date will be honored.

What are my rights under ERISA?

The following statement of ERISA rights is required by federal law and regulation. As a participant in this plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examination, without charge, at the Plan Administrator's office and other specified locations, such as work sites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make reasonable charge for copies.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan 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 the duty to do so prudently and in the interest of you and the other plan participants. No one, including your employer 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 welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to $100.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the 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 federal court. The court will decide who should pay the 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, for example, if the court finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you should have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.