

The Ohio State University Vision Plan Specific Plan Details Document

Program Provisions

*2012 Plan Year
(January 1 – December 31, 2012)*

*Office of Human Resources
Benefits Services
Suite 300
1590 North High Street
Columbus, OH 43201-2190*

Retain for your records through December, 2012

Contact Information

The Ohio State University Office of Human Resources

hr.osu.edu



Customer Service Center(614) 292-1050

1590 North High Street, Suite 300
Columbus, OH 43201-2190

1-800-678-6010

Fax: (614) 292-6235

E-mail: service@hr.osu.edu

Provides information regarding:

- Certification of state service requests
- Flexible Spending Accounts
 - Dependent Care and Health Care
- Health Insurance
 - Enrollment
 - Verification of coverage
- Life Insurance
 - Change of beneficiary
 - Enrollment
- Retirement Programs
 - ARP, OPERS, STRS
- Supplemental Retirement Accounts
 - 403(b) and 457 plans
- Tuition Assistance
 - For dependents
 - For faculty and staff
- Your Plan for Health, YourPlanForHealth.com

Benefits Consultants(614) 292-1050

Fax: (614) 292-7813

E-mail: benefits@hr.osu.edu

Available by appointment to provide:

- Department presentations
- Life event coordination
- New employee benefits orientation
- Personal benefits counseling

Employee and Labor Relations(614) 292-2800

Provides information regarding:

- Family/medical leave, sick leave, vacation leave, medical leave, personal leave, military leave, paid parental leave, organ donation leave, jury duty/court

Integrated Disability Services(614) 292-3439

1-800-678-6413

Fax: 688-8120

E-mail: ld@hr.osu.edu

Available by appointment to provide:

- Department presentations
- Long-Term and Short-Term Disability assistance
- OPERS/STRS Disability Retirement
- Unemployment Compensation(614) 688-3578
- Workers' Compensation

Payroll Services(614) 292-2311

E-mail: payrolloffice@osu.edu

- Credit union, direct deposit, taxation, paperless pay
- ePayroll: paperlesspay.talx.com/osu

The Work Number1-800-996-7566

Employment verification hr.osu.edu/payroll/verify.htm

Your Plan for Health(614) 292-1050

E-mail: yourplanforhealth@hr.osu.edu

- YourPlanForHealth.comWebMD Customer Service: 1-888-860-3095
- Biometric Health Screenings
- Personal Health Assessment (PHA)
- Incentive Programs
- Personal Health Coaching Program1-800-678-6269
- Care Coordination Program1-800-678-6269
- Educational Programming
- Ohio State Employee Assistance Program (EAP)1-800-678-6265
- Ohio State 24/7 NurseLine1-800-678-6269

Other Important Contacts

CareWorks of Ohio, Inc.1-888-627-0058

- Workers' compensation claims assistance

Delta Dental Plan of Ohio1-800-282-0749

Customer and Claims Services

deltadentaloh.com

- Dental providers and claims assistance

toolkitsonline.com

Express Scripts1-866-727-5867

- Prescription drugs—retail/home delivery/claims www.express-scripts.com
- Specialty medications assistance www.curascripts.com

GlobalCare ServicesU.S. 1-866-807-6193

- Medical care coordination outside Ohio International: 01-770-667-0247

IRS Publications1-800-TAX-FORM (829-3676)

Tax advice1-800-829-1040

irs.gov

Minnesota Life Insurance Company1-866-293-6047

- Life insurance administrator – conversion of coverage

NGS CoreSource1-866-44-BUCKS (442-8257)

- Medical claims assistance ngs.com
- Medical/prescription drug cards
- COBRA administration

Ohio State Educational Services

Bridge Program(614) 292-8860

Continuing Education(614) 292-8860

Fees and Deposits(614) 292-3337

Reach 1 Program(614) 292-1238

University Registrar(614) 292-8500

Ohio State Employee Assistance Program (EAP)

24/7/365 live connection1-800-678-6265

Employee Assistance Program serving faculty, staff, and their families

osuhealthplan.com/OhioStateEAP

The Ohio State University Health Plan Inc.(614) 292-4700

- Precertification of hospital admissions and other medical services
- Provides services for YP4H 1-800-678-6265 osuhealthplan.com

Unum1-866-245-3013

Disability claims assistance

Vision Service Plan (VSP)1-800-877-7195

- Vision providers and claims assistance

vsp.com

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Introduction

This Vision Plan – Specific Plan Details document describes and establishes the important provisions of the vision benefits provided to faculty and staff of The Ohio State University and their eligible dependents. It is very important that you have a good understanding of the covered services available to you and the items that are excluded or limited by the plan.

