Vision

The Vision Plan, administered by Davis Vision, offers a variety of routine vision care services and supplies. You do not have to be enrolled in the Plan to cover a dependent.

When you enroll in the Plan, it is on an annual basis. You can change your election only if you have a qualified status change, as described in the *Eligibility and Participation* section. When you enroll in the Plan, you will receive an ID card in the mail.

Both network and out-of-network benefits are available. You can split your benefit by going to both network and out-of-network providers. For example, you can obtain an annual eye examination from a Davis Vision provider while purchasing your frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

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Benefits at a Glance

The following table summarizes the vision benefits available to you and your eligible dependents:

Network benefit	Coverage
Eye exam	• Covered at 100% including dilation, one exam per calendar year.
Frames and lenses	• Covered at 100%, one pair of frames and lenses per calendar year. • Must be selected from the network-provided frames from Davis Vision's Exclusive "Collection"; or • $61 wholesale allowance toward retail frame purchases outside of the "Collection" or an equivalent retail allowance at a retail chain (e.g. Wal-Mart, Eye-Masters, VisionWorks, etc.) • 20% discount on additional pairs of glasses at most network providers.
Contact lenses (in lieu of glasses)	• Covered at 100%, limit 1 pair/supply per calendar year in lieu of eyeglasses; • Davis Vision Contact Lens "Collection"; one pair of soft, standard daily wear contact lenses; or • Davis Vision Contact Lens "Collection" covered; 4 boxes of disposable lenses; or • Davis Vision Contact Lens "Collection"; 2 boxes of planned replacement lenses; or • A $130 credit toward "Collection" contacts, fitting, and follow-up, plus 15% off overages; or • Medically necessary contact lenses covered in full with prior approval. The Plan covers a supply that is prescribed at the time of office visit.
Laser vision correction (Lasik)	• Up to 25% discount off reasonable and customary fees, or 5% discount off any advertised (discounted) fee when using one of Davis Vision's participating laser surgeons. Some centers have flat fees equivalent to these discounts.
Broken eyewear (frames, materials)	• Davis Vision "Collection" frames are covered by a one-year breakage warranty.
Maximum benefit	• Benefit that has been paid in full except for defined copayments.

Out-of-network benefit	Coverage
Eye exam	• Up to $30
Frames/lenses	• Frame; up to $50 • Single vision lenses up to $25, bifocal up to $35, trifocal up to $45, and lenticular up to $60
Contact lenses	• Contact lenses; up to $75 • Medically necessary contact lenses; up to $225

Network Services

To receive the greatest value for your dollar, you should receive vision care services from a Davis Vision network provider. However, you can also use out-of-network providers and still receive a benefit.

Network providers are licensed doctors in your area who provide quality vision care services and who meet Davis Vision's quality assurance standards. You and your covered family members can select a different Davis Vision network provider each time you receive vision care services.

Your doctor may apply to join the Davis Vision provider network by calling Davis Vision's Professional Relations Department at 1-800-933-9371. Membership in the network is not guaranteed.

Using network services

Davis Vision network services are easy to access. Below is the information you will need to find a network provider in your area and schedule an appointment.

- To locate a network provider, visit Davis Vision at **www.davisvision.com** or call 1-800-999-5431. If you are enrolled in the program, enter the employee's Member Identification number. If you are not enrolled in the program or are going through annual enrollment, you can access the open enrollment feature through the Davis Vision website (**www.davisvision.com**) and enter Client Control Code number 2227. You may also call Davis Vision during your enrollment period at 1-877-92-DAVIS. (For TDD services, call 1-800-523-2847.) An automated voice response unit (available 24/7) or one of Davis Vision's member service representatives (available from 8 a.m. to 11 p.m. on weekdays; 9 a.m. to 4 p.m. on Saturdays; and noon to 4 p.m. Eastern time on Sundays) will assist you. Once you are enrolled, you can call Davis Vision at 1-800-999-5431 to verify your eligibility.
- Call a network provider to schedule an appointment. Claim forms are not required.
- Provide the doctor with the Citi employee's member ID number. If you are calling for services for your covered dependent, you will need to provide your dependent's date of birth.
- A complete list of network providers is available at no cost to you by calling Davis Vision at 1-800-999-5431 or visiting Davis Vision at **www.davisvision.com**.

The network provider will obtain the necessary authorization. After the provider obtains authorization, you and/or your dependent(s) will have up to 45 days to receive your eye exam from that provider.

If you decide to use a different provider after the previous provider has received an authorization and you have made an appointment, you must call Davis Vision at 1-800-999-5431. You are responsible for canceling your appointment and any related cancellation fees.

