

# Group Vision Care Policy



Vision Care for Life

**Group Name:** ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST  
**Group Number:** 30094091  
**Effective Date:** JANUARY 1, 2020

## Certificate 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.#:

POLICY #:

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 Policy 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 Policy itself. A specimen copy of the Policy will be furnished upon request.

**DEFINITIONS:**

<b>ADDITIONAL BENEFIT RIDER</b>	The document attached to this Certificate 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 Policy.
<b>ANISOMETROPIA</b>	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
<b>BENEFIT AUTHORIZATION</b>	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.
<b>COPAYMENTS</b>	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
<b>COVERED PERSON</b>	An Enrollee or eligible dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under the Policy.
<b>EMERGENCY CONDITION</b>	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.
<b>ENROLLEE</b>	An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.
<b>EXPERIMENTAL NATURE</b>	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
<b>GROUP</b>	An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their eligible dependents.
<b>KERATOCONUS</b>	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.
<b>MEMBER DOCTOR</b>	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.
<b>NON-MEMBER PROVIDER</b>	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.
<b>PLAN BENEFITS</b>	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 on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Policy document maintained by your Group Administrator.
<b>PREMIUMS</b>	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 Policy document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which the Policy shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document, attached as Exhibit A to the Group Policy 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 the Policy.
<b>SCHEDULE OF PREMIUMS</b>	The document, attached as Exhibit B to the Group Policy document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

## ELIGIBILITY FOR COVERAGE

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

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

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

## 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 POLICY

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 Policy in spite of your termination of coverage or the termination of the Policy. 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 Policy. 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 Non-Member 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 Acute EyeCare and 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 Policy. When Covered Person requests services under this Policy, 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 Policy'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 Policies. 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 Policy 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 Policy 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 Policy 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.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

## NOT COVERED

There is no benefit under this plan for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than  $\pm.50$  diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
6. 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 POLICY.

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

## INDIVIDUAL CONTINUATION OF BENEFITS

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

## THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

**VISION SERVICE PLAN INSURANCE COMPANY**

**3333 Quality Drive**

**Rancho Cordova, CA 95670**

**Group Name:** ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST

**Plan Number:** 30094091

**Effective Date:** JANUARY 1, 2020

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

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

**PLAN ADMINISTRATOR:**

Katie Alioto

*(Name)*

Po Box 6

*(Address)*

Mukilteo, WA 98275-0006

*(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:**

**EXAM PLUS-CHOICE NETWORK**

**EXAMINATION: ONCE EVERY 12 MONTHS.**

**TERM, TERMINATION AND RENEWAL:**

**AFTER THE POLICY TERM, THIS POLICY 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:**

**BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.**

**VSP'S ADDRESS IS:**

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



## **SCHEDULE OF BENEFITS**

### **GENERAL**

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

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

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

### **PLAN BENEFITS**

### **MEMBER DOCTOR BENEFIT**

### **NON-MEMBER PROVIDER BENEFIT**

### **VISION CARE SERVICES**

*Vision Examination*

*Covered in Full\**

*Up to \$ 45.00\**

**COPAYMENT**

*A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.*

**ADDITIONAL DISCOUNT**

*Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.\**

*Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.\**

**LIMITATIONS:**

- *Discounts do not apply to vision care benefits obtained from Non-Member Providers.*
- *20% discount applies to complete pairs of glasses only.*
- *Discounts do not apply if prohibited by the manufacturer.*
- *Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.*

*\*Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.*

***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**

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**Plan Number:** 30094091

**Effective Date:** JANUARY 1, 2020

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

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

**PLAN ADMINISTRATOR:**

Katie Alioto

*(Name)*

Po Box 6

*(Address)*

Mukilteo, WA 98275-0006

*(City, State, Zip)*

**MONTHLY PREMIUM:**

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

**ELIGIBILITY:**

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

**PLAN AND SCHEDULE:**

**VSP CHOICE PLAN – Basic Plan A**

**EXAMINATION: ONCE EVERY 12 MONTHS.**

**LENSES: ONCE EVERY 24 MONTHS.**

**FRAMES: ONCE EVERY 24 MONTHS.**

**TERM, TERMINATION AND RENEWAL:**

**AFTER THE POLICY TERM, THIS POLICY 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:**

**BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.**

**VSP'S ADDRESS IS:**

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3333 QUALITY DRIVE  
RANCHO CORDOVA, CA 95670**

