NOTICE OF SUMMARY MATERIAL MODIFICATION

Dear Participant and Beneficiaries,

This summary of material modification ("**SMM**") describes changes to Grace Cottage Medical Insurance ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Medical Insurance

Reason for SMM

- Changes to any of the terms of the plan, not reflected in the most recently provided Summary of Benefits and Coverage (SBC)

Effective Date of Material Modification: 01/01/2022

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Grace Cottage.
Jennifer Newman
185 Grafton Road, Townshend, VT 05353
jnewman@gracecottage.org
(802) 365-3632

General Plan Information:
Plan Name: Grace Cottage's Health & Welfare Benefit Plan
Plan Number: 505
Plan Sponsor/Plan Administrator: Grace Cottage

Summary of Material Modification 2

This summary of material modification ("**SMM**") describes changes to Grace Cottage Health Reimbursement Accounts ("**Plan**") and supplements the Summary Plan Description ("**SPD**")

for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Health Reimbursement Accounts

Reason for SMM

- Changes to any of the terms of the plan, not reflected in the most recently provided Summary of Benefits and Coverage (SBC)

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Grace Cottage
Jennifer Newman
185 Grafton Road, Townshend, VT 05353
jnewman@gracecottage.org
(802) 365-3632

General Plan Information:
Plan Name: Grace Cottage's Health & Welfare Benefit Plan
Plan Number: 505
Plan Sponsor/Plan Administrator: Grace Cottage

Summary of Material Modification 3

This summary of material modification ("**SMM**") describes changes to Grace Cottage Cafeteria 125 Plan, Flexible Spending Accounts ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Cafeteria 125 Plan, Flexible Spending Accounts

Reason for SMM

- Changes to any of the terms of the plan, not reflected in the most recently provided Summary of Benefits and Coverage (SBC)

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Grace Cottage
Jennifer Newman
185 Grafton Road, Townshend, VT 05353
jnewman@gracecottage.org
(802) 365-3632

General Plan Information:
Plan Name: Grace Cottage's Health & Welfare Benefit Plan
Plan Number: 505
Plan Sponsor/Plan Administrator: Grace Cottage

Summary of Material Modification 4

This summary of material modification ("**SMM**") describes changes to Grace Cottage Vision ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Vision

Reason for SMM

- Provisions that establish new benefits or services

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Grace Cottage
Jennifer Newman
185 Grafton Road, Townshend, VT 05353
jnewman@gracecottage.org
(802) 365-3632

General Plan Information:
Plan Name: Grace Cottage's Health & Welfare Benefit Plan
Plan Number: 505
Plan Sponsor/Plan Administrator: Grace Cottage

GRACE COTTAGE
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #9 TO THE
JANUARY 1, 2016 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended in accordance with the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) to cover Emergency Care, Out-of-Network air ambulance services and certain non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility at the In-Network level of benefits, subject to the Qualifying Payment Amount; revise the definition of Allowed Amount and Emergency Care and add the definition of Qualifying Payment Amount; include continuity of care provisions for when a provider is no longer In-Network; and include final internal appeal denials related to compliance with the NSA as eligible for external review.

This Plan is also amended to include the following updates: update the URL for the HPI website; lower the age limit for routine colonorectal screenings; eliminate coverage for routine eye exam and routine eyewear benefits; update orthotics benefit to require precertification and include coverage for foot orthotics; refer Covered Persons to contact the Pharmacy vendor for assistance with formulary drug lists; and update the Plan's right of subrogation and reimbursement to ensure that the Plan is indemnified against attorney's fees, costs, or other expenses related to the recovery of funds. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Document and Summary Plan Description are hereby amended as follows:

SECTION I, ESTABLISHMENT OF PLAN; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

SECTION III, DEFINITIONS; The definitions of **Allowed Amount** and **Emergency Care** are hereby **deleted** and **replaced** in their entirety with the following:

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are **not** subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "Non-NSA Covered Services"), minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. See the definition of "Qualifying Payment Amount" for the Covered Services that are subject to the NSA.

The Allowed Amount for Non-NSA Covered Services received from an Out-of-Network Provider depends upon where the services are provided.

> If Non-NSA Covered Services are received from an Out-of-Network Provider in New England, the Allowed Amount is an amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements and geographic adjustments.
>
> If Non-NSA Covered Services are received from an Out-of-Network Provider located outside of New England, the Allowed Amount is applied based on the following order of payment:
>
> - Fee(s) that are negotiated with the Physician or facility;
> - 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic area; or

- 50% of the billed charges

The specific reimbursement formula used for services provided by an Out-of-Network Provider located outside of New England will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Covered Persons may be responsible for paying excess charges above the Allowed Amount for Non-NSA Covered Services after the Plan pays its portion.