Appointment Eligibility	<ul style="list-style-type: none"> • Eligibility for the benefits described in this document will be determined by the Office of Human Resources. These benefits are available only to employees who hold eligible appointments of 50% or greater full-time equivalency (FTE). Speak to your department human resources contact to verify if your specific appointment is eligible for these benefits. • Eligible university appointments include:
Regular or Term Appointments	<ul style="list-style-type: none"> • Classified Civil Service (CCS) Staff • Faculty • Unclassified Administrative and Professional (A&P) Staff • Senior Administrative and Professional (A&P) Staff
Auxiliary Faculty	<ul style="list-style-type: none"> • Clinical Auxiliary Faculty-Term • Lecturer-Benefit Eligible-Term • Senior Lecturer-Benefits Eligible-Term
Visiting Faculty	<ul style="list-style-type: none"> • 12-month Faculty-Clinical Instructor-Regular • Visiting Faculty-Benefits Eligible-Term
Clinical Instructor	<ul style="list-style-type: none"> • Clinical Instructor House Staff (CIHS) • Clinical Instructor House Staff Trainee
Post-Doctoral Fellow	<ul style="list-style-type: none"> • Post-Doctoral Fellow
Post-Doctoral Researcher	<ul style="list-style-type: none"> • Post-Doctoral Researcher
Intern	<ul style="list-style-type: none"> • Intern–Exempt–Benefits Eligible appointments of at least 75% FTE • Intern–Non-Exempt–Benefits Eligible appointments of at least 75% FTE
Affiliated Groups	<ul style="list-style-type: none"> • Eligible University Affiliated Groups include: <ul style="list-style-type: none"> – Alumni Association – Central Ohio Technical College (COTC) – Faculty Club – Internal Medicine Department (IMD) – Ohio State University Physicians (OSUP)
About this Document	<ul style="list-style-type: none"> • This document is a summary of the specific benefits of Ohio State’s vision care program and how you can obtain them. This plan is subject to and superseded by the provisions of any applicable agreement between Vision Service Plan (VSP) and The Ohio State University. • The benefits and contract described in this booklet are intended to acquaint you with your vision care coverage. The actual governing provisions of all benefits are contained in the Group Contract between The Ohio State University and Vision Service Plan. • If any state or federal legislation is in effect, enacted or amended requiring a change in the vision benefits, appropriate modifications may be made in the benefits provided under the plan.
For More Information (See inside front cover)	<ul style="list-style-type: none"> • Office of Human Resources Customer Service Center – general benefit information, brochures, enrollment, eligibility, family status changes • Vision Service Plan (VSP) – claims processing and provider directory assistance • Ohio State University Health Plan (OSU Health Plan) – coordination of vision benefits with medical plans and precertification

General Plan Provisions

Effective Date of Coverage	<ul style="list-style-type: none"> • The effective date for all eligible employees and their eligible dependents will be determined by the university and will be communicated to VSP for the purposes of claims administration. Coverage is effective on the date of: <ul style="list-style-type: none"> – Hire or transfer to an eligible appointment – Qualifying status change
Eligibility	<ul style="list-style-type: none"> • An eligible employee is any faculty or staff member who holds a qualifying appointment, as determined by The Ohio State University. • If you are an eligible employee, you may cover yourself and those persons who qualify as your eligible dependents. Dependents can only be enrolled if the eligible employee is enrolled for coverage. You may not be covered as both a spouse and dependent. • Coverage is not automatic. In order to cover yourself and your eligible dependents, you must enroll for coverage by completing the university Health Election Form. • You must enroll yourself and your eligible dependents when initially eligible, during an open enrollment period, or within 31 days of a qualifying status change.
Eligible Dependents	
Legal spouse	The legal spouse of a covered employee.
Dependent child	<p>A dependent child of a covered employee who meets all of the following eligibility criteria:</p> <ol style="list-style-type: none"> 1. has not reached the age limit of 26 (i.e. 26th birthday); and 2. fits into one of the following categories: <ul style="list-style-type: none"> – the employee’s biological child; – the employee’s adopted child; – the employee’s step-child; – the child of the employee’s covered same-sex domestic partner; or – the child for whom the employee has legal guardianship, legal custody, or an interlocutory order of adoption.
Adult Dependent Child	<p>Age 26 to 28; coverage to age 28 is contingent upon the dependent child of a covered employee meeting all of the following eligibility criteria:</p> <ol style="list-style-type: none"> 1. has not reached the age limit of 28 (i.e., 28th birthday); and 2. fits into one of the following categories: <ul style="list-style-type: none"> – the employee’s biological child; – the employee’s adopted child; or – the employee’s step-child; and 3. is not married; and 4. is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and 5. is not eligible for coverage under Medicaid or Medicare; and 6. resides in Ohio or is a full-time student at an accredited institution of higher education. <p>The rate to cover these adult dependent children will be the full rate, and will be taken out of the employee’s pay on an after-tax basis.</p>
Dependent child coverage beyond the age limit due to disability	<p>A dependent child may be eligible for continued coverage as a dependent child after attaining the limiting age if:</p> <ul style="list-style-type: none"> • the child is and continues to be incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and • the child is and continues to be primarily dependent upon the employee for support and maintenance; and • the child was (1) covered by a university medical, dental or vision plan when he or she reached the limiting age and the employee makes application for continuation of coverage to the university within 31 days after the child reaches the limiting age or (2) covered as a dependent under the medical plan of his or her parent’s employer immediately prior to a loss of coverage under such plan (documentation of prior coverage required) and the employee makes application for continuation of coverage to the university within 31 days after such loss of coverage occurs. In each case, the employee must provide satisfactory proof of the child’s incapacity and dependence upon the employee; and • the employee provides proof of the continuance of such incapacity and dependence upon request by the university.

