September 23, 2024

KELLY BONANNO
100 MERIDIAN CENTRE BLVD STE 100
ROCHESTER, NY 14618-3976

RE: UNIVERSITY OF ROCHESTER, GROUP #30077876, PLAN

Attention Kelly Bonanno:

Effective JANUARY 1, 2025, UNIVERSITY OF ROCHESTER's contract has been changed to reflect an additional plan.

Please retain a copy of the documents for your records and forward an additional copy directly to the client.

If you have any questions, or need additional information, please do not hesitate to contact us at 866-213-2249, and a VSP representative will assist you.

Enclosures

EASTERN VISION SERVICE PLAN, INC.

PLEASE ATTACH TO YOUR
GROUP VISION CARE POLICY

AMENDMENT TO GROUP VISION CARE POLICY

To be attached and made part of Group Vision Care Policy Number 30077876 issued to UNIVERSITY OF ROCHESTER.

EXCEPT as specifically amended herein, said Policy shall remain in full force and effect.

IT IS HEREBY AGREED that effective January 1, 2025, the Group Vision Care Policy shall be amended as attached hereto.

EXHIBIT A

EASTERN VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
VSP Choice Plan®
UR VISION BASIC PLAN

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of EASTERN VISION SERVICE PLAN, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of $35.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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 the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $100.00 once every 12 months**

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

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of $35.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $ 85.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

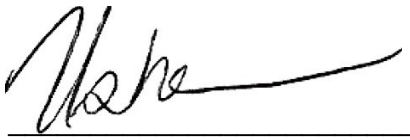
Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

OPEN ACCESS PROVIDERS

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



Usha Patil, Chief Insurance Officer

Exhibit B

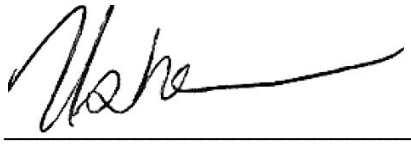
EASTERN VISION SERVICE PLAN, INC. (VSP)
SCHEDULE OF PREMIUMS
VSP Choice Plan
Divisions 1001, 1002

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$	4.07	per month for each eligible Enrollee without dependents.
$	8.12	per month for each eligible Enrollee with an eligible spouse or Domestic Partner.
$	8.70	per month for each eligible Enrollee with eligible child(ren).
$	13.89	per month for each eligible Enrollee with eligible spouse and child(ren).

Except as otherwise allowed under this agreement, said rate(s) shall be guaranteed for a term of 12 months through JANUARY 1, 2026.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.



Usha Patil, Chief Insurance Officer