Emergency Care – care administered in a Hospital, independent freestanding emergency department, clinic, urgent care center, or Physician's office for a Medical Emergency. Emergency Care includes: (1) an appropriate medical screening examination, including ancillary services routinely available to evaluate whether a Medical Emergency exists; and (2) such further medical examination and treatment as may be required to stabilize the Covered Person (regardless of the department of a Hospital or independent freestanding emergency department in which the further medical examination and treatment is furnished). Emergency Care does not include ambulance service to the facility where treatment is received.

SECTION III, DEFINITIONS; The definition of **Qualifying Payment Amount** is hereby **added** in its entirety:

Qualifying Payment Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "NSA Covered Services"). Such NSA Covered Services are: emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the NSA. The NSA Covered Services will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

The Qualifying Payment Amount will be based on the median of the contracted rate for the same or similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law. The Qualifying Payment Amount will be determined in accordance with the NSA, as amended. Any amendments to the foregoing methodology will be deemed to be included and in effect for the Plan as of the NSA amended date.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

SECTION IV, SCHEDULE OF MEDICAL BENEFITS (Silver EPO, Gold EPO and Platinum EPO Plans),

- **PREVENTIVE CARE; USPSTF Recommendations** for **Colorectal Screenings** are **updated** as follows:

  Colorectal Screenings - decrease minimum age from 50 to 45

- **VISION CARE; Routine Eye Exam** and **Routine Eyewear** benefits are hereby deleted in their entirety.

- **OTHER SERVICES & SUPPLIES; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Orthotics (*Precertification required;* includes coverage for foot orthotics; s*ee* Medical Benefits *section for other limitations*)	100%	NOT COVERED

SECTION V, MEDICAL BENEFITS, A. Benefit Levels;

- **In-Network Providers, Out-of-Network Providers** and **Traveling Benefit** are hereby **deleted** and **replaced** in its entirety with the following; and **No Surprises Billing** and **Continuity of Care** provisions are hereby **added** in their entirety with the following:

  In-Network Providers – If a Covered Person has incurred Covered Services rendered by an In-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Contracted Rate (after satisfaction of the applicable Calendar Year Deductible).

  Out-of-Network Providers – If a Covered Person has incurred Covered Services rendered by an Out-of-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

  No Surprises Billing - Covered Services that are emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

  When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

Traveling benefit – If a Covered Person is traveling out of country and requires medical treatment from an Out-of-Network Provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider Co-payment and Coinsurance levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

Continuity of Care - In the event a Covered Person is a continuing care patient receiving a course of treatment from an In-Network Physician Provider or from a provider that otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care, if so elected, for a period ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2) is undergoing a course of institutional or inpatient care from a specific Provider,
3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred. However, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

SECTION V, MEDICAL BENEFITS, C. Covered Services:

- **(1)** Prescription Drugs; The following provision is hereby added in its entirety:

  The presence of a drug on the Prescription Benefit Manager's formulary list does not guarantee coverage. The drugs listed on the Prescription Benefit Manager's formulary are subject to change. To find out if a medication is covered under the Plan, Covered Persons should contact the Pharmacy vendor at the phone number list on the back of his/her ID card for the most current formulary information.

- **(3)** **Vision Care; Routine Vision Exam** and **Routine Eyewear** are hereby **deleted** in their entirety.

- **(4)** **Physician Services; (h) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (h) Surgery (Inpatient/Outpatient/Office)

  Physician or surgeon charges for a surgical operation and for the administration of anesthesia

  If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be as follows:

  (i) For In-Network Providers: the Contracted Rate for the primary procedure and the greater of 50% of such Contracted Rate or the amount specified in the In-Network Provider's contract for the secondary or lesser procedure(s).

(ii) For Out-of-Network Providers (who are not in the network but otherwise covered, such as emergency medical care and urgent care received outside the service area): the Allowed Amount or Qualifying Payment Amount, as applicable, for the major procedure and 50% of the Allowed Amount or Qualifying Payment Amount, as applicable, for the secondary or lesser procedure(s).

No additional benefit will be paid under this Plan for incidental surgery done at the same time and under the same anesthetic as another surgery.

The Plan will also pay for a surgical assistant when the nature of the procedure is such that the services of an assistant Physician are Medically Necessary.

