Group Vision Care Policy

Group Name: **CHAMPLAIN COLLEGE**
Group Number: **30008842**
Effective Date: **JANUARY 1, 2024**

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: Champlain College
NAME OF PLAN: Vision Plan (VSP)
PRINCIPAL ADDRESS: 163 South Willard Street, Burlington, VT 05401

EMPLOYER I.D.#: 03-0220266

POLICY #: 3330042

PLAN ADMINISTRATOR: April O'Dell, Assistant VP of Finance & Assistant Treasurer
ADDRESS: 163 South Williard Street, P.O. Box 670, Burlington, VT 05402

PHONE NUMBER: 802-865-5734

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. It is not a substitute for the provisions of the Policy itself. A copy of the Policy will be furnished on 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 Policy.
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 the Company identifying the individual named as an Insured of the Company, and identifying those Plan Benefits to which an Insured is entitled.
COPAYMENTS	Any amounts required to be paid by or on behalf of an Insured for Plan Benefits that are not fully covered.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by the Company under section VI. ELIGIBILITY FOR COVERAGE of the Group Policy 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 Insured 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 Policy document maintained by your Group Administrator.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession.
GROUP	An employer or other entity which contracts with the Company for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
INSURED	An Enrollee or Eligible Dependent who meets the Company's eligibility coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Insureds of the Company.

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

PLAN BENEFITS The vision care services and vision care materials which an Insured is entitled to receive by virtue of coverage under this 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.

PREMIUMS The payments made to the Company by or on behalf of an Insured 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.

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

SCHEDULE OF BENEFITS 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 an Insured is entitled to receive by virtue of this Policy.

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

BENEFITS AND COVERAGES

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: 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..

   Elective or Necessary contact lenses are available in lieu of spectacle lenses and frames for the current eligibility as indicated on the enclosed insert.

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 extras, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits attached as Exhibit A to the Group Policy document 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.

Although a low vision benefit is available to Insureds diagnosed as having severe visual problems (i.e., partial sight), it is subject to limitations. Consult your Member Doctor or Benefits Representative for details. **There is no benefit for professional services or materials connected with**:

1. 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.

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. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

5. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.

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 the Company.

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, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible from the moment of birth who has not obtained the limiting age as shown on the enclosed insert page.

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

PREMIUMS

The Group is responsible for payments to the Company 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 the Company by the Group.

COPAYMENT

The benefits described herein are available to you from any participating Member Doctor, provided you follow the proper procedures by obtaining Benefit Authorization. THERE MAY BE A COPAYMENT AMOUNT PAYABLE BY YOU TO THE MEMBER DOCTOR AT THE TIME OF THE EXAMINATION. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

CHOICE OF PROVIDERS

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment).

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

BENEFIT AUTHORIZATION PROCESS

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

PROCEDURE FOR USING THE PLAN

1. When you desire to receive Plan Benefits from a Member Doctor, contact the Company or the Member Doctor. If you are eligible, the Company will provide Benefit Authorization to you or the Member Doctor.

2. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

3. A list of Member Doctors in your geographic location can be obtained from your Group or Plan Administrator. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographic area in which you desire to seek services, you may call or write the Company office nearest you to obtain one that does.

4. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. The Company will pay the Member Doctor directly according to its agreement with the doctor.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Insured can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider - if the attached Schedule of Benefits indicates that Insured's Plan includes such coverage). No prior approval from the Company is required for Insured to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company 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, Insured is not covered by the Company for medical services and should contact a physician under Insured's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Insured should contact the Company'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 the Company.

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 POLICY OTHER THAN THOSE NOT COVERED BY 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.

TERMINATION OF BENEFITS

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. 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.

COMPLAINTS AND GRIEVANCES

If Insured ever has a question or problem, Insured's first step is to call the Company's Customer Service Department. The Customer Service Department will make every effort to answer Insured's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of Insured, the Insured may communicate a complaint or grievance to the Company, 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. Insureds also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in the Company's review. The Company 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 the Company's receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Insured to indicate the Company's expected resolution date. Upon final resolution, the Insured will be notified of the outcome in writing.

