

# Vision Examination Rider

Your Certificate of Coverage is amended as described in this document. This Rider becomes a part of your Contract and is subject to all its provisions. Please refer to all sections of your Contract, including your Outline of Coverage, for guidelines on coverage, including out-of-pocket expenses.

## I. Covered Services

We cover one comprehensive vision examination each calendar year. This exam assesses your visual functions to:

- determine if you have any visual problems and/or abnormalities; and
- prescribe any necessary corrective eyewear.

We do not cover the evaluation and fitting of contact lenses or additional supplemental tests as part of this examination.

## II. General Provisions

Your vision benefits are administered by Vision Service Plan (VSP). To receive the best benefits for vision care, you must obtain services through a VSP Network Provider. For a list of providers, visit [www.vsp.com](http://www.vsp.com) or call VSP at (800) 877-7195.

We have a different Allowed Price for Out-of-Network Providers than we have for Network Providers. If you decide not to see a VSP Network Provider, you may pay a larger share of the cost. You must pay for your services at the time of your appointment. Follow the instructions below to be reimbursed for out-of-network services.

## III. Claim Filing

Your Network Provider will file your claim on your behalf. We will reimburse your Provider directly.

When you use an Out-of-Network Provider, you must pay for your services up front. We reimburse you only up to our Allowed Price for covered services. To receive reimbursement when you visit a non-VSP Provider, sign on to [www.vsp.com](http://www.vsp.com), select the "Out-of-Network Reimbursement Form" and follow the instructions. Or, you may send an itemized receipt

listing the services received along with the patient's name and covered subscriber's name and I.D. number to VSP. Out-of-Network claims must be submitted to VSP within six months of service. Send the original claims reimbursement request and receipts to VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

## IV. Exclusions

We do not cover services or supplies for:

- orthoptics, vision training or plano (nonprescription) lenses;
- vision materials (lenses, frames, etc.); and
- any eye examination or corrective eyewear required by an employer as a condition of employment.

Also refer to General Exclusions in your Certificate.



Don C. George  
President  
Blue Cross and Blue Shield of Vermont