## SCHEDULE OF BENEFITS

### GENERAL

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

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

<u>PLAN BENEFITS</u>	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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### VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$ 45.00*</i>
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### VISION CARE MATERIALS

#### *Lenses*

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$ 30.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 50.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 65.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$ 100.00*</i>

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

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$ 70.00*</i>
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*Frame Allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. However, lab-fabricated plano lenses are not covered*

### CONTACT LENSES

#### *Necessary*

<i>Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$ 210.00*</i>
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#### *Elective*

<i>Materials</i>		<i>Professional Fees and Materials</i>
<i>Up to \$ 130.00</i>		<i>Up to \$ 105.00</i>
<i>Elective Contact Lens fitting and evaluation** services are covered in full once every 24 months, after a maximum \$60.00 Copayment.</i>		

*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.*

*\*Subject to Copayment, if any.*

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

**COPAYMENT**

*A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.*

**LOW VISION**

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

<i>Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)</i>	<i>Covered in Full</i>	<i>Up to \$125.00</i>
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<i>Supplemental Aids</i>	<i>75% of cost</i>	<i>75% of cost</i>
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*Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) years.*

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**ELIGIBILITY:**

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

**PLAN AND SCHEDULE:**

**VSP CHOICE PLAN – Preferred Plan B**

**EXAMINATION: ONCE EVERY 12 MONTHS.**

**LENSES: ONCE EVERY 12 MONTHS.**

**FRAMES: ONCE EVERY 24 MONTHS.**

**TERM, TERMINATION AND RENEWAL:**

**AFTER THE POLICY TERM, THIS POLICY 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:**

**BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.**

**VSP'S ADDRESS IS:**

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

## SCHEDULE OF BENEFITS

### GENERAL

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

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

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

<u>PLAN BENEFITS</u>	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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### VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$ 45.00*</i>
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### VISION CARE MATERIALS

#### *Lenses*

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$ 30.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 50.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 65.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$ 100.00*</i>

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

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$ 70.00*</i>
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*Frame Allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. However, lab-fabricated plano lenses are not covered.*

### CONTACT LENSES

#### *Necessary*

<i>Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$ 210.00*</i>
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#### *Elective*

	<i>Materials</i>	<i>Professional Fees and Materials</i>
	<i>Up to \$ 150.00</i>	<i>Up to \$ 105.00</i>
	<i>Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum \$60.00 Copayment.</i>	

*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.*

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



*\*Subject to Copayment, if any.*

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

**COPAYMENT**

*A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.*

**LOW VISION**

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

<i>Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)</i>	<i>Covered in Full</i>	<i>Up to \$125.00</i>
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<i>Supplemental Aids</i>	<i>75% of cost</i>	<i>75% of cost</i>
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*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:** ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST

**Plan Number:** 30094091

**Effective Date:** JANUARY 1, 2020

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

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

**PLAN ADMINISTRATOR:**

Katie Alioto

*(Name)*

Po Box 6

*(Address)*

Mukilteo, WA 98275-0006

*(City, State, Zip)*

**MONTHLY PREMIUM:**

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

**ELIGIBILITY:**

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

**PLAN AND SCHEDULE:**

**VSP CHOICE PLAN - Enhanced Plan C**

**EXAMINATION: ONCE EVERY 12 MONTHS.**

**LENSES: ONCE EVERY 12 MONTHS.**

**FRAMES: ONCE EVERY 12 MONTHS.**

**TERM, TERMINATION AND RENEWAL:**

**AFTER THE POLICY TERM, THIS POLICY 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:**

**BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.**

**VSP'S ADDRESS IS:**

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

## SCHEDULE OF BENEFITS

### GENERAL

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

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

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

<u>PLAN BENEFITS</u>	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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### VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$ 45.00*</i>
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### VISION CARE MATERIALS

#### *Lenses*

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$ 30.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 50.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$ 65.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$ 100.00*</i>

*Polycarbonate lenses are covered in full for dependent children up to age 26*

*Standard Progressive Lenses covered in full*

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$ 70.00*</i>
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*Frame Allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. However, lab-fabricated plano lenses are not covered*

### CONTACT LENSES

#### *Necessary*

<i>Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$ 210.00*</i>
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#### *Elective*

<i>Materials</i>		<i>Professional Fees and Materials</i>
<i>Up to \$ 150.00</i>		<i>Up to \$ 105.00</i>
<i>Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum \$60.00 Copayment.</i>		

