Group Vision Care Plan

Group Name: **STATE OF OREGON**
Group Number: **12179989**
Effective Date: **JANUARY 1, 2025**

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 upon request.

DEFINITIONS:

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

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

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

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

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

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

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

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

ELIGIBILITY FOR COVERAGE

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

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

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

PREMIUMS

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

PROCEDURE FOR USING THE PLAN

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

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

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against 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 provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services covered by the 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 insert, less any applicable Copayments.

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

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

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

BENEFIT AUTHORIZATION PROCESS

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

BENEFITS AND COVERAGES

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

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

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

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 the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames 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.

   Necessary contact lenses, together with professional services, will be provided as indicated on the enclosed insert.

   When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials 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 THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

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

COPAYMENT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

This 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 options 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.
- 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 is no benefit for professional services or materials connected with:

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

LIABILITY IN EVENT OF NON-PAYMENT
IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION PLAN OTHER THAN THOSE NOT COVERED BY THE PLAN.

COMPLAINTS AND GRIEVANCES
If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

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

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

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

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

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

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

TERMINATION OF BENEFITS

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by Group or by VSP due to nonpayment of Premium.

If service is being rendered to you 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 of the Group who may desire to retain their coverage.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: *STATE OF OREGON*

Plan Number: *12179989 DIVISIONS 2020, 2021 AND 2022*

Effective Date: *JANUARY 1, 2025*

Plan Term: *TWELVE (12) MONTHS*

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

Cindy Bowman
(Name)
1225 Ferry St Se
(Address)
Salem, OR 97301-4278
(City, State, Zip)

MONTHLY PREMIUM:

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

ELIGIBILITY:

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

PLAN AND SCHEDULE:

SIGNATURE PLAN - BASIC PLAN

EXAMINATION:	*ONCE EVERY PLAN YEAR**
LENSES:	*ONCE EVERY PLAN YEAR**
FRAMES:	*ONCE EVERY PLAN YEAR**

*PLAN YEAR BEGINS JANUARY 1ST.

TERM, TERMINATION AND RENEWAL:

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

TYPE OF ADMINISTRATION:

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

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS
Basic Plan

GENERAL

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

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

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***	
VISION CARE SERVICES			
Vision Examination	*Covered in Full after copay**	*Up to $*	*50.00 after copay**
VISION CARE MATERIALS			
Lenses			
Single Vision	*Covered in Full after copay**	*Up to $*	*50.00 after copay**
Bifocal	*Covered in Full after copay**	*Up to $*	*75.00 after copay**
Trifocal	*Covered in Full after copay**	*Up to $*	*100.00 after copay**
Lenticular	*Covered in Full after copay**	*Up to $*	*125.00 after copay**

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

Frames	*Covered up to $150.00** toward the retail cost of the frame after copay**	*Up to $*	*70.00 after copay**

***Costco equivalent frame allowance is $80.00. All other retail chains including Walmart/Sam's Club covered up to $150.00.*

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. However, lab-fabricated plano lenses are not covered.

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

LENS OPTIONS

Standard Progressive lenses	*Covered in Full after copay**	*Up to $*	*75.00 after copay**

CONTACT LENSES

Necessary		
Professional Fees and Materials	*Covered in Full after copay**	*Up to $ 210.00 after copay**
Elective	*Materials*	*Professional Fees and Materials*
	Up to $ 200.00	*Up to $ 105.00*
	*Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.*	

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

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

****COPAYMENT***

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

LOW VISION

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	*Covered in Full*	*Up to $125.00*
Supplemental Aids	*75% of cost*	*75% of cost*

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

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

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: *STATE OF OREGON*

Plan Number: *12179989 DIVISIONS 2023, 2024 AND 2025*

Effective Date: *JANUARY 1, 2025*

Plan Term: *TWELVE (12)) MONTHS*

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

Cindy Bowman
(Name)
1225 Ferry St Se
(Address)
Salem, OR 97301-4278
(City, State, Zip)

MONTHLY PREMIUM:

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

ELIGIBILITY:

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

PLAN AND SCHEDULE:

SIGNATURE PLAN - PLUS PLAN

EXAMINATION:	*ONCE EVERY PLAN YEAR**
LENSES:	*ONCE EVERY PLAN YEAR**
FRAMES:	*ONCE EVERY PLAN YEAR**

*PLAN YEAR BEGINS JANUARY 1ST.