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<p style="color: red; margin: 0;">Same-Sex Domestic Partner (SSDP)</p>	<p>The same-sex domestic partner of a covered employee who meets all of the following criteria:</p> <ol style="list-style-type: none"> 1. shares a permanent residence with the employee (unless residing in different cities, states or countries on a temporary basis); 2. is the sole same-sex domestic partner of the employee, has been in a relationship with the employee for at least six (6) months, and intends to remain in the relationship indefinitely; 3. is of the same sex as the employee and is not currently married to or legally separated from another person under either statutory or common law; 4. shares responsibility with the employee for each other's common welfare; 5. is at least eighteen (18) years of age and mentally competent to consent to contract; 6. is not related to the employee by blood to a degree of closeness that would prohibit marriage in the state in which they legally reside; and 7. is not related to the employee by blood to a degree of closeness that would prohibit marriage in the state in which they legally reside; and 8. is financially interdependent with the employee in accordance with the plan requirements outlined by Ohio State. Financial interdependency may be demonstrated by the existence of three (3) of the following: <ul style="list-style-type: none"> – joint ownership of real estate property or joint tenancy on a residential lease – joint ownership of an automobile – joint bank or credit account – joint liabilities (e.g. credit cards or loans) – a will designating the same-sex domestic partner as primary beneficiary – a retirement plan or life insurance policy beneficiary designation form designating the same-sex domestic partner as primary beneficiary – a durable power of attorney signed to the effect that the employee and the same-sex domestic partner have granted powers to one another
<p style="color: red; margin: 0;">Sponsored Dependent</p>	<p>A sponsored dependent of a covered employee who meets all of the following criteria:</p> <ol style="list-style-type: none"> 1. resides at the employee's same principal place of abode and is a member of the employee's household for the entire tax year during which sponsored dependent coverage is provided; 2. shares a relationship with the employee as defined by one of the following: <ul style="list-style-type: none"> – parent, step-parent, parent-in-law, or person who stood in loco parentis to the employee as a child – grandparent or grandparent of the employee's spouse – sibling or sibling-in-law – aunt or uncle – niece or nephew – son- or daughter-in-law – grandchild or spouse of the employee's grandchild – biological, adopted, step or foster child who is not otherwise eligible for coverage under the terms of the university's group health plans – opposite-sex domestic partner who is unmarried, and with whom the employee is not related by blood to a degree of closeness which would prohibit marriage in the state in which they legally reside, and with whom the employee has been in a relationship for at least six (6) months and intends to remain so indefinitely; 3. is dependent upon the employee for more than 50% of his or her support, I can provide documentation of such support to the Office of Human Resources or to the university's third party administrator for claims administration, if requested, to verify the dependent status of this individual. Support includes: <ul style="list-style-type: none"> – housing/shelter; – cost for his or her clothing, food, education, recreation, and transportation expenses; – cost for his or her medical, dental, and/or vision care; and – cost for a proportionate share of other expenses necessary to support the sponsored dependent within the employee's household (such as food and utilities), but which cannot be directly attributed to that individual; and 4. is enrolled in Medicare if he or she is eligible for such coverage. The university's health plan will be a secondary payor to Medicare. 5. The individual is the employee's dependent under Section 152 of the Internal Revenue Code of 1986, as amended (taxalmanac.org/index.php/Sec. 152. Dependent defined). Consult with a tax advisor with any questions regarding whether or not the individual meets the IRS qualifications.
<p style="color: red; margin: 0;">Ineligible Dependents</p>	<ul style="list-style-type: none"> • A dependent spouse who would otherwise be eligible for coverage, but who is on active duty in any military, naval or air force of any country is not eligible for coverage during the period of active duty. • Dependents who do not meet the eligibility requirements outlined in this section.

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General Plan Provisions

Benefit Plan Year	January 1 to December 31.
Change in Coverage Due to a Qualifying Status Change	The Internal Revenue Code restricts you from dropping, adding, or changing health plan coverage during the plan year unless a qualifying status change occurs. The request for change in coverage must be consistent with the qualifying status change. There are two types of qualifying status changes:
Qualifying Status Changes	<ul style="list-style-type: none"> • Some specific events that constitute qualifying status changes include: <ul style="list-style-type: none"> – Family status changes—marriage, meeting the criteria of a same-sex domestic partnership or sponsored dependency, divorce, termination of a same-sex domestic partnership or sponsored dependency, childbirth, adoption or legal guardianship of a child, death of a covered dependent, dependent no longer meeting eligibility criteria established under the vision plan, or gain or loss of other coverage. – Employment status changes—a change in the type or FTE of your appointment that affects benefits eligibility, a benefits open enrollment at your spouse’s employer, or a change in your spouse’s eligibility for benefits. • You may only make Vision Plan election changes that are consistent with your qualifying status change. • Refer to the Life Events section of the OHR website at hr.osu.edu/events to determine the type(s) of benefit election changes you may make as a result of specific qualifying status changes. <ul style="list-style-type: none"> – The Office of Human Resources must receive notification of such change within 31 days of the event.
FTE changes to OSU appointment must meet these conditions:	<ul style="list-style-type: none"> • Significant change in vision contributions due to a change in FTE. • Loss of eligibility due to decrease in combined FTE to below 50% FTE. • A gain in eligibility for benefit programs as a result of an increase in combined FTE to above 50% FTE.
Coverage Election for Rehires	If you are rehired by the university into a benefits-eligible position, you will be able to re-enroll and elect the same coverage options that were in effect before your termination from the university for the balance of the plan year, and accumulations for plan features such as annual deductibles and out-of-pocket limits, as well as expenses you had accumulated towards the plan’s lifetime maximums, will continue to apply as if there was no loss of coverage. You can change coverage levels upon your re-enrollment, but you cannot change your coverage option until the next annual Open Enrollment period.
When a qualifying status change occurs:	<ul style="list-style-type: none"> • You must complete the university Health Election Form, available online at hr.osu.edu/forms, in order to make enrollment changes. Documentation may be required for some events. <ul style="list-style-type: none"> – The completed form must be submitted to the Office of Human Resources Customer Service Center within 31 days of the qualifying status change. The university must approve all qualifying status changes according to eligibility and plan guidelines. – Coverage and contributions will be effective back to the qualifying status change date. – If you do not notify the university within 31 days, the change can only be made at the next open enrollment period or future qualifying events. The university determines the open enrollment period. • Note: A newborn infant must be added within 31 days of the birth. Otherwise the newborn cannot be added until the next open enrollment period. If coverage is already in effect, you must add the newborn, even if you have family coverage. – The form may not be altered by anyone other than the employee unless the employee has given written consent allowing alterations. • The university must approve all qualifying status changes. The university determines the effective date for all enrollment changes and any contribution changes that may be required. <p>Note: Your coverage level and premium contributions may be adjusted based on the qualifying status change.</p>
Dual Coverage	<ul style="list-style-type: none"> • No person may be covered at the same time as both a covered employee and dependent or as a dependent of more than one covered employee. • If you and your spouse both work at the university and are both eligible for university vision benefits, your dependent children may enroll under only one of you. Coverage can only be changed during the annual open enrollment or when there is a qualifying status change as defined under Internal Revenue Code Section 125.
Choice of Providers	You may choose to receive service from network or non-network providers. Note: Your out of pocket costs may be greater when using non-network providers.

