Group Vision Care Plan

vsp vision care

Group Name: **HEALTHEDGE SOFTWARE, INC.**
Group Number: **30045907**
Effective Date: **JANUARY 1, 2023**

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER:
NAME OF PLAN:
PRINCIPAL ADDRESS:

EMPLOYER I.D.#:

PLAN #:

PLAN ADMINISTRATOR:
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

This form is a summary of the Plan provisions and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Plan itself. A specimen copy of the Plan will be furnished on request.

DEFINITIONS:

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	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.
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 the Plan.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of Group who meets the eligibility criteria established by Group and approved by VSP under Section VI. ELIGIBILITY FOR COVERAGE of the Plan under which such Enrollee is covered.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person or Eligible Dependent to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of the Group who meets the eligibility criteria specified under Section VI. ELIGIBILITY FOR COVERAGE of the Plan.
EXPERIMENTAL NATURE	A procedure or lens that is neither used universally nor accepted by the vision care profession, as determined by VSP.
GROUP	An employer or other entity that contracts with VSP for coverage under this Plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
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 that a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

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 the Plan shall renew or terminate if proper notice is given.
SCHEDULE OF BENEFITS	The document attached as Exhibit A to the Group Plan maintained by your Group Administrator, that lists the vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
SCHEDULE OF PREMIUMS	The document attached as Exhibit B to the Group Plan 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 covered, a person must currently be an employee or member of the Group and meet the established coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible shall include: the legal spouse of any Enrollee; any child of an Enrollee who has not reached the limiting age as shown on the enclosed insert, including any newborn infant and newborn infant of a dependent from the moment of birth; a legally adopted child from the date of placement with the Enrollee, or, if a foster child, from the date of filing of the petition to adopt; any other child for whom a court or administrative agency holds the Enrollee responsible.

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 the Enrollee for support and maintenance.
Pre-existing Conditions: The Plan has no pre-existing condition limitations or exclusions.

PREMIUMS

Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.

PROCEDURE FOR USING THE PLAN

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

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact the Member Doctor directly, you must identify yourself as a VSP member so the doctor can 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 the Plan, in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a Non-Member Provider, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services under this Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

   Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed Schedule of Benefits and Additional Benefit Rider (if applicable), 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, you can obtain covered services by contacting a Member Doctor (or Non-Member Provider if the attached Schedule of Benefits and, if applicable, Additional Benefits Rider, indicates Covered Person's Plan includes such coverage). Services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If there is no Additional Benefit Rider for one of these plans attached to this Evidence of Coverage, 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.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will be liable to the Member Doctor for services rendered to you at the time of termination and permit the 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 Member Doctor.

BENEFIT AUTHORIZATION PROCESS

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

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.

3. Frames: The Member Doctor will assist in frame selection, proper fit and frame adjustment, and provide subsequent frame adjustments to maintain comfort and efficiency.

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 for the current eligibility period.

When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance towards the cost of professional fees and materials as shown on the enclosed insert. 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 a Member Doctor, 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/her 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 MATERIALS. Availability of the 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 with acuity or vision field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he/she is 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

This vision service plan is designed to cover *visual needs* rather than *cosmetic materials.* If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the option's extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Plan maintained by your Group Administrator.

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

NOT COVERED

There are no benefits for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above Plan Benefit allowances indicated on the following schedules and riders.
6. Services and/or materials not indicated on the following schedules and riders as covered Plan Benefits.

GRIEVANCE PROCESS

If you ever have a question or problem, your first step is to call VSP's Customer Service Department: the toll free number is 800-877-7195. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. Complaints and grievances include disagreements regarding access to care, quality of care, treatment or service.

Complaints and Grievances:

1. Internal Grievance Process: If the matter is not resolved to the reasonable satisfaction of a Covered Person, the Covered Person may initiate a formal grievance with VSP, by telephone, in person, by mail, or by electronic means. Except where a time limit is waived or extended by mutual written agreement, VSP will: (i) reduce any oral grievance received to a writing, with a copy forwarded to the Covered Person within 48 hours of receipt, or (ii) with respect to any other form of grievance, forward, within 15 business days of receipt, written acknowledgement. Records of any formal grievance received will be maintained by VSP for a period of seven (7) years, and will be subject to inspection by the Commissioner of Insurance and the Department of Public Health.

