# Group Vision Care Plan

## EVIDENCE OF COVERAGE
## &
## DISCLOSURE FORM

Provided by:
VISION SERVICE PLAN

3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM DISCLOSES THE TERMS AND CONDITIONS OF COVERAGE. PLEASE READ THE FORM COMPLETELY AND CAREFULLY. INDIVIDUALS WITH SPECIAL HEALTHCARE NEEDS SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THEM. ALL APPLICANTS HAVE A RIGHT TO REVIEW THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT.

CAASP-00890 07/18/24 UU

**THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE TERMS AND CONDITIONS OF COVERAGE. THE PLAN CONTRACT ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING TERMS AND CONDITIONS OF COVERAGE.**

**DEFINITIONS:**

| | |
|---|---|
| **ADDITIONAL BENEFIT RIDER** | The document attached to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan. |
| **ANISOMETROPIA** | A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other. |
| **BENEFIT AUTHORIZATION** | Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled. |
| **COPAYMENTS** | Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered. |
| **COVERED PERSON** | An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan. |
| **ELIGIBLE DEPENDENT** | Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator under which such Enrollee is covered. |
| **EMERGENCY CONDITION** | A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action. |
| **ENROLLEE** | An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator. |
| **EXPERIMENTAL NATURE** | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP. |
| **GROUP** | An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents. |

**KERATOCONUS** A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

**MEMBER DOCTOR** An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

**NON-MEMBER PROVIDER** Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

**PLAN BENEFITS** The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

**PREMIUMS** The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.

**RENEWAL DATE** The date on which this plan shall renew or terminate if proper notice is given.

**SCHEDULE OF BENEFITS** The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.

**SCHEDULE OF PREMIUMS** The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

**ELIGIBILITY FOR COVERAGE**

Enrollees: To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any child of an Enrollee who has not attained the limiting age as shown on the enclosed insert, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

A dependent, unmarried child over the limiting age as shown on the enclosed insert may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the Enrollee for support and maintenance.

**ANNUAL ENROLLMENT/DISENROLLMENT**

Except for new Enrollees joining this plan, Enrollees and Eligible Dependents shall have the right to become covered or cancel coverage once each year during the thirty (30) day period beginning sixty (60) days prior to the anniversary of the effective date of this plan (or as may otherwise be allowed by mutual agreement between the Group and VSP). Any such coverage or cancellation of coverage may be accomplished only by Group giving VSP written notice thereof on behalf of the Enrollee or Eligible Dependent before the end of the prescribed thirty (30) day period and will take effect on the anniversary date following receipt of such notice.

**PREMIUMS**

Your Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by your Group.

**PROCEDURES FOR USING THIS PLAN**

**PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.**

1. When you desire to obtain Plan Benefits from a Member Doctor, you should contact a Member Doctor or VSP. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one which does.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against this plan in spite of your termination of coverage or the termination of this plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to the Member Doctor for the services covered by this plan. VSP will pay the Member Doctor directly according to their agreement with the doctor. VSP reimburses its Member Doctors on a fee-for-service basis. There are no incentives or financial bonuses paid to Member Doctors for services covered under this plan.

   **Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.**

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Essential Medical Eye Care. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

   Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

**BENEFIT AUTHORIZATION PROCESS**

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

**BENEFITS AND COVERAGES**
Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

**IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.**

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Covered Person is entitled to a Eye Examination as indicated on the enclosed insert.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Covered Person is entitled to new lenses as indicated on the enclosed insert.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Covered Person is entitled to new frames as indicated on the enclosed insert.

4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein.

   When you obtain Necessary contact lenses from a Member Doctor, professional fees and materials will be covered as indicated on the enclosed insert.

   When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from one of the Member Doctors, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

**6.** Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials including but not limited to supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

**COPAYMENT**
The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

**Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.**

**This Plan is designed to cover *visual* needs rather than *cosmetic* materials. If you select any of the following extras, this Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra is defined as a Plan Benefit in the enclosed Schedule of Benefits insert.**

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

**NOT COVERED**
**There is no benefit under this plan for professional services or materials connected with:**

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.

- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.

- Medical or surgical treatment of the eyes.

- Corrective vision treatment of an Experimental Nature.

- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.

- Services/materials not indicated as covered Plan Benefits on the enclosed insert.

**LIABILITY IN EVENT OF NON-PAYMENT**
In the event VSP fails to pay the provider, you shall not be liable for any sums owed by VSP other than those not covered by the policy.