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General Plan Provisions

Coordination with Medical Coverage	<ul style="list-style-type: none"> • On occasion, your vision care provider may identify a condition and recommend further treatment. Sometimes the condition is medical in nature and therefore covered in part or totally by your medical insurance. In these cases, all rules of your medical insurance apply. <ul style="list-style-type: none"> – If you are enrolled in Prime Care Advantage, Prime Care Connect, Prime Advantage Value, or Prime Advantage Plus, you must use a provider in your medical plan network to receive maximum benefits. – For additional information or assistance with coordination with your OSU medical benefits, contact OSU Health Plan, at (614) 292-4700, 1-800-678-6269, or visit osuhealthplan.com.
Cost of the Program	The university pays the full cost for vision coverage for the employee. The employee is responsible for the additional cost for dependent coverage.
Coordination of Benefits (COB)	<ul style="list-style-type: none"> • All benefits provided as described in this document are subject to coordination of benefits (COB). COB is a feature that prevents duplicate payment by the university's health plans and any other group insurance program. COB determines whether a benefit plan is primary or secondary when you and/or your dependents are covered by more than one benefit plan. All university health plans follow the COB rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure that the combined payments of all plans are not more than your actual bills. • You must first submit all bills to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance of the bill to the secondary plan. • COB affects benefits in the following manner when you are covered by more than one benefit plan: <ul style="list-style-type: none"> – If the total benefits for covered services to which you would be entitled as described in this document, and under all other benefit plans, exceed the covered services you receive, then the benefits provided will be determined according to this provision. – When this plan is primary, the claims processor will authorize the payment of benefits on behalf of the university without regard to any other benefit plan. – When this plan is secondary, the benefits authorized on behalf of the university may be reduced and will not exceed the balance of charges remaining after payment by the other benefit plan. <p>Note: No more than 100% of the covered expenses will be paid. If the university plan and another insurer make a duplicate payment to you, you are responsible for reimbursing the university for the duplicate payment.</p>
Determining Primary Coverage	<ul style="list-style-type: none"> • To decide which plan is primary, the university plan must consider both the coordination provisions of the other plan and which member of your family is involved in a claim. • The primary plan will be determined by using the first of the following rules that applies:
Non-coordinating plan:	Another group plan with no COB provision is always primary
Employee:	The plan that covers you as an employee is always primary
Children:	<ol style="list-style-type: none"> 1. The Birthday Rule – The plan of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary for the children. If your birthday is in March and your spouse's birthday is in June, your plan will be primary for all of your children. <ul style="list-style-type: none"> – If both parents have the same birthday, the plan that covered the parent longer will be primary. – If a dependent is covered by two plans and the other contract does not have this COB rule, the rule of the other contract will determine the primary contract. For example, the other plan uses a "gender rule" which says that the father's plan is always primary, then the rules of that plan will be followed. 2. Parents separated or divorced – the following rules apply: <ul style="list-style-type: none"> – If the court decree specifies one parent as responsible for health care expenses, that parent's plan is primary – If the court decree gives joint custody and does not mention health care, the birthday rule will apply – If neither rule 1 or 2 applies, the order will be determined in accordance with the Ohio Department of Insurance rule on Coordination of Benefits.
Other Situations:	<ul style="list-style-type: none"> • The program that has covered the individual for the longer period of time is always primary. • For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on Coordination of Benefits.
Coordination of Benefits Disputes	If you believe that VSP has not paid a claim properly, you should first attempt to resolve the problem by contacting VSP. You may also contact a Benefits Consultant in the Office of Human Resources for assistance.