In a manner consistent with state and federal law, the Covered Person, or an authorized representative, will have access to any medical information and records relevant to the grievance, which is in the possession and under the control of VSP. Any request requiring the release or review of the Covered Person's confidential medical records relevant to the grievance must include the signature of the Covered Person or an authorized representative, on a form authorizing the release of medical and treatment information, which form will be promptly provided by VSP on written request.

2. External Review Process: The Covered Person may request an external review of a final adverse determination made by VSP by filing a written request with the Office of Patient Protection, which toll free telephone number is (800) 436-7757, within one hundred eighty (180) days of receipt of such final adverse determination.

TERMINATION OF BENEFITS

Cancellation conditions of your vision care plan are shown on the enclosed insert. Your coverage may be canceled, or its renewal refused, only in the following circumstances: 1) failure by the Covered Person or other responsible party to make payments required under the contract; 2) misrepresentation or fraud on the part of the Covered Person; 3) commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other Covered Persons of the carrier and which are unrelated to the physical or mental condition of the Covered Person; provided, that the Massachusetts Commissioner of Insurance prescribes or approves the procedures for the implementation of the provisions of this clause; 4) relocation of the Covered Person outside the service area of the carrier; or 5) non-renewal or cancellation of the group contract through which the Covered Person receives coverage. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by your Group or by VSP due to nonpayment of Premium, to the extent permitted by law.

If you are receiving service as of the termination date of the Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the 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 who may desire to retain same.

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.

ADDITIONAL DISCLOSURES – COMMONWEALTH OF MASSACHUSETTS

MEMBERS RIGHTS AND RESPONSIBILITIES

You have the right to be treated with consideration, dignity and respect and to have Member Doctors:

- Provide you with complete information about your eye care and any proposed procedures or alternatives - regardless of cost or benefit coverage.
- Assure that you control decisions about your eye care treatment.
- Provide 24-hour access for ocular emergencies.
- Maintain privacy and confidentiality regarding your care.
- Make available to you appropriate preventive health services.
- Give prompt and reasonable responses to questions and requests.
- Provide information regarding their services and qualifications.
- Provide you with VSP grievance procedures if there is dissatisfaction with services.
- Obtain your input regarding services and assist you with any problems.

Your responsibility is to remember to practice healthy living habits, follow preventive health and eye care guidelines, and:

- Check the health care benefits and exclusions of your coverage.
- Establish and maintain a relationship with your primary eye care provider.
- Give your eye care providers the complete and accurate information needed in order to care for you.
- Notify your eye care provider if you are going to be late or need to reschedule an appointment.
- Know the cost (Copayment, deductible, coinsurance) of your care.
- Carry out the treatment plan agreed upon by you and your eye care provider or primary care physician.
- Know how to access urgent, emergency and out-of-area medical eye care services.

CONTACTING VSP

VSP representatives are available to help you get the information you need. You can contact a Member Service Representative at: Vision Service Plan, 3333 Quality Drive; Rancho Cordova, CA 95670 Toll-free: 1-800-877-7195 Phone: 916-635-7373, FAX: 916-851-4852 TDD:800-428-4388.

Subscribers and enrollees may confirm status of providers, receive administrative/appeal process information, and file a complaint.

INVOLUNTARY DISENROLLMENT RATE OF COVERED PERSONS

Pursuant to Massachusetts regulations, involuntary disenrollment may occur as a result of the following: 1) misrepresentation or fraud on the part of the Covered Person, or 2) commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other Covered Persons of VSP and which are unrelated to the physical or mental condition of the Covered Person. The involuntary disenrollment rate of Massachusetts Vision Service Plan for the year ended December 31, 2000, was 0%.