TERM, TERMINATION AND RENEWAL:

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

TYPE OF ADMINISTRATION:

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

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS
Plus Plan

GENERAL

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

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

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***	
VISION CARE SERVICES			
*Vision Examination and Retinal Screening****	*Covered in Full after copay**	*Up to $*	*50.00 after copay**

***Coverage for retinal imaging as an enhancement to eye examination.

VISION CARE MATERIALS			
Lenses			
Single Vision	*Covered in Full after copay**	*Up to $*	*50.00 after copay**
Bifocal	*Covered in Full after copay**	*Up to $*	*75.00 after copay**
Trifocal	*Covered in Full after copay**	*Up to $*	*100.00 after copay**
Lenticular	*Covered in Full after copay**	*Up to $*	*125.00 after copay**

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

Frames	*Covered up to $225.00** toward the retail cost of the frame after copay**	*Up to $*	*70.00 after copay**

***Costco equivalent frame allowance is $125.00. All other retail chains including Walmart/Sam's Club covered up to $225.00.*

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility. However, lab-fabricated plano lenses are not covered.

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

LENS OPTIONS			
Standard Progressive lenses	*Covered in full after copay**	*Up to $*	*75.00 after copay**
Anti-reflective coating	*Covered in full after copayl[1]*	*Not Covered*	
Premium and Custom Progressive lenses	*Covered in full after copay[1]*	*Up to $*	*75.00 after copay**

1. *Less $20.00 Copayment*

CONTACT LENSES

Necessary			
Professional Fees and Materials	*Covered in Full after copay**	*Up to $*	*210.00 after copay**
Elective	*Materials*	*Professional Fees and Materials*	
	Up to $ 225.00	*Up to $*	*105.00*
	*Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.*		

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

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

COPAYMENT

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

LOW VISION

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	*Covered in Full*	*Up to $125.00*
Supplemental Aids	*75% of cost*	*75% of cost*

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

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

ADDENDUM

ADDITIONAL BENEFIT RIDER
PRIMARY EYECARE

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 Primary EyeCare 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 Plan and Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any unmarried 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.

Unmarried dependent children are covered until the end of the month in which they attain 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.

Plan Benefits under the supplemental Primary EyeCare 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 Primary EyeCare 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 Primary EyeCare 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 PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The supplemental Primary EyeCare 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 provides Plan Benefits as follows:

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

2. Covered Person pays the applicable Copayment at the time of each 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 Member Doctor, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the Primary EyeCare Plan, the Member Doctor 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 Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
MEMBER DOCTOR

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 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

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

PRIMARY EYECARE 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.

PLAN BENEFITS
NON-MEMBER PROVIDERS

An Eyecare Professional that is a Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered up to $ 100.00 less a Copayment amount of $ 20.00.

Special Ophthalmological Services: Covered up to $ 120.00 per individual service.

Eye and Ocular Adnexa Services: Covered up to $ 120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

ADDENDUM

VISION SERVICE PLAN
ADDITIONAL BENEFIT - VISION THERAPY

Persons covered under this benefit are entitled to vision therapy and associated materials.

A. Covered Persons who have visual problems diagnosed by a Member Doctor are entitled to professional services and ophthalmic materials or other aids as prescribed by the doctor subject to the limitations described in "PLAN LIMITATIONS."

Services and materials covered can include supplementary testing, evaluations, and training.

B. Vision therapy is defined as the science of developing and remediating visual abilities for those persons who have severe visual problems associated with sensory and/or muscular deficiencies of the visual system. Some conditions which may lead to the need for vision therapy are as follows:

- Near point visual difficulties ranging from eye strain, blurred and double vision; to headaches and constant loss of place;
- Strabismus or misalignment of the eyes;
- Amblyopia or lack of normal vision, also known as "lazy eye";
- Inability to read for normal amounts of time after working on a Video Display Terminal.

C. COPAYMENT - 75% of the cost being paid by VSP and 25% of the cost being paid by the Covered Person.

D. MAXIMUM BENEFIT - VSP will pay a maximum annual benefit of $750.00, excluding Copayment, for approved vision therapy care.

NON-MEMBER PROVIDERS

Vision therapy benefits rendered by a Non-Member doctor are subject to the same time limits and Copayment arrangements described herein. The Covered Person will pay the Non-Member Provider his full fee. Covered Persons will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. THERE IS NO ASSURANCE THAT THIS AMOUNT WILL BE 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The furnishing of corrective eyewear (lenses and frames) (may be covered under core vision benefits);

- Medical or surgical treatment of the eyes;
- Perceptual training for a learning disability;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

ADDENDUM

VISION SERVICE PLAN

VI. ELIGIBILITY FOR COVERAGE

6.01 (b) **Eligible Dependents**, Add the Following:

(1a) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2b) Any unmarried children of the domestic partner provided they depend upon the Enrollee for support and maintenance.

Summary of Benefits and Coverage
SIGNATURE PLAN
Basic Plan & Plus Plan

Prepared for: **STATE OF OREGON**
Group ID: **12179989**
Effective Date: **JANUARY 1, 2025**

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

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $50.00	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 $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	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.