*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.*

*\*Subject to Copayment, if any.*

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

**COPAYMENT**

*A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.*

**LOW VISION**

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

<i>Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)</i>	<i>Covered in Full</i>	<i>Up to \$125.00</i>
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<i>Supplemental Aids</i>	<i>75% of cost</i>	<i>75% of cost</i>
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*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: ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST**

**Plan Number: 30094091**

**Effective Date: JANUARY 1, 2020**

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

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

**PLAN ADMINISTRATOR:**

**Katie Alioto**

**(Name)**

**Po Box 6**

**(Address)**

**Mukilteo, WA 98275-0006**

**(City, State, Zip)**

**MONTHLY PREMIUM:**

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

**ELIGIBILITY:**

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

**PLAN AND SCHEDULE:**

**VSP CHOICE PLAN - EasyOptions Plan**

**EXAMINATION: ONCE EVERY 12 MONTHS.**

**LENSES: ONCE EVERY 12 MONTHS.**

**FRAMES: ONCE EVERY 12 MONTHS.**

**TERM, TERMINATION AND RENEWAL:**

**AFTER THE POLICY TERM, THIS POLICY 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:**

**BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.**

**VSP'S ADDRESS IS:**

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

## **SCHEDULE OF BENEFITS**

### **GENERAL**

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

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

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

### **PLAN BENEFITS**

<b><u>VISION CARE SERVICES</u></b>	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
<b><u>Eye Examination</u></b>	Covered in Full*	Up to \$ 45.00*
<b>Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.</b>		
<b>Subsequent regular eye examinations every 12 months.</b>		

\*Less any applicable Copayment.



## VISION CARE MATERIALS

<u>Lenses</u>	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Single Vision	Covered in full*	Up to \$ 30.00*
Bifocal	Covered in full*	Up to \$ 50.00*
Trifocal	Covered in full*	Up to \$ 65.00*
Lenticular	Covered in full*	Up to \$ 100.00*

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

Standard Progressive Lenses covered in full  
Available once every 12 months.

<u>Frames</u>	Covered up to Plan Allowance*	Up to \$ 70.00*
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Available once every 12 months.  
\*Less any applicable Copayment.

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

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

**CONTACT LENSES**

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

**Necessary-**

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 the Company are not required for Covered Person to be eligible for Necessary Contact Lenses.

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

**Professional Fees and Materials**  
Covered in full\*

**Professional Fees and Materials**  
Up to \$210.00\*

**Elective -**

**MEMBER DOCTOR  
BENEFIT**

**NON-MEMBER  
PROVIDER BENEFIT**

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

**Materials**  
Up to \$170.00

**Professional Fees and Materials**  
Up to \$105.00

\*Subject to Copayment

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

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

**FRAMES: An Additional Allowance of \$ 50.00 once every 12 months\*\***

**OR**

**LENS ENHANCEMENT**

**Premium and Custom Progressive lenses: Covered in full once every 12 months\*\*.**

**OR**

**LENS ENHANCEMENT**

**Photochromic: Covered in full once every 12 months\*\*.**

**OR**

**LENS ENHANCEMENT**

**Anti-reflective coating: Covered in full once every 12 months\*\*.**

**OR**

**CONTACT LENSES**

**ELECTIVE: An Additional Allowance of \$ 50.00 once every 12 months\*\***

**\*Less any applicable Copayment.**

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



**LOW VISION BENEFIT**

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

	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
Supplementary Testing	Covered in Full	Up to \$125.00
Supplemental Care Aids	75% of Cost	75% of Cost

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

Subsequent low vision aids.

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

**Benefit Maximum**

The maximum benefit available is \$1000.00 (excluding Copayment) every two years.

**NON-MEMBER PROVIDER BENEFIT**

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

## **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.

### **PATIENT OPTIONS**

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

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

### **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 a  $\pm .50$  diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy 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;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

## **ADDENDUM**

### **VISION SERVICE PLAN INSURANCE COMPANY ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PLUS PROGRAM**

#### **GENERAL**

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

#### **ELIGIBILITY**

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

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

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

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

## **PROGRAM DESCRIPTION**

The Diabetic Eyecare Plus Program (“DEP Plus”) is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will 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.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- “floating” spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

## **REFERRALS**

If Covered Person's Member Doctor cannot provide Covered Services, 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 DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Person 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  
VSP NETWORK DOCTORS**

**COVERED SERVICES**

**Eye Examination: Covered in full after a Copayment of \$20.00.**

**Special Ophthalmological Services: Covered in Full.**

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

**NOT COVERED**

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
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.