NOTICE OF MATERIAL MODIFICATIONS/CHANGES TO PLAN COVERAGE

Your Group may notify you, within the required timelines as established by the Commonwealth of Massachusetts, of material modifications or changes to your Plan coverage.

OFFICE OF PATIENT PROTECTION

The Office of Patient Protection (OPP) in Massachusetts assists consumers with questions regarding managed care, monitors quality-related health plan information, formulates recommendations regarding ways to improve the quality of managed care plans, develops Internet programs, and otherwise communicates information about managed care.

The following information is available from the OPP:

1. A list of sources of independently published information assessing Covered Person's satisfaction and evaluating the quality of health care services offered by the Plan.
2. The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the Plan during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment.
3. The percentage of premium revenue expended by the Plan for health care services provided to Covered Persons for the most recent year for which information is available.
4. A report detailing, for the previous calendar year, the total number of a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution, and b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

Covered Persons may contact the OPP via the following methods:

Telephone #: 1-800-436-7757 (toll free) or 617-284-8315
Fax #: 617-624-5046.
Address: Office of Patient Protection
Massachusetts Department of Public Health
250 Washington St.
Boston, MA 02108
E-Mail: opp@state.ma.us
Web site address: www.state.ma.us/dph/opp

PHYSICIAN PROFILING

Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

PROCEDURE FOR OBTAINING CARE

Choice of Providers

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. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment).

When vision care services are received from a Non-Member Provider, you will be reimbursed for such benefits according to the schedule shown on the enclosed insert, less any applicable Copayment.

Procedure for Using the Plan

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or the Member Doctor. If you are eligible, VSP will provide Benefit Authorization to you or the Member Doctor.
2. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a Non-Member Provider, you are responsible for payment in full to the provider.
3. A list of Member Doctors in your geographical location can be obtained from your Group or Plan Administrator or at www.vsp.com. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographical area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.
4. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

Emergency Services and Out-of-Service-Area Care

In the event a VSP member has an emergency related to vision care at home or out of state, they should call 911 if needed. They should also call a Member Doctor to inform the doctor of their situation. Only those vision care services negotiated with the patient's group and for which the patient is eligible are covered in an emergency under VSP. Medically related emergencies or conditions would be covered under the patient's medical carrier.

QUALITY ASSURANCE

The purpose of VSP's Quality Management (QM) and Quality Improvement (QI) Program is to ensure quality eye care to members accessing VSP's providers. The program is designed to objectively and systematically evaluate the quality, appropriateness, and outcome of care and services provided to VSP patients. We strive to continuously pursue opportunities for improvement and problem resolution. VSP ensures that members receive appropriate care provided by highly qualified vision care professionals, in accordance with VSP standards, state and federal regulatory agencies.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable 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 benefits may be received from any licensed eye care provider whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Evidence of Coverage to which it is attached.

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 Member Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-Member Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-Member Providers.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any 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.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.

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

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.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from Member Doctors and Non-Member Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

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

PLAN BENEFITS

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 45.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
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*	
Plan Benefits for lenses are per complete set, not per lens. 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. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Covered in full	Not Covered	
** Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 12 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. *Less any applicable Copayment.			

**Beginning with the first date of service.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full*	Up to $ 210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $ 150.00	**Professional Fees/Materials** Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.
***15% Discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

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

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Non-Member Providers (if covered) are subject to the same time and Copayment provisions described above for Member Doctors. The Covered Person should pay the Non-Member Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a Member Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

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 Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate 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 are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that 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.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable 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 benefits may be received from any licensed eye care provider whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Evidence of Coverage to which it is attached.

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 Member Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-Member Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-Member Providers.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any 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.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.

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

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.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from Member Doctors and Non-Member Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

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

PLAN BENEFITS

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 45.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
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*	
Plan Benefits for lenses are per complete set, not per lens. 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. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Covered in full	Not Covered	
** Beginning with the first date of service.			

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 12 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. *Less any applicable Copayment.			