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General Plan Provisions

Privacy of Health Information	Federal HIPAA regulations restrict how the university and the OSU Plans may use information about you and your family.
Permitted Uses and Disclosures	<ul style="list-style-type: none"> • Subject to your written authorization, the OSU Plans may release Protected Health Information (PHI) to the university, provided that the university does not use or disclose that information except for the following purposes: <ul style="list-style-type: none"> – To perform health plan administrative functions – To obtain premium bids for group health insurance, or – To modify, amend or terminate the OSU Health Plans. • All disclosures of Protected Health Information must be consistent with Federal Privacy Regulations.
Conditions of Disclosure	<ul style="list-style-type: none"> • The OSU Plans may disclose Protected Health Information to the university only upon receipt of a certification from the university, as plan sponsor of the OSU Plans, that the plan documents have been amended to incorporate the provisions set forth below and that the university, in its capacity as plan sponsor, agrees to such provisions. • The university, as plan sponsor of the OSU Plans, agrees to: <ul style="list-style-type: none"> – Not use or further disclose PHI other than as permitted or required by plan documents or as required by law. – Ensure that any agents or subcontractors to whom it provides PHI received from the OSU Plans agrees to the same restrictions and conditions that apply to the university with respect to such PHI and that they agree to implement reasonable and appropriate security measures to protect the information. – Not use or disclose the PHI received from the OSU Plans for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the university (except to the extent that such other benefit or employee benefit plans is part of the organized health care arrangement of which the Plans are a part). – Report to the OSU Plans any use or disclosure of the information that is inconsistent with the uses or disclosures provided and/or any security incident of which it becomes aware. – Make a covered person’s PHI available to them if they request access, in accordance with federal HIPAA regulations. – Incorporate any approved amendments to a covered person’s PHI requested by a covered person, in accordance with federal HIPAA regulations. – Make available an accounting of disclosures of a covered person’s PHI when requested in accordance with federal HIPAA regulations. – Make internal practices, books and records relating to the use and disclosure of PHI received from the OSU Plans available to the Secretary of Health and Human Services for purposes of determining compliance of the Plans with the law. – If feasible, return or destroy all PHI received from the OSU Plans that the university still maintains in any form and retain no copies of information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible. – Ensure adequate separation between the OSU Plans and the university as required by federal law.
Permitted Uses and Disclosures of Summary Health Information	The OSU Plans may disclose Summary Health Information to the university, provided that the Summary Health Information is only used by the university for the purpose of: <ul style="list-style-type: none"> – Obtaining premium bids for providing health insurance coverage; or – Modifying, amending or terminating the vision plan.
Permitted Uses of Enrollment and Disenrollment Information	The OSU Plans may disclose enrollment and disenrollment information and information on whether individuals are participating in the medical plans to the university, provided such enrollment and disenrollment information is only used by the university for the purpose of performing its administrative functions.
Security of Protected Health Information	The OSU plans will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan.
Adequate Separation Between Plan and Plan Sponsor	Within the university, only employees of the Office of Human Resources shall have access to and use PHI. Such employees shall have access to PHI only to the extent necessary to perform plan administrative functions, unless an individual authorization exists. In the event that any such employees do not comply with these provisions, the employee shall be subject to disciplinary action by the university for non-compliance pursuant to the discipline procedures established by the university. This separation will be supported by reasonable and appropriate security measures.
Records	<ul style="list-style-type: none"> • By accepting coverage as described in this document, you agree that the university, OSU Health Plan and VSP may request, and anyone may give to the university, OSU Health Plan, and VSP, any information (including copies of records) about your condition for which benefits are claimed. If requested, the university, OSU Health Plan or VSP may give similar information to anyone providing similar benefits to you. • The covered employee will furnish a specific release of medical information as necessary for the purposes of determining liability under the plan.

Termination of Coverage

Termination of Coverage

- **Coverage will terminate for the following covered person(s) when the following events occur:**
 - For the covered **employee** and enrolled dependents, coverage will terminate at the end of the pay period in which the covered employee ends his/her employment with the university.
 - For the **spouse/same-sex domestic partner** of the covered employee, coverage will terminate at the end of the covered employee's pay period in which a decree of divorce, dissolution, legal separation, or affidavit of termination of same-sex domestic partner status occurs.
 - For a **dependent child** and other eligible individuals as defined by the university, coverage will terminate:
 - At the end of the covered employee's pay period in which the child no longer qualifies as a dependent.
 - At midnight on the date of the child's 23rd birthday.
- The covered employee is responsible for notifying the university **within 31 days** of the date of any status change involving the eligibility of a covered dependent. Failure to provide timely notification of such information may result in disciplinary action of an employee up to and including termination of benefits and/or employment. The university may also recover from the employee all damages sustained from losses (including paid claims and premium costs) and reasonable attorneys' fees incurred to recover such damages that are brought about as a result of the employee's failure to notify the university of status changes which affect dependent eligibility.
- Upon termination of coverage, individuals may be eligible for Coverage Continuation as detailed. However, if the university is not notified within 60 days of the last day of eligibility and/or coverage the dependent will not be eligible for Coverage Continuation as detailed.
- The university will make all determinations regarding when a covered person is no longer eligible under this plan. It is the responsibility of the university to make all final determinations when coverage will end for a covered person and to communicate all terminations of coverage to NGS.
- Coverage under the plan ends for all covered persons on the date on which the plan terminates or is not renewed by the university. The university reserves the right to terminate this plan, in whole or in part, at any time.

Benefits Description

Your vision plan provides for routine eye care services and materials. VSP pays benefits for covered services or supplies up to a predetermined amount of coverage. The schedule of benefit allowances for specific services is listed below. However, if you select a VSP provider, these covered services and supplies are paid in full up to plan allowances.