**Timely Access to Care**
Covered Persons have the right to receive care and services in a timely manner.

| **Appointment Type** | **Timeframe** |
|---|---|
| Routine Eye Exam | Within 15 business days |
| Non-Urgent Medical | Within 10 business days |
| Urgent Care | If call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 24 hours |
| Telephone Screening | Evaluated to determine the severity of the condition and disposition of the patient |

**Language Interpreter Services**
Covered Persons have the right to receive language interpreter services. When scheduling an appointment, they can tell the provider's office that they need an interpreter at the time of their visit.

**COMPLAINTS AND GRIEVANCES**

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt.

**Claim Payments and Denials**

**A. Initial Determination**: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

**B. Request for Appeals**: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

**VSP**
**Member Appeals**
**3333 Quality Drive**
**Rancho Cordova, CA 95670**
**(800) 877-7195**

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

**ARBITRATION**
Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration. The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

**TERMINATION OF BENEFITS**

Terms and cancellation conditions of this plan are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this plan whether the cancellation is by Group or by VSP due to non-payment of Premium. If service is being rendered to you as of the termination date of this plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this plan.

**INDIVIDUAL CONTINUATION OF BENEFITS**

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

**THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)**
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

***VISION SERVICE PLAN***
***3333 Quality Drive***
***Rancho Cordova, CA 95670***

*Group Name:* *GROUP INSURANCE TRUST OF THE CALCPAS*

*Plan Number:* *00427201*

*Effective Date:* *JANUARY 1, 2025*

*Plan Term:* *FORTY-EIGHT (48) MONTHS*

*VISION CARE PLAN*
*DISCLOSURE FORM AND EVIDENCE OF COVERAGE*

***PLAN ADMINISTRATOR:***

*Ron Lang*
*(Name)*
*1800 Gateway Dr Ste 130*
*(Address)*
*San Mateo, CA 94404-4072*
*(City, State, Zip)*

***MONTHLY PREMIUM:***

*YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.*

***ELIGIBILITY:***

*ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.*

***PLAN AND SCHEDULE:***

***VSP CHOICE PLAN*** ***DIVISIONS 0022 AND 0024***

| | |
|---|---|
| ***EXAMINATION:*** | *ONCE EVERY 12 MONTHS.* |
| ***LENSES:*** | *ONCE EVERY 24 MONTHS.* |
| ***FRAMES:*** | *ONCE EVERY 24 MONTHS.* |

***TERM, TERMINATION AND RENEWAL:***

*AFTER THE PLAN TERM, THIS PLAN WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.*

***TYPE OF ADMINISTRATION:***

*VSP WILL PROVIDE ADMINISTRATIVE SERVICES OF THE FOLLOWING NATURE: CLAIM AND BILLING ADMINISTRATION. BENEFITS PROVIDED UNDER THIS PLAN ARE SELF-INSURED BY THE EMPLOYER.*

***VSP'S ADDRESS IS:***

*VISION SERVICE PLAN*
*3333 QUALITY DRIVE*
*RANCHO CORDOVA, CA 95670*

# *SCHEDULE OF BENEFITS*

***GENERAL***

*This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.*

*Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.*

*When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.*

| ***PLAN BENEFITS*** | ***MEMBER DOCTOR BENEFIT*** | ***NON-MEMBER PROVIDER BENEFIT*** |
|---|---|---|
| ***VISION CARE SERVICES*** | | |
| *Vision Examination* | *Covered in Full** | *Up to $ 45.00** |
| ***VISION CARE MATERIALS*** | | |
| *Lenses* | | |
| *Single Vision* | *Covered in Full** | *Up to $ 30.00** |
| *Bifocal* | *Covered in Full** | *Up to $ 50.00** |
| *Trifocal* | *Covered in Full** | *Up to $ 65.00** |
| *Lenticular* | *Covered in Full** | *Up to $ 100.00** |

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

| | | |
|---|---|---|
| *Frames* | *Covered up to Plan Allowance** | *Up to $ 70.00** |

Client charge shall be determined by the then applicable wholesale/retail equivalent conversion factor.