Network benefits

Network benefits include:

- Exam: one eye examination, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year from the Davis Vision "Collection" covered at 100%; or
- A $61 wholesale allowance toward the cost of any network provider's frame or an equivalent retail allowance at a retail chain, for example, a $150 allowance at a Wal-Mart location; spectacle lenses will be covered at 100%; or
- Contact lenses in lieu of eyeglasses: plan formulary contact lenses; one pair of soft standard daily-wear or four boxes of disposable or two boxes of planned replacement contact lenses, fitting, and follow-up care each calendar year covered at 100%, or, if you choose contact lenses that are not covered under the Plan formulary, you will receive a maximum credit of $130 toward other lenses plus 15% off the amount above $130 (additional discount not applicable at Wal-Mart locations); the $130 credit is applied toward non-plan contacts, fitting, and follow-up.
- 20% discount on additional pairs of glasses at most network providers.

The following lenses are covered at 100%: glass or plastic lenses (single, bifocal, or trifocal); all prescription ranges, including post-cataract lenses; tinting of plastic lenses; standard and premium progressive addition multifocals; polycarbonate lenses; oversize lenses; ultraviolet coating; blended segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; intermediate-vision lenses; anti-reflective coatings; hi-index lenses; polarized lenses; and plastic photosensitive lenses.

Mail order contact lenses: Lens 1-2-3® option

You can purchase replacement or additional pairs of contact lenses by mail through the Lens 1-2-3® program, a Davis Vision program. Call 1-800-LENS-123 (1-800-536-7123) for answers to your questions or to place an order. To receive lenses through Lens 1-2-3®, mail your current prescription to:

Lens 1-2-3®
2921 Erie Boulevard East
Syracuse, NY 13224.

You can also fax your prescription to 1-315-449-0563.

If you do not have a copy of your prescription, a Lens 1-2-3® representative can contact your provider directly.

Out-of-network benefits

If you receive services outside the Davis Vision provider network, the Plan will provide reimbursements of up to the following amounts:

- Annual exam: $30;
- Lenses: single vision, $25; bifocal, $35; trifocal, $45; lenticular, $60;
- Frame only: $50;
- Contact lenses: $75 elective; $225 medically necessary (with prior approval from Davis Vision).

Definition of medical necessity

Davis Vision may determine your contact lenses to be medically necessary and appropriate in the treatment of certain conditions. In general, contact lenses may be medically necessary and appropriate when their use, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be determined to be medically necessary in the treatment of keratoconus, anisometropia corneal disorders, pathological myopia, aniseikonia post-traumatic disorders, aphakia, aniridia, and irregular astigmatism. Davis Vision must review and approve any coverage for medically necessary contact lenses.

Low vision

Low vision is defined as a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the usable vision that remains.

With prior approval by Davis Vision, covered low-vision services will include:

- **Low-vision evaluation:** One comprehensive exam every five years is covered with a maximum charge of $300; sometimes called a functional vision assessment, this exam can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast, and lighting requirements for optimum vision.
- **Maximum low-vision aid:** Aids such as high-power spectacles, magnifiers, and telescopes are covered at a maximum of $600 per aid with a lifetime maximum of $1,200. These devices are used to improve the levels of sight, reduce problems of glare, or increase contrast perception based on the individual's visual goals.
- **Follow-up care:** The Plan covers four visits in any five-year period with a maximum charge of $100 per visit.

Laser vision correction

Laser vision correction is not covered under the Plan. However, a discount is available if you use a provider in the Davis Vision laser vision correction network. You are eligible for up to a 25% discount off the provider's reasonable and customary fees or a 5% discount off any advertised fee for laser vision correction surgery at a Davis Vision provider.

Some facilities may offer a flat rate, which equates to these discount levels. You are responsible for paying all fees directly to the provider or facility. *Davis Vision and Citi assume no financial responsibility for access to these discounts in your location.*

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call Davis Vision at 1-877-923-2847 or visit **www.davisvision.com**. Enter Citi code 2227 for a list of participating providers.

What is not covered

The following services and materials are not covered under the Plan:

- Medical treatment of eye disease or injury;
- Vision therapy;
- Special lens designs or coatings (other than those previously described);
- Replacement of lost eyewear;
- Two pairs of eyeglasses in lieu of bifocals;
- Services or materials covered under Workers' Compensation;
- Eye exams required as a condition of employment;
- Non-prescription eyewear or lenses;
- Contact lenses and eyeglasses in the same benefit cycle; and
- Services not performed by licensed personnel.

Note: You may purchase glasses from a network provider and order contact lenses through Lens 1-2-3® in the same 12-month benefit cycle. You will have to pay the out-of-pocket costs for the contact lenses; but the prices generally are discounted approximately 50%.

Splitting of benefits

To maintain continuity of care, whenever possible you should obtain all available services at one time from either a network or an out-of-network provider. However, you may "split" the benefit by receiving services from both network and out-of-network providers.

Travel and student coverage

If you or your covered dependent(s) require vision care services while traveling or away at school, visit Davis Vision at **www.davisvision.com** or call Davis Vision at 1-800-999-5431 and enter the employee's member ID number.