- **(10) Other Services and Supplies; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

  Orthotics

  For the purpose of treating an Illness or Injury, services and equipment such as orthopedic braces, including leg braces with attached shoes; arm, back and neck braces; surgical supports; and head halters and specially molded orthopedic shoes and/or orthotic inserts

SECTION VI, MEDICAL LIMITATIONS AND EXCLUSIONS; The following exclusions are hereby **added** in their entirety, with all other items renumbered accordingly:

(25) Eyewear, routine (including lenses, frames and contact lenses, and their fitting)

(42) Vision exams for routine care

SECTION XII, THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT, C. Right of Reimbursement, paragraph (2) is hereby **deleted** and **replaced** in its entirety with the following:

C. Right of Reimbursement

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent

SECTION XV, CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby amended as follows:

Final internal appeal denials related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021 are added as denials eligible for external review.

Accepted by:
Grace Cottage

Director of Human Resources

Authorized Signature | **Title**

Jennifer Newman | 5/9/2022

Print Name | **Date**

GRACE COTTAGE
HEALTH REIMBURSEMENT ARRANGEMENT PLAN
AMENDMENT #1 TO THE
JANUARY 1, 2016 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

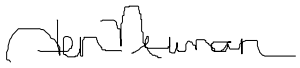
This Plan is amended to include the following updates: update the URL for the HPI website. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Document and Summary Plan Description are hereby amended as follows:

SECTION II, GENERAL INFORMATION; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

Accepted by:
Grace Cottage



Authorized Signature	**Title**
Jennifer Newman	5/9/2022
Print Name	**Date**

Director of Human Resources

GRACE COTTAGE
FLEXIBLE BENEFITS PLAN GENERAL PURPOSE MEDICAL CARE REIMBURSEMENT ACCOUNT/DEPENDENT CARE REIMBURSEMENT ACCOUNT
AMENDMENT #2 TO THE
JANUARY 1, 2021 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

This Plan is amended to include the following updates: update the URL for the HPI website. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Document and Summary Plan Description are hereby amended as follows:

SECTION II, GENERAL INFORMATION; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

Accepted by:
Grace Cottage

	Director of Human Resources
Authorized Signature	**Title**
Jennifer Newman	5/9/2022
Print Name	**Date**

GRACE COTTAGE
FLEXIBLE BENEFITS PLAN GENERAL PURPOSE MEDICAL CARE REIMBURSEMENT ACCOUNT/DEPENDENT CARE REIMBURSEMENT ACCOUNT
AMENDMENT #1 TO THE
JANUARY 1, 2021 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

The purpose of this amendment is: to revise the maximum allowable employee salary reduction contributions to the Plan's Medical Care Reimbursement Account, as noted in section 125 (i) of the Internal Revenue Code; to increase the amount a Participant is permitted to carryover of unused MCRA balances to subsequent Plan Years, in accordance with IRS Notice 2020-33. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan(s) are hereby amended, effective as of the date specified for each provision below:

MAXIMUM ELECTIVE CONTRIBUTIONS
The maximum amount which a Participant may elect to contribute to the Medical Care Reimbursement Account ("MCRA") under this Plan is $2,850 per Plan Year.
Effective January 1, 2022

CARRYOVER OF UNUSED ACCOUNT BALANCE
Participants in this Plan may carry over a maximum of $570 of unused MCRA balances from one Plan Year to the following Plan Year.
Effective January 1, 2021

Accepted by:
Grace Cottage

Authorized Signature	**Title** Director of Human Resources
Print Name Jennifer Newman	**Date** 12/28/2021

Client Vision Care Plan

Client Name: **CARLOS G OTIS DBA GRACE COTTAGE FAMILY HEALTH & HOSPITAL**
Client Number: **30106930**
Effective Date: **JANUARY 1, 2022**

EVIDENCE OF COVERAGE

Provided by:

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

The insurance policy under which this Evidence of Coverage is issued is not a policy of worker's compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the worker's compensation system.

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

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

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

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

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

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

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

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

TO OBTAIN FURTHER INFORMATION

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

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

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

URGENT VISION CARE

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

HOLD HARMLESS

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

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

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

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

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

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

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

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

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

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Signature Plan®

GENERAL

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

BENEFIT PERIOD

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

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 Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN BENEFITS
VSP Preferred PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

LENS OPTIONS

Anti-reflective coating covered in full once every 12 months.**
Scratch coating covered in full once every 12 months.**
Blended lenses covered in full once every 12 months.**
Premium and Custom Progressive lenses covered in full once every 12 months.**
Tinted/Photochromic covered in full once every 12 months.**

FRAMES - Covered up to the Plan allowance* once every 12 months**

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

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients as determined by VSP Preferred Provider.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $200.00 once every 12 months**