| | | |
|---|---|---|
| ***CONTACT LENSES*** | | |
| *Necessary* | | |
| *Professional Fees and Materials* | *Covered in Full** | *Up to $ 210.00** |
| *Elective* | *Materials* | *Professional Fees and Materials* |
| | *Up to $ 130.00* | *Up to $ 105.00* |
| | *Elective Contact Lens fitting and evaluation** services are covered in full once every 24 months, after a maximum $60.00 Copayment.* | |

*Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.*

***LOW VISION***

*The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.*

| | ***MEMBER DOCTOR BENEFIT*** | ***NON-MEMBER PROVIDER BENEFIT*** |
|---|---|---|
| ***Supplementary Testing*** | *Covered in Full** | *Up to $125.00** |

*Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.*

| | | |
|---|---|---|
| ***Supplemental Care Aids*** | *75% of Cost** | *75% of Cost** |

*Subsequent low vision aids.*

*Copayment for Supplemental Aids: 25% payable by Covered Person.*

***Benefit Maximum***

**The maximum benefit available is $1000.00 (excluding Copayment) every two (2) years and a maximum of two supplemental tests within a two-year period.*

*NON-MEMBER PROVIDER BENEFIT*

*Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature..*

***Subject to Copayment, if any.**

****15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.**

***COPAYMENT***

*There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.*

***THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.***

**ADDENDUM**

## ADDITIONAL BENEFIT RIDER
## SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

### GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

### ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee.
- Legal spouse of Enrollee or Domestic Partner.
- Any child of an Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they attain the age of 26 years.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

## OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB."). Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

**PLAN BENEFITS**
**MEMBER DOCTORS**

## COVERED SERVICES

**Medical Eye Examinations:** Covered in Full after a Copayment of $20.00.

**Urgent/Emergency Care* and Special Ophthalmological Services**:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

## NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

**ADDENDUM**

## EVIDENCE OF COVERAGE & DISCLOSURE FORM

Please note the following revisions to your Evidence of Coverage and Disclosure Form. Keep this document with your Evidence of Coverage and Disclosure Form for a complete and accurate description of your benefits.

1. The following provision is added to the section titled **DEPENDENT ELIGIBILITY**:

   Domestic Partners: Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits.

vsp vision care

CONTINUATION COVERAGE UNDER CAL-COBRA

If you are covered under a group policy providing coverage to 2 to 19 eligible employees, you may be eligible to purchase continued coverage under this group vision plan under California Health and Safety Code Section 1366.20 et seq. (Cal-COBRA).

You may qualify for Cal-COBRA continuation coverage if you lose coverage for one of the following reasons:

a. The death of the covered employee.
b. The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.
c. The divorce or legal separation of the covered employee from the covered employee's spouse.
d. The loss of dependent status by a dependent enrolled in the group benefit plan.
e. With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

As a condition of receiving benefits, you must notify VSP within 60 days of the loss of coverage for one of the foregoing reasons. FAILURE TO NOTIFY VSP WITHIN THE REQUIRED 60 DAY PERIOD WILL DISQUALIFY YOU FROM RECEIVING CONTINUATION COVERAGE.

You must request the continuation in writing and deliver the written request to VSP by first class mail or other reliable means of delivery within the 60 day period following the later of (1) the date your coverage under the group benefit plan terminated or will terminate by reason of a qualifying reason, or (2) the date you were sent notice from the group benefit plan or VSP of eligibility to continue coverage under Cal-COBRA.

In order to continue receiving coverage under this plan, you are responsible for making all of the required premium payments in accordance with the terms and conditions of the plan contract. The first premium payment must be made to VSP by first-class mail, certified mail or other reliable means of delivery including personal delivery, express mail, or private courier within 45 days of the date you provided written notice to VSP of your election of continuation of benefits. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify you from receiving continuation coverage.

Notice: If the contract between VSP and the employer is terminated prior to the date your continuation coverage would terminate pursuant to the Cal-COBRA statute, you may elect continuation coverage under the employer's subsequent group benefit plan, if any, for the balance of the period you would have remained covered under this plan. However, continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in and payment of premiums to the new benefit plan within 30 days of receiving notice of termination of the prior group benefit plan.