Cost of the Program	The university pays the full cost for coverage of the faculty or staff member. Faculty and staff are responsible for the additional cost for dependent coverage.
Choice of Provider	<ul style="list-style-type: none"> • Your plan covers services or materials provided by any licensed ophthalmologist, optometrist, or optician. Therefore, you may choose an eye care specialist who is or is not on the list of VSP network doctors. • VSP has contracts with over 23,000 private eye care practitioners nationally to form a panel of doctors to provide professional vision care for persons covered under this plan. This assures that only the finest quality professional care and materials are provided to you.
Examination	<ul style="list-style-type: none"> • A complete analysis of the eyes and related structures to determine the presence of vision problems is available once every plan year. <ul style="list-style-type: none"> – A refraction of the eye must be completed for the exam to be covered as a routine eye exam and paid by VSP. – Contact lens evaluation and fitting fee, or additional supplemental tests, are not covered under the standard examination. <p>Note: Some VSP network providers will bill your medical insurance as primary for the exam if any medical diagnosis is included on the claim. If this does occur and there is a secondary routine diagnosis, VSP can be billed as secondary. If you are enrolled in a network medical plan, the optical provider must be in the medical plans network in order to be covered by the medical plan. For example, if your VSP provider includes a medical diagnosis on your claim, VSP will send the claim to your medical administrator (NGS for university medical plans). You are responsible for the applicable medical plan copayment or coinsurance for a specialist office visit. The specialist copayment can be sent to VSP for reimbursement.</p>
Spectacle Lenses	Coverage for lenses is available once every plan year.
Frames	An allowance of \$155 will be made toward the cost of frames. The plan offers a selection of frames; however, if you select a frame that costs more than the amount allowed by the plan (or a frame requiring oversized lenses) you must pay any additional cost. You will receive a 20% discount on any amount above the allowance. Coverage for frames is available every other plan year.
Medically Necessary Contact Lenses	<ul style="list-style-type: none"> • Contact lenses and the necessary ophthalmic materials are covered in full once each plan year by VSP when a VSP provider receives prior approval for one of the following medical conditions: <ul style="list-style-type: none"> – following cataract surgery (aphasic conditions) – to correct extreme visual acuity problems not correctable with spectacle lenses – to correct for significant anisometropia – keratoconus
Elective Contact Lenses	<ul style="list-style-type: none"> • Prescription contact lenses may be selected instead of glasses (spectacle lenses and frames). Patients choosing contact lenses will not be eligible for glasses until the next plan year. • An allowance of \$130.00 will be made toward the cost of elective contact lenses <ul style="list-style-type: none"> – This allowance is in place of glasses once each plan year. – This allowance will be paid toward the contacts and the VSP provider's professional fees which includes the contact lens evaluation examination, fitting costs, and any follow-up evaluations. – Any costs exceeding the allowance are the patient's responsibility. – In addition to the allowance, VSP also offers a 15% discount off the VSP provider's professional fees when the patient purchases prescription contacts. This discount applies only to the professional services and not to the contacts (contacts are provided at usual and customary fees). The 15% discount may be used for 12 months following the date of the covered eye examination and is only offered through the VSP provider who provided the last covered eye exam. <p>Note: For example, if contacts are selected during the 2012 plan year, glasses may be selected during the 2013 plan year.</p>

Schedule of Benefits

Effective for the 2012 Plan Year (January 1 – December 31, 2012)

Covered Services	Network	Non-Network
Annual Deductible	\$15 per person, applies to materials only (lenses and frames)	
Vision Examination	100% paid; no deductible	Maximum of \$30 paid; no deductible
Frequency	Once per plan year	
Frames	Maximum of \$155 paid, after annual deductible; 20% discount off any amount over \$155	Maximum of \$60 paid, after annual deductible
Frequency	Once every other plan year	
Lenses	100% paid, after annual deductible, for: <ul style="list-style-type: none"> • Single Vision Lenses • Lined Bifocal Lenses¹ • Lined Trifocal Lenses¹ • Lenticular Lenses¹ 	Maximum paid as indicated, after annual deductible, for: <ul style="list-style-type: none"> • Single Vision Lenses: \$45 • Any Bifocal Lenses: \$70 • Any Trifocal Lenses: \$70 • Lenticular Lenses: \$100
Contact Lenses (includes disposables)	Maximum of \$130 paid; no deductible; 15% discount off the contact lens fitting fee ²	Maximum of \$105 paid, no deductible
Frequency	Only one lens benefit (either glasses or contact lenses) is payable each plan year	

¹ Blended (seamless) lenses are available at Vision Service Plan's (VSP) preferred member pricing; however, the plan does not pay for any additional charges above the cost of lined lenses.

² If an eligible medical condition (keratoconus, significant anisometropia, aphasic condition) exists, VSP pays for this service in full.