**DIABETIC EYECARE PROGRAM DEFINITIONS**

<b>Diabetes</b>	<b>A disease where the pancreas has a problem either making, or making and using, insulin.</b>
<b>Type 1 Diabetes</b>	<b>A disease in which the pancreas stops making insulin.</b>
<b>Type 2 Diabetes</b>	<b>A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.</b>
<b>Diabetic Retinopathy</b>	<b>A weakening in the small blood vessels at the back of the eye.</b>
<b>Rubeosis</b>	<b>Abnormal blood vessel growth on the iris and the structures in the front of the eye.</b>
<b>Diabetic Macular Edema</b>	<b>Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.</b>

**ADDITIONAL BENEFIT RIDER  
COMPUTER VISIONCARE PLAN**

**AZTC Enhanced Plan C and AZTC EasyOptions**

**GENERAL**

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

**COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED BELOW AND WHO UTILIZE A COMPUTER MONITOR SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.**

**ELIGIBILITY**

The following are Covered Persons under this Policy.

- Enrollee.

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

**COPAYMENT**

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

A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor or the Non-Member Provider at the time services are rendered.

**PLAN BENEFITS**

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Available once each 12 months**
A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use.		
*Less any applicable Copayment. **Beginning with the first date of service.		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use.	
Single Vision	Covered in full *	Available once each 12 months**
Bifocal	Covered in full *	
Trifocal	Covered in full *	
Near Variable Focus	Covered in full *	
Occupational Progressive	Covered in full *	
Plan Benefits for lenses are per complete set, not per lens.		
*Less any applicable Copayment. **Beginning with the first date of service.		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Available once each 12 months**
VSP reserves the right to limit the cost of the frames provided by Member Doctors under this Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.		
*Less any applicable Copayment **Beginning with the first date of service.		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Associated Vision Therapy (specific to computer use)	Up to \$200.00 per year (includes any supplemental testing)	Available once each 12 months**
**Beginning with the first date of service.		
This benefit is limited to Covered Persons who are eligible for CVC Coverage and who are diagnosed as having one of the following conditions:		
<p>Accommodative Infacility – The inability (or inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at things up close.)</p> <p>Convergence Insufficiency – The occasional problem with the eye muscles' ability to point the eyes straight when working up close.</p>		

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

### **CVC VISIONCARE PLAN**

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.

### **PATIENT OPTIONS**

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

#### **Optional cosmetic processes.**

- Anti-reflective coating.
- Color coating.
- Mirror coating.
- 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.

### **NOT COVERED**

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

- Subnormal vision aids.
- Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- 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.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

**ADDENDUM**

**EVIDENCE OF COVERAGE & DISCLOSURE FORM**

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

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

**Domestic Partners:** Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits. The domestic partner's unmarried dependent children are also covered provided they depend upon the Enrollee for support and maintenance.



Summary of Benefits and Coverage

Choice Exam Plus Plan

AZTC Exam Plus

Prepared for: ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST  
Group ID: 30094091  
Effective Date: JANUARY 1, 2020

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

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	\$10.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	N/A	N/A	N/A	N/A
	Fees			

\*\* Beginning with the first date of service.

**Your Grievance and Appeals Rights:**

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

Summary of Benefits and Coverage

VSP Choice Plan  
AZTC Basic Plan A

Prepared for: ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST  
Group ID: 30094091  
Effective Date: JANUARY 1, 2020

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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	\$10.00 Copay	Reimbursed up to \$45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: \$0.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam	Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00	Frames covered every 24 months** Lenses covered every 24 months**
	Fees			

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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  
AZTC Preferred Plan B**

Prepared for: **ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST**  
 Group ID: **30094091**  
 Effective Date: **JANUARY 1, 2020**

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	Frames, Lenses or Contacts	Glasses: \$0.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam	Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00	Frames covered every 12 months** Lenses covered every 24 months**
	Fees			

\*\* Beginning with the first date of service.

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**Summary of Benefits and Coverage**  
**VSP Choice Plan**  
**AZTC Enhanced Plan C and AZTC EasyOptions**

Prepared for: **ARIZONA TECHNOLOGY COUNCIL EMPLOYEE BENEFIT TRUST**  
 Group ID: **30094091**  
 Effective Date: **JANUARY 1, 2020**

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