**Beginning with the first date of service.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full*	Up to $ 210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $ 300.00	**Professional Fees/Materials** Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.
***15% Discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

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

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Non-Member Providers (if covered) are subject to the same time and Copayment provisions described above for Member Doctors. The Covered Person should pay the Non-Member Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a Member Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

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 Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate 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 are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that 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.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

Exhibit C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("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 that 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:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from 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.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.

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

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 VSP Preferred Provider 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
VSP PREFERRED PROVIDERS

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.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

An eye care professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. Covered Person may then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Urgent/Emergency Care, and Special Ophthalmological Services: Covered up to $300.00 less any applicable Copayment amount; based on coverage limits for the specific medical eye care service and state service was received.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SECOND PAIR
CHOICE NETWORK

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

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

ELIGIBILITY:

The following are Covered Persons under this Plan:

- Enrollee
- The legal spouse of Enrollee.
- Any unmarried child of Enrollee, including any 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.
    - The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.

Unmarried dependent children are covered up to the end of the month in which they turn age 26 or up to the end of the month in which they turn age 26 if full-time students.

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.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

A Copayment amount of $25.00 shall be payable by the Covered Person at the time services are rendered.

PLAN BENEFITS

MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Covered in full *	Available once each 12 months**
Polycarbonate lenses are covered in full for dependent children up to age 26. Standard Progressive Lenses covered in full. *Less any applicable Copayment. **Beginning with the first date of service. Plan Benefits for lenses are per complete set, not per lens.		
Frames	Covered up to Plan allowance *	Available once each 12 months**

MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lens Options		Available once each 12 months**
Scratch coating	Covered in full	

Contact Lenses		
Necessary	Covered in full *	Available once every 12 months**
Elective	Up to $ 300.00*	Available once every 12 months**

*Less any applicable Copayment.
**Beginning with the first date of service.

Elective Contact Lens fitting and evaluation services are covered in full once every 12 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 Out-of-network provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact lenses are provided in lieu of all other lens and frame benefits available herein.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

SECOND PAIR BENEFIT ONLY

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.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Eye examinations.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Plano contact lenses to change eye color cosmetically.
- 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.
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowance.
- Services and/or materials not included on this Rider as covered Plan Benefits.

SERVICES FROM OUT-OF-NETWORK PROVIDERS

LIABILITY OF COVERED PERSONS FOR PAYMENT
REIMBURSEMENT PROVISIONS

When a Covered Person chooses to receive services from an Out-of-network provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This Plan then becomes an indemnity plan reimbursing according to a schedule of allowances. The Covered Person should pay the Provider's fee in full. VSP will reimburse the Covered Person in accordance with the following schedule.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL BE SUFFICIENT TO PAY THE EXAMINATION OR THE MATERIALS IN FULL.

AVAILABILITY OF SERVICES UNDER THIS REIMBURSEMENT SCHEDULE IS SUBJECT TO THE SAME TIME LIMITS AND COPAYMENT AS THOSE DESCRIBED FOR MEMBER DOCTORS. SERVICES OBTAINED FROM OUT-OF-NETWORK PROVIDERS ARE IN LIEU OF SERVICES FROM A MEMBER DOCTOR.

VSP IS UNABLE TO REQUIRE OUT-OF-NETWORK PROVIDERS TO ADHERE TO VSP'S QUALITY STANDARDS.

SCHEDULE OF ALLOWANCES

MATERIAL	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Lenses		
Single Vision	Up to $ 30.00*	Available once each 12 months**
Bifocal	Up to $ 50.00*	Available once each 12 months**
Trifocal	Up to $ 65.00*	Available once each 12 months**
Lenticular	Up to $ 100.00*	Available once each 12 months**
Frame	Up to $ 70.00 *	Available once each 12 months**
*Less any applicable Copayment **Beginning with the first date of service. Plan Benefits for lenses are per complete set, not per lens.		
Contact Lenses		
Necessary	Up to $ 210.00*	Available once each 12 months**
Elective	Up to $ 105.00*	Available once each 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a $60.00 Copayment.

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

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **HEALTHEDGE SOFTWARE, INC.**
Group ID: **30045907**
Effective Date: **JANUARY 1, 2023**

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 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 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.