Using the Benefit

How do I use the benefit?	<ul style="list-style-type: none"> • When you choose to obtain vision services, this plan covers the benefits described in this document (examination, professional services, spectacle lenses and frames) up to plan limitations. • Any additional care, services and/or materials not covered by this plan (such as those considered cosmetic in nature) may be arranged between you and your doctor. • To obtain vision care benefits, choose one of the following options to obtain vision care.
Option 1	<p>If you choose to see a VSP provider:</p> <ul style="list-style-type: none"> • Verify your eligibility for services on VSP's website at vsp.com or call VSP at 1-800-877-7195. If you have not already registered, you will need to register in order to view your eligibility status. • Choose a doctor from the list of VSP providers and make an appointment for an examination. • Inform the VSP provider that you are covered by VSP benefits through the Ohio State plan. • The VSP provider will verify your eligibility and plan coverage with VSP, and obtain authorization so you can receive an eye examination and corrective eyewear, if necessary. If you are not currently eligible for services and/or materials the provider will notify you of this. • During your examination, the VSP provider will determine if eyewear is necessary. If so, the provider will coordinate your prescription with one of VSP's contract wholesale laboratories and dispense your eyewear. • VSP will pay up to the plan limitations for covered services; you are responsible for any additional costs.
Option 2	<p>If you choose to see a non-VSP provider:</p> <ul style="list-style-type: none"> • Make an appointment and receive the necessary services from the provider. Pay the provider the full fee and obtain an itemized receipt containing the following information: <ul style="list-style-type: none"> – Patient's name – Date services began and materials received – Services and materials received – The type of lenses received (single vision, bifocal, trifocal, etc.) – The covered employee's Social Security number • Mail your receipts to VSP, P.O. Box 997105, Sacramento, CA 95899-7105 • You will be reimbursed directly according to the Non-VSP Provider Reimbursement Schedule as outlined in the Schedule of Benefits. • VSP reserves the right to reject any and all claims for services or benefits that are filed more than 180 days after completion of services. • There is no assurance the Non-VSP Provider Reimbursement Schedule will cover the entire cost of the examination or materials.
Option 3	<p>If you choose to see a non-VSP provider for an examination and have a VSP provider fill your prescription:</p> <ul style="list-style-type: none"> • After receiving an examination from the non-VSP provider, pay the examination fee. Obtain a receipt for the exam and the prescription for your lenses. Send the exam receipt to VSP as outlined in Option 2. You will be paid directly according to the non-VSP provider Reimbursement Schedule for your exam. • Call one of the VSP providers and after verifying that the provider is willing to fill another provider's prescription, make an appointment to have your prescription filled. Inform the VSP provider that you have VSP benefits through the Ohio State plan. • Take your prescription to the VSP provider who will fit you for your new eyewear and take care of any further paperwork for payment. The VSP provider will be paid directly by VSP up to the Schedule of Benefits. You are responsible for any additional costs.

Benefit Exclusions

Vision benefits are not paid for the following services or supplies:

- Lenses not requiring a prescription.
- Drugs or medications.
- Plain safety glasses or goggles.
- Two pair of basic lenses in place of bifocal lenses.
- Sunglasses (tinted glasses with tints other than #1 or #2 or photo chromic glasses with light transmittance value less than 85%).
- Orthoptics, vision training and subnormal vision aids.
- Frames used with lenses that do not require a prescription or prescription change.
- Benefits payable under your medical plan, such as eyeglass prescription or fitting made necessary by damage to the natural eye, or contact lenses in connection with cataract surgery.
- For services not medically necessary to the care and treatment of any injury or furnished without recommendation and approval of an optometrist acting within the scope of his/her license except for those periodic routine examinations listed in this document.
- Services or supplies provided after coverage ends. However, lenses and frames will be covered for 30 days after coverage ends if a complete eye examination, including refraction, was performed 30 days prior to the termination of coverage and which resulted in a prescription of eyeglasses for the first time, or a change in prescription.
- For injuries or conditions compensable under Workers' Compensation or Employer's Liability laws; or benefits or services that are available from any federal or state government agency, from any municipality, county or other political subdivision or community agency, or from any foundation or similar entity.
Note: This provision does not apply to any programs provided under Title XIX Social Security Act (Medicaid).
- Services and/or Materials:
 - Furnished by any governmental agency, which would be provided free of charge in the absence of insurance, or which are covered by another insurance contract.
 - For which a benefit is not specifically provided by your contract.
 - Provided before coverage begins.
 - Received from a member of your immediate family.
 - That are covered under a hospital, surgical/ medical or prescription drug program.
 - Incurred as a result of a covered person's voluntary involvement or participation in a felony or an illegal activity, including a riot or act of civil disobedience.
 - For injury or sickness arising in the course of employment. This applies whether or not you claim any compensation or recover losses from a third party.
 - For injury or sickness that occurs as a result of any act of war, declared or undeclared, or service in the armed forces of any country.
 - For which you have no legal obligation to pay in the absence of this or like coverage.
 - Which are experimental/investigative, including investigational, surgical procedures, as well as associated health services and/or supplies as defined by the Plan.
 - For which the university cannot by law provide such benefit.
 - For telephone consultations, missed appointments, completion of claim forms.
 - For which no charge is made.
 - For which the person is not legally obligated to pay.
 - For which no charge would be made in the absence of eligibility.
 - Primarily for educational, vocational or training purposes.
 - Excluded by the rules and regulations of the plan, including the processing policies, which may change periodically.
 - For personal hygiene and convenience items.
 - Which are not specified in this document as covered services.
 - Once the maximum benefits have been provided as outlined in this document and the Schedule of Benefits.

Benefit Limitations

This plan is designed to cover your visual needs rather than cosmetic materials. There will be extra costs involved if you select materials or services which are cosmetic in nature, such as:

- Blended or progressive lenses.
- Oversized lenses.
- A frame that costs more than the plan allowance.
- Elective contact lenses (in excess of the plan allowance) described on the Schedule of Benefits.
- Contact lens evaluation and fitting.
- #1 or #2 tinted or coated lenses (other than solid pink #1 or #2).
- Additional supplemental tests not covered under the standard vision examination.
- Any materials or services not necessary for the patient's visual welfare.

