

### WHEN WILL MY BENEFITS BEGIN?

You will be eligible for all services on your plan's effective date.

### WHAT TYPE OF FRAMES ARE COVERED?

Your retail frame allowance through Nationwide Vision is \$ 100. The inside chart indicates the approximate number of covered frames available when members elect to use a Nationwide™ Vision office or its contracted providers as listed. If you select a frame that exceeds the retail allowance. You will receive a credit up to the frame allowance and you will be responsible for the difference in price.

### IF I CHOOSE CONTACTS, CAN I GET GLASSES?

No, you can choose the benefit allowance for either contact lenses **OR** eyeglasses as stated in your benefit description.

### WHAT DOES THE CONTACT ALLOWANCE COVER?

The allowance indicated for contact lenses is the dollar amount the member may use to purchase contact lens product through Nationwide Vision. The allowance **is not** reduced by contact lens fitting fees. Through SightCare's contracted Provider allowance is for fitting and purchase of contacts. The Out-of-Network benefit is an allowance towards the exam, fitting and purchase of contact lenses.

### WHAT ARE MEDICALLY NECESSARY CONTACT LENSES?

Medically Necessary contact lenses are typically covered for members with the following conditions:

- a) following cataract surgery,
- b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, (If you cannot be corrected to better than 20/70 with spectacle lenses)
- c) certain conditions of anisometropia,
- d) keratoconus.

### WHAT IF I RECEIVE SERVICES FROM AN OUT-OF-NETWORK?

The member must pay the Out-of-Network Provider their usual and customary fees for their services then submit itemized receipts to SightCare along with your name, address, and Social Security number.

You will be reimbursed according to the plan's Out-of-Network Reimbursement Schedule, provided you submit your claim within 6 months of the date you receive services. There is no assurance that the reimbursement schedule will be sufficient to pay for the examination, lenses, or frames.

Services provided through an Out-of-Network Provider are subject to the eligibility, availability, copayments, and limitation provisions of the plan as described in the Group Services Agreement and are "In Lieu" of services provided by a Nationwide Vision office.

### SPECIAL LASIK DISCOUNT

SightCare members are entitled to receive a LASIK allowance of \$150, if the member elects not to use their eye examination, eyeglass, or contact lens benefit. The LASIK Procedure must be done through Nationwide™ Vision Laser & Eye Center located at 2222 East Camelback Road. The price of the procedure is based upon the prescription. The LASIK Fee includes the pre and postoperative care of the patient. Nationwide™ Vision offers a free no obligation consultation for members interested in learning more about the LASIK procedure. Call Nationwide™ Vision Laser & Eye Center at (602) 26-LASIK.

### WHO DO I CALL WITH QUESTIONS?

You may call our Customer Service Department at (480) 961-1702.

**Monday - Friday 8:00 am to 5:00 pm**

All Nationwide Vision locations are on-line with SightCare's eligibility and verification system. Verification can be done in the evenings and on the weekends so the member is not inconvenienced.

### RIGHT TO APPEAL

In the event we do not authorize or pay a claim we must notify you of your right to appeal that decision. You may call our customer service number at (480) 961-1702 to obtain a Health Care Appeals Packet that will be sent to you.

### ITEMS NOT COVERED

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training, subnormal vision aids, aniseikonic lenses, plano (nonprescription) lenses, or glasses secured when there is no prescription change.
2. Lenses and frames furnished under this plan which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Services or materials provided as a result of any Workmen's compensation law or similar legislation, or obtained through or required by government agency or program whether, federal, state or any subdivision thereof.
5. Any eye examination required by an employer as a condition of employment, unless it is obtained at the normal interval for such services.
6. Coated, tinted, photochromic, and/or laminated lenses unless specifically indicated as a covered benefit.
7. Vision services and supplies that cost more than the Plan's allowance.
8. Two pairs of glasses in lieu of bifocals.
9. Benefits incurred beyond the termination date of the Plan, unless COBRA coverage is in place.



## Vision Plan

Benefit Schedule

## DIOCESE OF TUCSON and CATHOLIC COMMUNITY SERVICES

Certificate of Coverage

## Group Voluntary Custom Plan Design B

SIGHTCARE™, INC. CORPORATE OFFICE  
220 NORTH MCKEMY  
CHANDLER, ARIZONA 85226  
(480) 961-1702

## INTRODUCING SIGHTCARE, INC.

SightCare, Inc. is a licensed non-profit optometric service corporation in the State of Arizona, whose mission is to provide and administer consistently high quality optometric service plans that are accessible, accountable, and cost effective.

SightCare's Provider Network of Nationwide Vision offices and outlying contracted providers are staffed with licensed Doctors of Optometry, along with professionally trained staff to give you quality care and products.

