

Supplemental Vision Benefit



Client Name: UNIVERSITY OF ROCHESTER
Client Number: 30077876
Effective Date: JANUARY 1, 2024

EVIDENCE OF COVERAGE



Provided by:

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

A handwritten signature in black ink, appearing to read 'Kate Renwick-Espinosa'.

Kate Renwick-Espinosa, President

NAME OF CLIENT: University of Rochester

NAME OF PLAN: Supplemental Vision Benefit

PRIMARY ADDRESS OF CLIENT: Office of Human Resources, Total Rewards
60 Corporate Woods, Suite 310
PO Box 270453
Rochester, NY 14627-0453

PLAN ADMINISTRATOR: Vice President & CHRO, University of Rochester

ADDRESS: University of Rochester (Employer ID No. 16-0743209)
Office of Human Resources, Total Rewards
60 Corporate Woods, Suite 310
PO Box 270453
Rochester, NY 14627-0453

PHONE NUMBER: 1-585-275-2084

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by the University of Rochester (also referred to as "Client"):

All regular, actively at work, full-time and part-time faculty and staff, residents and fellows and SEIU 1199 members are eligible. You are eligible to enroll in the Plan for yourself and your eligible dependents.

Dependents include your current spouse, if the marriage was valid in the state or country where it was performed, your eligible domestic partner, your children up through the end of the month in which they turn 26, your domestic partner's children up through the end of the month in which they turn 26, or your children who are handicapped prior to age 26 and are dependent on you for support.

Your children include: biological children, legally adopted children, stepchildren, children who are placed with you by an authorized placement agency or by judgement, decree, or other order of any court of competent jurisdiction.

An employee's domestic partner can have the same or opposite gender as the employee. The employee and his/her domestic partner must satisfy all of the following criteria:

- Have an exclusive mutual commitment, similar to that of marriage;
- Are each other's sole domestic partner and intend to remain so indefinitely;
- Neither partner is legally married under a marriage recognized by state or federal law;
- Are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the partners legally reside;
- Are at least eighteen (18) years of age and are legally competent to contract;
- Are currently residing together and have resided together in a common household for at least six consecutive months and intend to reside together indefinitely. The residency requirement can be suspended for up to 12 months when a spouse or partner resides in a different geographical area on a temporary basis.

- At least six months have elapsed since the Office of Total Rewards has received a Statement of Termination of Domestic Partnership from either partner; and

- Share joint responsibility for the partners' common welfare and financial obligations demonstrated by:

a) The existence of a domestic partner agreement (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e. joint and several liability for each other's debts and expenses, responsibility for mutual care, etc.); and

b) At least two other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable power or health care power of attorney, co-parenting agreement or adoption agreement.

COST OF COVERAGE

You pay the full cost of coverage with pre-tax dollars through automatic payroll deductions.

ENROLLMENT

Eligible employees may enroll online at www.YOURBenefitsExtras.com. During the University of Rochester's annual open enrollment period, you can enroll, update or cancel your benefits selection. If you are a newly eligible employee, you can elect to participate in the Plan within 30 days of employment. You will be enrolled in the Plan for the remainder of the plan year and your coverage will roll into another plan year unless you cancel during the open enrollment period or have a qualifying event.

WHEN YOU ARE ON AN UNPAID LEAVE

Coverage for VSP Vision Care will be continued during a Leave of Absence, Long-Term Disability, Layoff, Worker's Compensation or NYS Paid Family Leave for up to 90 days from the start of your unpaid leave. If you return to work in an active, benefit-eligible position within 90 days from the start of your unpaid leave, Corestream will recoup any missed premiums by double deducting your premium in your paycheck(s) until the deficit has been recouped. If you do not return to an active, benefits-eligible position within 90 days from the start of your unpaid leave you may, if you wish, continue coverage under VSP Vision Care under the COBRA Policy.

WHEN COVERAGE BEGINS

Generally, Plan coverage becomes effective on January 1 for elections made during open enrollment. If you were hired or become newly eligible after an open enrollment period, and enroll by the 15th of the month, coverage for the Plan will be effective 1st of the following month. If you enroll on the 16th-30th/31st, coverage will be effective 1st of the second following month.