All notices to VSP must be sent to:

VISION SERVICE PLAN
Attn: COBRA Administration
3333 Quality Drive
Rancho Cordova, CA 95670

## ***VISION SERVICE PLAN - HEALTH BENEFITS AND COVERAGE MATRIX***

*This matrix is intended to be used to help you compare coverage benefits and is a summary only, the evidence of coverage and plan contract should be consulted for a detailed description of coverage benefits and limitations.*

| TYPE OF SERVICE (Not all services are listed) Call VSP or check Official Plan Documents for details. | Benefit Description | Copayment | Patient Out-of-Pocket | Plan Maximum (Eligibility) | Emergency Service | Out-Patient Service | Hospitalization Service | Ambulance Service | Prescription Drug Coverage | Durable Medical Equipment | Mental Health Service | Chemical Dependency Service | Home Health Service |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Eye Examination | Complete vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. | Normally ranges from $0 - $50 (Can be group specific) | None. Covered in full. | Once every 12, 24 or 36 months (as determined by the group) | Yes. In emergency cases, when immediate vision care is necessary, Covered Persons may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. Emergency Vision care is subject to the same benefit frequencies, plan allowances, Copayments, and exclusions stated herein for Member Doctor and Non-Member Provider services. | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |
| Lenses | Includes such professional services as are necessary, which shall include: prescribing and ordering proper lenses; verifying the accuracy of the finished lenses; progress or follow-up work as necessary. Covered lenses include: Single vision, Bi-focal, Tri-focal and Lenticular | Normally ranges from $0 - $50 (Can be group specific and may be a combined copayment with frame) | Any cosmetic options not covered by the group | Once every 12, 24 or 36 months (as determined by the group) | Yes | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |
| Frame | Includes such professional services as are necessary, which shall include: assisting in the selection of frames; proper fitting and adjustment of frames; subsequent adjustments to frames to maintain comfort and efficiency; progress or follow-up work as necessary. | Normally ranges from $0 - $50 (Can be group specific and may be a combined copayment with lenses) | Any amount exceeding VSP's frame allowance (as determined by the group) | Once every 12, 24 or 36 months (as determined by the group) | Yes | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Contact Lenses (Elective) | Includes such professional services as are necessary, which shall include: contact lens evaluation, fitting, and verifying the accuracy of the finished lenses. | Copay for exam (if applicable) would apply here.<br><br>Normally ranges from $0 - $50 (Can be group specific) | Any amount exceeding VSP's contact lens allowance (as determined by the group). | Maximum determined by lens eligibility.<br><br>Can be once every 12, 24 or 36 months (as determined by the group) | Yes | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |
| Contact Lenses (Necessary) | Prior Authorization required.<br><br>Includes such professional services as are necessary, which shall include: contact lens evaluation, fitting, and verifying the accuracy of the finished lenses. | Copay for exam and materials (lenses and frame - if applicable) would apply here<br>Normally ranges from $0 - $50 (Can be group specific) | None.<br>Covered in full for most lens types. | Maximum determined by lens eligibility.<br><br>Can be once every 12, 24 or 36 months (as determined by group) | Yes | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |
| Low Vision | If included in the plan: Prior authorization required.<br>Includes such professional services as are necessary, which shall include:<br>Supplemental testing<br>Low Vision RX<br>Evaluations<br>Optical & non-optical aids<br>Training<br>Plan pays 50-75% of the approved allowable amount (maximum allowable is $500 to $1,000. Benefit is plan specific and can be group specific. | 25-50% of the approved allowable amount<br>(Maximum allowable is $500 to $1,000. Benefit is plan specific and can be group specific.) | Any amount exceeding the maximum allowable amount. | Every 2 years | No | NONE | NONE | NONE | NONE | NONE | NONE | NONE | NONE |

**Summary of Benefits and Coverage**
**VSP Choice Plan**
**Divisions 0022 and 0024**

**Prepared for:** **GROUP INSURANCE TRUST OF THE CALCPAS**
**Group ID:** **00427201**
**Effective Date:** **JANUARY 1, 2025**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations and Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you or your dependents (if applicable) need eyecare | Eye Exam | $10.00 Copay | Reimbursed up to $45.00 | Exam covered in full every 12 months** |
| | Frames, Lenses or Contacts | Glasses: $25.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam | Frames reimbursed up to $ 70.00<br>SV Lenses reimbursed up to $ 30.00<br>Bi-Focal Lenses reimbursed up to $ 50.00<br>Tri-Focal Lenses reimbursed up to $ 65.00<br>Lenticular Lenses reimbursed up to $100.00<br>ECL reimbursed up to $105.00 | Frames covered every 24 months**<br>Lenses covered every 24 months** |
| | Fees | | | |

** Beginning with the first date of service.

**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.