## WHAT ARE MY BENEFITS?

The following services are available to members who choose to receive services through SightCare's Exclusive Provider Network (Nationwide Vision), after the copayment, (if applicable) is met:

Eye Examination	\$ 10 CoPayment
<b>\$ 10 Co-Payment on Materials</b>	
Frame Allowance	Up to \$ 100
Standard Lenses	
Single Vision	100% Covered
Bifocal FT-28	100% Covered
Trifocal 7x28	100% Covered
Progressive (standard)	\$ 30 CoPayment
Lens Options	
Tint	100% Covered

### OR

Contact Lenses	
Elective Contacts	\$ 100 Allowance
Medically Necessary	\$ 250 Allowance

\*(Contact lenses are in place of spectacle lenses and frame.)

A summary chart of benefits are further contained on the right hand side of this brochure.

## HOW OFTEN ARE SERVICES AVAILABLE?

Eye Examination	Once Every 24 Months
Lenses (pair)	Once Every 12 Months
Frame	Once Every 24 Months
Contact Lens Benefit	Once Every 12 Months

## IS THERE A CO-PAYMENT ON MY PLAN?

Yes, \$ 10 CoPay applies toward the exam.  
\$ 10 CoPay applies toward materials.

You pay required copayments directly to Nationwide Vision locations or SightCare's contracted providers (as listed in the DOT directory). Services (as described in the section entitled "What Are The Benefits?") provided by a Nationwide Vision provider or a SightCare contracted provider (as listed in the DOT directory) are at no additional expense to you except for your copayments.

## HOW DO I USE THE PLAN?

There are no forms or authorization codes you need to obtain. Simply call any Nationwide Vision location or any of the approved providers to schedule an appointment and inform the office you are a SightCare member. The office will verify eligibility prior to your appointment. When you arrive for your appointment, present your SightCare identification card. It's that easy!

## WHERE ARE SERVICES OBTAINED?

SightCare's Provider Network is Nationwide Vision, as well as contracted providers in the outlying Arizona areas. Members are free to use any of the 60 Nationwide Vision locations throughout the State of Arizona. If member's elect not to obtain services through a Nationwide Vision office they are eligible to be reimbursed based upon the stated maximum Out-of-Network allowance.

## NATIONWIDE VISION A FULL SERVICE PROVIDER

All Nationwide Vision locations are full-service providers. This means that you can have your eye's examined, pick out your glasses, obtain your contact lenses at the same location. You do not need to take your prescription to another location to have it filled.

## Plan Benefits

<u>Plan Feature</u>	<u>Nationwide Vision Network (EPN)</u>	<u>SightCare Doctor Network (PPN)</u>	<u>Out-of-Network Allowance</u>
<b>Eye Examination</b>			
Eyeglass or Contact Lens	<b>\$ 10 CoPayment</b>	<b>\$10 CoPayment</b>	\$ 25
Contact Lens Fitting Fee	100% Covered	See CL's* Section	See CL's* Section
<b>Ancillary Testing for Exams</b>			
Dilation	100% Covered	100% Covered	See Exam Allowance
Visual Fields Testing	\$ 9 CoPayment	20% discount	Not Covered
<b>Frames</b>			
Frame Allowance	<b>\$10 CoPay on Materials</b> Up to \$100	<b>\$10 CoPay on Materials</b> Up to \$100	\$ 25
Number of Frames Covered	600+	N/A	N/A
Men/Women/Children	(Approximately)		
<b>Standard Lenses</b>			
Single Vision	100% Covered	100% Covered	\$ 25
Bifocal FT-28	100% Covered	100% Covered	\$ 35
Trifocal 7x28	100% Covered	100% Covered	\$ 50
Lenticular	100% Covered	100% Covered	\$ 50
Progressive (standard)	\$30 Co-Pay	Bifocal Rate	Bifocal Rate
<b>Options</b>			
Polycarbonate (under 18 yrs.)	100% Covered	20% Discount	Not Covered
Tint	100% Discount	20% Discount	Not Covered
Lens Options	20% Discount	20% Discount	Not Covered
<b>In Lieu of Eyeglasses (frame &amp; lenses)</b>			
<b>Contact Lens</b>	<b>\$10 CoPay on Materials</b>	<b>\$10 CoPay on Materials</b>	
<b>Product Allowance</b>		\$100 Allowance towards	\$ 80 Allowance towards Exam, Fitting and CL's purchase.
Elective/Cosmetic	Up to \$100	C/Ls and Fitting	Up to \$ 100
Medically Necessary	Up to \$250	Up to \$250	
<b>In Lieu of Exam, Eyeglasses (frame &amp; lenses) or Contact Lenses</b>			
<b>LASIK Benefit</b>	\$150 Allowance	Not Covered	Not Covered
<b>2nd Pair</b>			
<b>2nd Pair Purchases</b>			
Frames	25% Discount	Not Covered	Not Covered
Lenses	25% Discount	Not Covered	Not Covered
Options	25% Discount	Not Covered	Not Covered
<b>Replacement Lenses</b>			
Disposable	10% Discount	10% Discount	Not Covered
Conventional	20% Discount	20% Discount	Not Covered

### Notations:

\*CL's = See Contact Lens Section

EPN = Exclusive Provider Network - Nationwide Vision Offices Only.

PPN = A Provider Network is a part of SightCare's Participating Network

Out-of-Network = Member must pay first and then submit receipts to SightCare to be reimbursed.