WHEN COVERAGE ENDS

Your ability to receive services under the Plan ends if you are no longer an eligible employee or if you choose to cancel coverage during future open enrollment periods or qualifying events. COBRA will apply in the event coverage ends due to loss of eligibility or other COBRA qualifying event.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. If an Open Access Provider agrees to submit a claim to VSP on behalf of Covered Person, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

5. If the cost of services is less than the Copayment for the service, the Covered Person is responsible for the lesser amount.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

A. This coordination of benefits (COB) provision applies when a Covered Person has vision care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. Definitions

- a. A "plan" has the meaning defined in the Definitions provision of this Evidence of Coverage, but for the purposes of this section also includes the provisions herein described. A plan is any of the following that provides vision care services or materials.
 - i. "Plan" includes: group insurance and Medicare or other governmental benefits, as permitted by law.
 - ii. "Plan" does not include: individual or family insurance; coverage through health maintenance organizations (HMOs) or closed panel plans; blanket insurance policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

- iii. "This plan" refers to the part or parts of this Policy providing vision care benefits to which the COB provision applies and which may be reduced on account of the benefits of the other plans. Each contract for coverage under a. or b. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
- b. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
- c. "Allowable expense" means a vision care service or expense that is covered at least in part by any of the plans covering the Covered Person except where a statute requires a different definition. An expense or service that is not covered by any of the plans is not an allowable expense.
 - i. If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
 - ii. If a Covered Person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fees is not an allowable expense.
 - iii. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the plan whose payment arrangement is based on a negotiated fee shall be the allowable expense for all plans.
 - iv. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions.
 - v. Amounts for Plan Benefits under the Computer VisionCare, Repair or Safety Plans are not allowable expenses under this plan.
- d. "Claim determination period" may be either a calendar year or a benefit year, but shall be no less than twelve (12) consecutive months. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.
- e. "Closed panel plan" is a plan that provides vision care benefits to Covered Persons through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- f. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. Order Of Benefit Determination Rules:

- a. When two or more plans pay benefits the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The plan that does not contain a coordination of benefits provision, or that contains a coordination of benefits provision that differs from those permitted by this Coordination of Benefits section is always primary. If all plans which cover the Covered Person use the order of benefits determination rules required by this section and under those rules a plan determines its benefits first, that plan is primary.
- b. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- c. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - i. The benefits of a plan which covers the Covered Person as an Enrollee is primary.
 - ii. The order of benefits when a child is covered by more than one plan is:
 - 1. The primary plan is the plan of the parent whose birthday (based only on the month and day within a calendar year) falls earlier in the year whether the parents are married, are not separated (whether or not they ever have been married); or a court decree awards joint

custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
 3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is: the plan of the custodial parent; the plan of the spouse of the custodial parent; the plan of the noncustodial parent; and then the plan of the spouse of the noncustodial parent.
- iii. The plan that covers a person as an Enrollee who is neither laid off nor retired, is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - iv. If none of the above rules determines the order of benefits, the plan that covered the person as an Enrollee longer is primary.
- D. Effect On Plan Benefits : When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses, or of the total billed amount, whichever is less.
- E. Right To Receive And Release Needed Information: VSP has the right to decide which facts it needs to implement COB provisions. VSP may get needed facts from or give them to any other organization or person. VSP need not disclose to nor obtain permission from the Covered Person in order to obtain these facts, except as required by applicable state or federal law.
- F. Facility Of Payment: A payment made under another plan may include an amount that should have been paid under this plan. If it does, VSP may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. VSP will not have to pay that amount again.

Right Of Recovery: If the amount of the payments made by VSP is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at . Complaints and grievances are disagreements regarding access

to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, at any time, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than forty-five (45) calendar days after VSP's receipt of all necessary information. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

If a Covered Person is not satisfied with the resolution of any complaint and/or grievance, the Covered Person may file an appeal in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. A Covered Person has up to sixty (60) business days from receipt of the complaint and/or grievance determination to file an appeal. VSP will make a determination of an appeal within thirty (30) business days of receipt of all necessary information. If Covered Person remains dissatisfied with VSP's appeal determination or at any other time, Covered Person may call the New York State Department of Financial Services at 1-800-342-3736 or write them at New York State Department of Financial Services, Consumer Assistance Unit, One Commerce Plaza, Albany, NY 12257.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. 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.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, 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 an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

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

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

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 be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required

continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.