Claims and appeals for the Vision Benefit Plan

The amount of time Davis Vision will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

You will have 180 days following receipt of a claim denial to appeal the decision. You have the right to voice a grievance or complaint against Davis Vision at any time. Davis Vision will not retaliate or take any discriminatory action against you because you have filed a grievance, complaint or appeal. A grievance is a complaint that may or may not require specific corrective action and is made:

- Via the telephone;
- In writing to Davis Vision; or
- Via the Davis Vision website.

Claims include, but are not limited to, the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;
- Difficulty accessing or using a benefit and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, "adverse determination."

You may file a grievance by

- Calling Davis Vision's toll free hot line 24 hours a day at 1-800-584-1487;
- Sending a letter via U.S. mail or overnight delivery; or
- Visiting the website at **www.davisvision.com**.

Written grievances should be sent to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attention: Quality Assurance/Patient Advocate Department

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

You will be contacted by a Davis Vision associate within five business days of receipt of a concern or grievance to confirm that the concern was received and is being investigated. A designated Davis Vision associate will review the appeal with you and may request additional information. You will be provided with the associate's name, phone number, department, and the estimated time needed to perform the research (for preservice appeals, 15 days; for post-service appeals, 30 days) and when you can expect a determination. You will also be informed of your right to have a representative, including your provider, present during the review of the concern and final outcome of the investigation. You also will be informed of your right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions, the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point-of-service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. When further information is required, Davis Vision will contact you and inform you of the status of the investigation and/or the need for more information.

At the conclusion of the investigation, the determination will be communicated within 15 days for preservice claims and 30 days for post-service claims, or as required by state statute, (or an additional 10 days may be requested to complete further research). The appeal determination will include the following:

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were used and a summary of the evidence, including the documentation supporting the decision;
- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;
- Copy of the appeals process, if applicable; and
- Name, position, phone number, and department of the person(s) who was responsible for the outcome.

The decision of the Quality Assurance/Patient Advocate Department is final and binding unless you appeal to Davis Vision within 15 business days of the date of notice of the decision.

Davis Vision level two appeal

Should Davis Vision uphold a denial, as the result of a level one review, you have the right to request a level two appeal.

A level two appeal will not include any associate(s) or licensed (peer) health care professional(s) who was involved in the level one review.

A level two appeal requires you to contact Davis Vision in writing or by telephone within 15 days following your receipt of the level one summary statement.

If you are requesting a level two appeal, you must indicate the reason you believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to solicit further information from you and/or the provider.

Davis Vision has 30 days, or as required by state statute, from the date the requested information is received, to respond to the level two review, or 45 days, or as required by state statute, if it is a post-service review. A level one decision will be reviewed by a Davis Vision associate(s), a Regional Quality Assurance Representative(s) (RQAR), and a licensed optometrist, all of whom were not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within five days.

Notification will include, but may not be limited to:

- The outcome of the investigation and a summary stating the nature of the concern and the material facts related to the issue;
- Criteria that were used and a summary of the evidence, including documentation that was used to support the decision;
- A statement indicating that the decision will be final and binding unless you appeal in writing or by telephone to the Quality Assurance/Patient Advocacy Department within 45 days of the date of the notice of the level two decision;
- A copy of the appeals process, if applicable; and
- The name, position, phone number, and department of person(s) who was responsible for the outcome.

External review

Davis Vision gives you, as required by state statute, an opportunity to request an impartial review of concerns that resulted in coverage denials. If you have used and exhausted the internal appeals process, you may appeal the final decision if the denial for services exceeds $250 and was not deemed medically necessary or the requested service was deemed investigational or experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organization will have up to 30 days, or as required by state statute, to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that each state has implemented an external review process that is unique to its residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. You can call the Member Service Department at 1 800 999 5431 for information unique to your state of residence. You also have the right to contact your state insurance or health department for further information.

You have the right to an external review of a denial of coverage. You have the right to an external review of a final adverse decision under the following circumstances:

- You have been denied a vision care service, which should have been covered under the terms of the Vision Plan;
- Services were denied on appeal on the basis that requested services were not medically necessary;
- A treatment or service that will have a significant positive impact on you has been denied and any alternative service or treatment will not affect your ocular health and/or will produce a negative outcome;
- The services denied are related to a current illness or injury;
- The cost of the requested services will not exceed that of any equally effective treatment;
- The denied service, procedure, or treatment is a covered benefit under the Vision Plan; or
- You have exhausted all internal appeal processes with an adverse determination upheld at each level.

The vision care provider may contact the appropriate state agency to determine if other documentation may be required for the appeal process.

The external review representative must make a decision within 30 days of receipt of documentation, or as required by state statute, and notify you within two business days of a determination. Notification must be in writing and include an explanation and the clinical criteria used in the decision.