Claim Payments and Denials

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

B. Request for Appeals: If the Insured's claim for benefits is denied by the Company in whole or in part, the Company will notify the Insured 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, Insured may make a verbal or written request to the Company for a full review of such denial. The request should contain sufficient information to identify the Insured for whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, the Insured's name and date of birth, the name of the provider of services and the claim number. The Insured may state the reasons the Insured believes that the claim denial was in error. The Insured may also provide any pertinent documents to be reviewed. The Company will review the claim and give Insured 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. Insured or Insured's authorized representative should submit all requests for appeals to:

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

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

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

When Insured 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. Insured 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)], Insured 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 Insured disagrees with the outcome.

OTHER FACTS YOU SHOULD KNOW ABOUT THE PLAN

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents such as detailed annual reports and Plan descriptions, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor or the Internal Revenue Service.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and your claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

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.

The Plan Administrator and the employer are subject to numerous obligations in connection with continuation coverage, including an obligation to notify eligible participants and their dependents of the existence of said continuation coverage. In this regard, the U.S. Department of Labor has issued ERISA Technical Release No. 86-2 dated June 26, 1986, setting forth a Model Statement of the required notice. Providing said notice by first class mail to each covered employee and his or her spouse, if any, at their last known address will constitute a good faith effort at compliance of the notice requirement in the absence of promulgated COBRA regulations.

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

Group Name: *CHAMPLAIN COLLEGE*

Plan Number: *30008842*

Effective Date: *JANUARY 1, 2024*

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

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

Sporzynski, Kathi
(Name)
84 South Service Road
(Address)
Middlebury, VT 05753
(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: DOMESTIC PARTNER, 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

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

*PLAN YEAR BEGINS JANUARY 1ST.

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 Insureds of the Company are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. 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 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 $ 50.00**
VISION CARE MATERIALS		
Lenses		
Single Vision	*Covered in Full**	*Up to $ 50.00**
Bifocal	*Covered in Full**	*Up to $ 75.00**
Trifocal	*Covered in Full**	*Up to $ 100.00**
Lenticular	*Covered in Full**	*Up to $ 125.00**

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

Frames	*Covered up to Plan Allowance**	*Up to $ 70.00**

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

CONTACT LENSES		
Necessary		
Professional Fees and Materials	*Covered in Full**	*Up to $ 210.00**
Elective	*Materials*	*Professional Fees and Materials*
	Up to $ 150.00	*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.

When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for one plan year.

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 $15.00 shall be payable by the Insured to the Member Doctor or Non-Member Doctor at the time services are 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.

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

Group Name: *Champlain College*

Plan Number: *30008842*

Effective Date: *JANUARY 1, 2024*

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

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

Sporzynski, Kathi
(Name)
84 South Service Road
(Address)
Middlebury, VT 05753
(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: DOMESTIC PARTNER 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

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

*PLAN YEAR BEGINS JANUARY 1ST.

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TYPE OF ADMINISTRATION:

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VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

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

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

Frames	*Covered up to Plan Allowance**	*Up to $ 70.00**

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

CONTACT LENSES		
Necessary		
Professional Fees and Materials	*Covered in Full**	*Up to $ 210.00**
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.

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 $15.00 shall be payable by the Insured to the Member Doctor or Non-Member Doctor at the time services are 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
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

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

- Enrollee.
- Legal spouse of Enrollee.
- Domestic Partner
- Any child of an Enrollee, including a 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.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB."). Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

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

2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY

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 gender as Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits.

Summary of Benefits and Coverage
SIGNATURE PLAN
BASE

Prepared for: **CHAMPLAIN COLLEGE**
Group ID: **30008842**
Effective Date: **JANUARY 1, 2024**

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	*	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* 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 24 months** Lenses covered every 12 months**
	Fees	$15.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
SIGNATURE PLAN
BUY UP

Prepared for: **CHAMPLAIN COLLEGE**
Group ID: **30008842**
Effective Date: **JANUARY 1, 2024**

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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	*	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* 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**
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