Hallmark Cards, Incorporated - Diabetic Plan

EyeMed Vision Care Diabetic Product

Diabetic Care Services

	With Us	Out-of-Network Reimbursement
Office Service Visit (Medical Follow-up Exam) Type 1 and Type 2 diabetics Frequency: Up to (2) services per benefit year	**Covered 100%** $0 Co-pay	**Up to $77** per service

Diagnostic Services

	With Us	Out-of-Network Reimbursement
Retinal Imaging Type 1 and Type 2 diabetics Frequency: Up to (2) services per benefit year	**Covered 100%** $0 Co-pay *Not covered if Extended Opthalmoscopy is provided within 6 months	**Up to $50** per service
Extended Ophthalmoscopy Type 1 and Type 2 diabetics Frequency: Up to (2) services per benefit year	**Covered 100%** $0 Co-pay *Not covered if Fundus Photography is provided within 6 months	**Up to $15** per service
Gonioscopy Type 1 and Type 2 diabetics Frequency: Up to (2) services per benefit year	**Covered 100%** $0 Co-pay	**Up to $15** per service
Scanning Laser Type 1 and Type 2 diabetics Frequency: Up to (2) services per benefit year	**Covered 100%** $0 Co-pay	**Up to $33** per service

Definitions

Office Service Visit (Medical Follow-up Exam): A follow-up examination for diabetic vision care.

Some or all of the diagnostic services described below will be provided as deemed appropriate by your provider.

Retinal Imaging
A photograph of portions, or the complete retinal surface and structures. (Not covered if Extended Ophthalmoscopy was provided in previous six months.)

Extended Ophthalmoscopy
Procedure to examine the interior of the eye, focusing on the posterior segment of the eye, including the vitreous retina and optic nerve. (Not covered if Retinal Imaging was provided in previous six months.)

Gonioscopy
An eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea.

Scanning Laser
Computerized ophthalmic diagnostic imaging of the posterior segment of the eye.

Exclusions & Limitations

The Diabetic benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:

1. Costs associated with securing frames, lenses or any other materials
2. Orthoptics or vision training and any associated supplemental testing
3. Surgical procedures, including laser or any other form of refractive surgery, and any pre- or post-operative services
4. Pathological treatment of any type for any condition
5. Any eye examination required by an employer as a condition of employment
6. Insulin or any medications or supplies of any type
7. Services and/or materials not included in this rider

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