ASSIGNMENT OF BENEFITS A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

CLIENT An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.

COORDINATION OF BENEFITS Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.

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 ordered.

COVERED PERSON An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.

ENROLLEE An employee or member of Client who meets the criteria for eligibility established by Client.

PLAN OR PLAN BENEFITS The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).

OPEN ACCESS 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 ADMINISTRATOR The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.

POLICY The contract between VSP and Client upon which this Plan is based.

SCHEDULE OF BENEFITS The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.

VSP PREFERRED PROVIDER An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.

URGENT CARE Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

**EASTERN VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
UR VISION PLUS PLAN**

EXHIBIT A

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.

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of \$20.00 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.

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 they turn 26 years of age.

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 \$200.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum \$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 not correctable 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 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

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ 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.
- 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 \$20.00 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.

COVERED SERVICES AND MATERIALS

Special Ophthalmological Services: Payable benefits will be limited to 80% of the amount allowed by Medicare for each service rendered, not to exceed the billed amount.

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 \$185.00 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 not correctable with regular lenses, including:

Supplemental Testing: Up to \$125.00*.

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

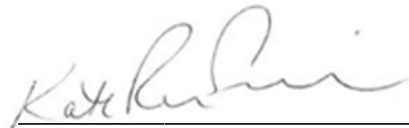
Supplemental Aids: 75% of VSP Preferred Provider's fee, up to \$1000.00*

*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.

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.



Kate Renwick-Espinosa, President

EXHIBIT B

EASTERN VISION SERVICE PLAN, INC. SCHEDULE OF BENEFITS 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 Deductibles 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.

BENEFIT PERIOD

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

PLAN BENEFITS

VSP PREFERRED PROVIDERS

DEDUCTIBLE

A Deductible amount of \$ 35.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

FRAMES - Up to \$ 100.00* once every 12 months**

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

*Less any applicable Deductible.

** beginning with the first day of the Benefit Period.

CONTACT LENSES

Elective

Elective Contact Lenses are covered up to \$ 100.00 once every 12 months.**

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

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

*Less any applicable Deductible.

** beginning with the first day of the Benefit Period.

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.

NOT COVERED

1. Services and/or materials not specifically included in this schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
3. Two pair of glasses instead of bifocals.
4. 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.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Refitting of contact lenses after the initial (90-day) fitting period.
8. Contact lens modification, polishing or cleaning.
9. Local, state and/or federal taxes, except where VSP is required by law to pay.

PLAN BENEFITS

OPEN ACCESS PROVIDERS

DEDUCTIBLE

A Deductible amount of \$ 35.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Up to \$ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Lens, Frame or Elective Contact lens - Up to \$ 100.00* once every 12 months**

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

*Less any applicable Deductible.

** beginning with the first day of the Benefit Period.

CONTACT LENSES

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

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

*Less any applicable Deductible.

** beginning with the first day of the Benefit Period.

EXCLUSIONS AND LIMITATIONS OF BENEFITS 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 or an Affiliate 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.



Kate Renwick-Espinosa, President

EXHIBIT C

EASTERN VISION SERVICE PLAN, INC. ADDITIONAL BENEFIT RIDER SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of EASTERN VISION SERVICE PLAN, INC. (“VSP”) are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

PLAN DESCRIPTION

Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional’s state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the PEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan 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 how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "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, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Network Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Preferred Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.

PLAN BENEFITS

VSP Preferred PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of \$20.00.

Special Ophthalmological Services: Covered in Full

Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited 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 Covered Persons upon request.

NOT COVERED

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

Summary of Benefits and Coverage

**VSP Choice Plan
UR VISION PLUS PLAN**

Prepared for: UNIVERSITY OF ROCHESTER
Group ID: 30077876
Effective Date: JANUARY 1, 2022

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	\$20.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: \$20.00 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 \$185.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

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.

Summary of Benefits and Coverage

VSP Choice Plan

UR VISION BASIC PLAN

Prepared for: UNIVERSITY OF ROCHESTER
Group ID: 30077876
Effective Date: JANUARY 1, 2022

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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	\$35.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Reimbursed up to \$ 100.00	Frames, Lenses or Contacts reimbursed up to \$ 100.00	Materials covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

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