Continuation of Coverage

COBRA	<ul style="list-style-type: none"> • Vision benefits may be continued under certain circumstances in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA). Coverage under the university's health plans may be extended beyond your normal coverage termination date based on the following "qualifying events": <ul style="list-style-type: none"> – Termination of employment (for reasons other than gross misconduct) – Reduction in the number of hours of employment that affects coverage – Divorce or legal separation – Employee's death (for eligible dependents) – A dependent child ceases to be eligible for coverage under the plans – Covered employee or spouse becomes eligible for Medicare <p>The federally mandated provision for COBRA provides an opportunity for you and/or your dependent(s) to purchase the group health plan at the group rate (the full cost – the employer makes no contribution) plus an administrative charge for a specified period following the above coverage termination date. Election of COBRA will provide the same coverage as provided by the university's health plans to its employees.</p>
Enrollment Period	Enrollees have 60 days from the date of coverage termination to elect continuation of coverage through COBRA.
Period of Health Coverage	<ul style="list-style-type: none"> • The period of continuation coverage depends on the qualifying event causing the loss of coverage: <ul style="list-style-type: none"> 18 months: for termination of employment or reduced working hours (length of coverage applies to the employee and eligible dependents). 29 months: if the employee becomes disabled and has a reduction of working hours that affects coverage, or must terminate employment due to the disability (length of coverage applies to the employee and eligible dependents). – In the event that you are receiving extended continuation coverage as a result of your being disabled under the Social Security Act, your extended continuation coverage may be terminated by the plan on the first day of the month at least 31 days after a final determination that you are no longer disabled. You must notify the plan within 30 days of the date of any final determination under the Social Security Act that you are no longer disabled. 36 months: for spouses and dependent children who lose coverage due to other qualifying events such as, divorce, legal separation, employee's death, etc. 36 months: for dependent children who lose coverage due to exceeding eligible age.
Cost of COBRA Health Coverage	Your COBRA contributions will be the same amount you were contributing before losing coverage plus a 2% administrative fee. Your contributions will be made on an after-tax basis, which means they will no longer be tax-free.
Payment of COBRA Health Contributions	Your first COBRA contribution will be due within 45 days after your initial election of COBRA continuation coverage. Subsequent contributions will be due on the first day of each subsequent month for that month's coverage. All payments should be made payable to NGS American/CoreSource and sent to NGS CoreSource, P.O. Box 72323, Cleveland, OH 44192-2323.
Termination of COBRA Coverage	Your coverage through COBRA generally will end on the earlier of the last day of the plan year or on the last day of the month in which contributions are received.
Additional Information	For more information and enrollment materials regarding COBRA, you should contact OHR Customer Service.

Subrogation

Subrogation

- This provision applies if you receive benefits for covered services when you are injured as a result of the neglect or wrongful act of another person. VSP may recover the amount paid in benefits for your injuries from the person who is responsible, or from any other person or insurance company held liable, when payments have been made in settlement. If you sue the person or company that is liable, any benefits paid or payable to VSP must be included in your suit.
- When the suit is settled, you must reimburse VSP for the amount of benefits previously provided.
- In order for VSP to be kept aware of possible subrogation, you will be asked to complete a questionnaire and agreement when you file a claim. You or your attorney must complete these papers and return them to VSP.

The following statement is required for this document by Ohio law:

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Provider Directory

The directory is a list of optometrists and ophthalmologists who participate in Vision Service Plan's Provider Network. The VSP Provider network is available on the Internet at: vsp.com or as a link through the Office of Human Resources homepage at: hr.osu.edu. You can also contact VSP directly to assist you in locating a network provider by calling 1-800-877-7195 and give the advisor your employer name (The Ohio State University) and the region in which you reside. The advisor will give you a list of VSP providers in your area.

Definitions

Plan Sponsor	The plan sponsor is The Ohio State University.
Protected Health Information (PHI)	<ul style="list-style-type: none"> • Information that is created or received by the Ohio State University Employee Health Plans and relates to the past, present or future physical or mental health of a covered person; the provision of health care to a covered person; or the past, present or future payment for the provision of health care to a covered person; and that identifies the covered person or there is a reasonable basis to believe that the information could be used to identify the covered person. It includes information about living or deceased people. • The following components of a covered person's information when received, created or maintained by the OSU Plans are also considered PHI: <ul style="list-style-type: none"> – Names – Street address, city, county, precinct, zip code – Dates directly related to a covered person (including birth dates, admission dates, discharge dates, date of death) – Telephone numbers, fax numbers and electronic mail addresses – Social Security numbers – Medical record numbers – Account numbers – Certificate/license numbers – Vehicle identifiers, serial numbers and license plate numbers – Device identifiers and serial numbers – Web Universal Resource Locators (URLs) – Biometric identifiers (including finger and voice prints) – Full face photographic images or comparable images – Any other unique identifying number, characteristic or code
Summary Health Information	<ul style="list-style-type: none"> • Information that may be individually identifiable health information that: <ul style="list-style-type: none"> – Summarizes claim history, claim expenses, or types of claim experienced by individuals for whom the university has provided health benefits under a group health plan; and – From which all identifiers described above have been deleted. Geographic information need only be aggregated to a five-digit zip code level.