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

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

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

*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

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

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

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of spectacle lenses, frames and/or contact lenses furnished under this plan which are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 50.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 50.00* once every 12 months**

Bifocal Up to $ 75.00* once every 12 months**

Trifocal Up to $100.00* once every 12 months**

Lenticular Up to $125.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

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

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

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

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

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

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

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

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

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

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

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 Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

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

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

PLAN DESCRIPTION

The Supplemental Primary EyeCare Plan ("PEC") 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 a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

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

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

- ocular hypertension
- retinal nevus
- macular degeneration
- corneal dystrophy

- glaucoma
- cataract
- pink eye
- corneal abrasion
- blepharitis
- sty

REFERRALS

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

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

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

PLAN BENEFITS
VSP Preferred PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of $20.00.
Special Ophthalmological Services: Covered in Full
Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

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

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

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

PLAN BENEFITS
OPEN ACCESS PROVIDERS

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

COVERED SERVICES

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: **CARLOS G OTIS DBA GRACE COTTAGE FAMILY HEALTH & HOSPITAL**
Group ID: **30106930**
Effective Date: **JANUARY 1, 2022**

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

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	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**
	Fees	$20.00 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.

2022 Full-Time Rates (30+ Hours)

Annual Wages < Than 35K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$62.12	$36.53	$23.13
EE + Spouse	$99.38	$58.44	$36.99
EE + Child(ren)	$86.96	$51.15	$32.38
Family	$155.29	$91.33	$57.81

Annual Wages 35-70K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$88.53	$62.94	$49.54
EE + Spouse	$141.64	$100.70	$79.25
EE + Child(ren)	$123.93	$88.12	$69.35
Family	$221.31	$157.36	$123.83

Annual Wages > 70K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$114.94	$89.36	$75.95
EE + Spouse	$183.90	$142.96	$121.51
EE + Child(ren)	$160.90	$125.09	$106.33
Family	$287.34	$223.39	$189.86

2022 Part-Time Rates (20-29 Hours)

Annual Wages < Than 35K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$93.18	$54.80	$34.69
EE + Spouse	$149.07	86.67	$55.49
EE + Child(ren)	$130.43	$76.72	$48.57
Family	$232.93	$137.00	$86.71

Annual Wages 35-70K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$132.80	$94.41	$74.30
EE + Spouse	$212.46	$151.05	$118.88
EE + Child(ren)	$185.89	$132.18	$104.03
Family	$331.97	$236.04	$185.75

Annual Wages > 70K

Semi-Monthly Paycheck Cost	Platinum	Gold	Silver
Employee Only	$172.42	$134.03	$113.93
EE + Spouse	$275.85	$214.44	$182.27
EE + Child(ren)	$241.36	$187.64	$159.49
Family	$431.01	$335.08	$284.79

Dental Rates & Discount Programs thru Delta

Dental Rates

Semi-Monthly Paycheck Cost

	Employee Only	EE+ Spouse	EE + Child(ren)	Family
Core	$0.00	$23.46	$26.38	$48.84
Buy-Up	$1.53	$26.44	$33.66	$57.11

Delta Dental is proud to offer Health through Oral Wellness- better known as HOW- patient centered oral health program designed to promote good oral and overall health for members. By completing a very simple questionnaire with your provider you can determine if you would qualify for additional FREE benefits under the HOW Program and enhance your current dental program. Speak with your provider today!

EyeMed & Amplifon Discounts

Northeast Delta Dental cares about your total health and wellness, we are proud to partner with EyeMed Vision Care to include discount programs to help our members enjoy all of life's sights and sounds to the fullest. EyeMed Vision Care offers access to vision care providers nationwide. Hearing Care Program offered through Amplifon – the nation's largest independent hearing care network.

Vision Coverage

Grace Cottage offers vision coverage to all full time employees working a minimum of 32 hours per week. An employee is eligible to participate on the first day of the month following one month of employment.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$20 for exam and glasses	Every calendar year
PRESCRIPTION GLASSES			
FRAME	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart*/Sam's Club* frame allowance • $110 Costco* frame allowance	Combined with exam	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every calendar year
LENS ENHANCEMENTS	• Progressive lenses • Anti-glare coating • Tints/Light-reactive lenses • Scratch-resistant coating • Average savings of 40% on other lens enhancements	$0 $0 $0 $0	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

Vision Rates

Semi-Monthly Paycheck Cost

Employee Only	Employee + Spouse	EE + Child(ren)	Family
$1.94	$3.11	$3.18	$5.12