

January 4, 2022



Vision Care for Life

STEPHEN MURPHY
330 N BRAND BLVD STE 1100
GLENDALE, CA 91203-2337

RE:ALAMEDA COUNTY EMPLOYEES RETIREMENT ASSOCIATION, GROUP # 12110712, PLAN CHANGE

Attention Stephen Murphy:

Effective February 1, 2023 ALAMEDA COUNTY EMPLOYEES RETIREMENT ASSOCIATION 's contract has been changed to reflect a plan change.

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

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

Enclosures

**VISION SERVICE PLAN
PLEASE ATTACH TO YOUR
GROUP VISION CARE PLAN
AMENDMENT TO GROUP VISION CARE PLAN**

To be attached to and made part of Group Vision Care Policy number 12110712 issued to ALAMEDA COUNTY EMPLOYEES RETIREMENT ASSOCIATION.

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

IT IS HEREBY AGREED that effective February 1, 2023 Exhibit A, Schedule of Benefits, Exhibit B, Schedule of Premiums of the Group Vision Care Plan shall be amended as follows:

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan Base Plan

GENERAL

This Schedule lists 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. This Schedule forms a part of the Plan or Policy to which it is attached.

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 Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$25.00 payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	Covered in Full*	Up to \$ 45.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
<u>Lenses</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*

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 24 months.

*Less any applicable Copayment.

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.

Lens Options

UV coating	Covered in full	Not Covered
Polycarbonate lenses	Covered in full	Not Covered

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 24 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 VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

MEMBER DOCTOR BENEFIT

Professional Fees and Materials
Covered in full*

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$210.00*

Elective -

MEMBER DOCTOR BENEFIT

Professional Fees and Materials**
Up to \$175.00

NON-MEMBER PROVIDER BENEFIT

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.

EXHIBIT A

VISION SERVICE PLAN SCHEDULE OF BENEFITS VSP Choice Plan Buy-Up Plan

GENERAL

This Schedule lists 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. This Schedule forms a part of the Plan or Policy to which it is attached.

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 Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

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

A Copayment amount of \$15.00 shall be payable by the Covered Person to the Member Doctor at the time services are rendered. Additionally, a separate Copayment as stated in the Lens Options section of this Schedule of Benefits shall also apply.

PLAN BENEFITS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	Covered in Full*	Up to \$ 45.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
<u>Lenses</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*

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.

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.

Lens Options

Polycarbonate lenses	Covered in full	Not Covered
UV coating	Covered in full	Not Covered
Anti-reflective coating	Covered in full ¹	Not Covered
Premium and Custom Progressive lenses	Covered in full ¹	Up to \$50.00
Tinted/Photochromic	Covered in full	Not Covered

Available once every 12 months.

¹After \$25.00 Copayment

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

MEMBER DOCTOR BENEFIT

Professional Fees and Materials
Covered in full*

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$210.00*

Elective -

MEMBER DOCTOR BENEFIT

Professional Fees and Materials**
Up to \$250.00

NON-MEMBER PROVIDER BENEFIT

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.

EXHIBIT B

VISION SERVICE PLAN SCHEDULE OF PREMIUMS VSP Choice Plan Base

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

Divisions 0003, 0004 & 0007

\$ 4.63	per month for each eligible Enrollee without Eligible Dependents.
\$ 6.73	per month for each eligible Enrollee with one Eligible Dependent.
\$ 12.08	per month for each eligible Enrollee with two or more Eligible Dependents.

Divisions 0005, 0006 & 0008

\$ 6.69	per month for each eligible Enrollee without Eligible Dependents.
\$ 9.70	per month for each eligible Enrollee with one Eligible Dependent.
\$ 17.42	per month for each eligible Enrollee with two or more Eligible Dependents.

Except as otherwise allowed under this agreement, said rate(s) shall be guaranteed for a term of 36 months through January 31, 2026

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

Premiums are subject to annual Board approval for the guarantee period.

EXHIBIT B

VISION SERVICE PLAN SCHEDULE OF PREMIUMS VSP Choice Plan Buy-Up

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

Divisions 0009, 0010 & 0013

- \$ 16.63 per month for each eligible Enrollee without Eligible Dependents.
- \$ 24.15 per month for each eligible Enrollee with one Eligible Dependent.
- \$ 43.36 per month for each eligible Enrollee with two or more Eligible Dependents.

Divisions 0011, 0012 & 0014

- \$ 18.43 per month for each eligible Enrollee without Eligible Dependents.
- \$ 26.77 per month for each eligible Enrollee with one Eligible Dependent.
- \$ 48.07 per month for each eligible Enrollee with two or more Eligible Dependents.

Except as otherwise allowed under this agreement, said rate(s) shall be guaranteed for a term of 36 months through January 31, 2026

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

Premiums are subject to annual Board approval for the guarantee period