IBEW/NECA SOUND & COMMUNICATIONS HEALTH AND WELFARE TRUST FUND

IBEW/NECA SOUND & COMMUNICATIONS HEALTH & WELFARE TRUST FUND
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119
Telephone: (408) 288-4400 or (877) 827-4239
Email: infos&c@uastpa.com

January 2021

TO: PARTICIPANTS & DEPENDENTS

RE: SUMMARY OF MATERIAL MODIFICATION (SMM)

The Board of Trustees of the IBEW/NECA Sound and Communications Health and Welfare Trust Fund ("Plan") is pleased to provide you with the following summary of changes to the Plan, called the Summary of Material Modification (SMM). If you have any questions, please contact the Trust Fund Office at (408) 288-4400 or (877) 827-4239.

Ongoing Reminder: Please also keep your current address and contact information (including cell phone numbers and e-mails) up to date with the Administrator's Office.

Article XIII, VISION BENEFIT PLAN RULES– Vision Benefit Updates/Changes With VSP Effective January 1, 2021

This Plan's Vision Benefits are insured through contract with Vision Service Plan ("VSP"). Below please find updated changes to the Plan's vision benefits, effective January 1, 2021, for eligible Participants and Dependent Children (under age 19 and children over age 19 to age 26) and Spouse. Vision benefits are available to you and your eligible dependents from any VSP Network provider or Non-VSP Provider.

If You choose to visit a VSP network Provider, there is a copay amount payable by You to the VSP network Provider at the time of the exam and a separate copay when frames and lenses are ordered.

NOTE: The copays do not apply to elective contact lenses.

A. Vision Benefits

1. **Exam:** You and your Dependents, including child(ren) are entitled to a comprehensive eye exam to determine the presence of vision problems or other abnormalities. Services shall be provided **once every 12 (twelve) months** for adults, dependent children over age 19 and dependent children under age 19.

2. **Lenses:** The VSP network Provider will order the proper lenses necessary for Your visual welfare. The Doctor shall verify the accuracy of the finished lenses. The Plan covers lenses **once every 12 (twelve) months** for adults and all dependent children. Impact-resistant lenses, UV coating and scratch-resistant coating for children under age 19 are covered in full when dispensed by a VSP network Provider

3. **Frame:** VSP covers a frame allowance of up to $150 for in-network and up to $70 for out-of-network. The frame benefit provides You the choice to select a frame that fits Your lifestyle. Have Your Doctor help You choose the best frame for You, based on Your VSP coverage. The Plan covers frames **once every 12 (twelve) months** for adults, dependent children over age 19 and dependent children under age 19 after applicable copay. For information on how Your eligibility for frames may be affected if You receive contact lenses, please see "Contact Lenses" below.

4. **Contact Lenses:** Elective contact lenses are covered up to $150 and medically necessary contact lenses are covered in full in-network **every 12 months**. The contact lens exam (fitting and evaluation) is a separate exam for ensuring proper fit of Your contacts and evaluating Your vision with the contacts. The Plan covers a contact lens exam (fitting and evaluation) in full after a up to $60 copay in-network. Contact lenses are in lieu of all lenses and frame) for that eligibility period.

   Medically Necessary contact lenses may be prescribed by a VSP network Doctor for certain conditions. A VSP network Doctor must receive prior approval from VSP for Medically Necessary contact lenses. When the VSP network Doctor receives prior approval for such cases, they are fully covered by VSP and are in lieu of all benefits for that eligibility time period. Subject to $25 materials copay. If You receive Medically Necessary contact lenses through a non-VSP Provider, You will be reimbursed according to a Provider schedule (see PROVISIONS FOR A NON-VSP PROVIDER Section).

5. **Extra Discounts and Savings:**

   - Average 40% savings on lens options, such as scratch-resistance, anti-reflective coatings and progressives

   - 30% savings on additional glasses and sunglasses including lens enhancements from the same VSP provider on the same day as your well vision exam or get 20% from any VSP provider within 12 months of your last well vision exam.
   - Save on eyewear and eye care when you see a VSP network doctor. Take advantage of Exclusive member extras for additional savings.

6. **Retinal Screening:** Guaranteed in network member pricing of $39. as an enhancement to Your Well Vision exam. Use of retinal imaging, which takes a picture of the back of Your eye, helps Your VSP Doctor find and track possible signs of eye disease.

7. **Low Vision:** The low vision benefit is available if You have severe visual problems that are not correctable with regular lenses. This benefit is subject to the following limitations:

   a. **Prior Authorization** – When a VSP network Doctor suspects a low vision condition and the Doctor requests advance approval prior to beginning service, VSP may authorize supplementary testing by the Doctor to determine the nature of the problem and to allow the Doctor to gather enough facts to propose a treatment plan. The supplementary testing is paid by the Plan with no copay by You.

   b. **Copay** – After supplementary testing, the Doctor submits the treatment plan to VSP consultants for review. If the plan is approved, VSP will authorize benefits, on a copay basis, with 75% of the cost being paid by VSP and 25% of the cost being paid by You.

   c. Maximum Benefit – VSP will pay a maximum of $1,000. (excluding copays) every two years for approved low vision care. The maximum includes the supplementary testing.

Low vision benefits secured from a non-VSP Provider are subject to the same time limits and copay arrangements as described herein for a VSP network Provider. You should pay the non-VSP Provider the full fee. You will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Provider in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

Laser Vision Care Program: VSP has contracted with many of the nation's finest laser surgery facilities and Providers offering You access to laser vision correction surgery for hundreds of dollars less than what You might pay privately. Average 15% off the regular price or 5% off the promotional price. Discounts on LASIK, Custom LASIK, and PRK, plus patient education Wavefront technology with the microkeratome surgical device only. Discounts are only available from VSP contracted facilities. Other LASIK procedures performed at additional cost. Details about VSP's Laser Vision Care Program, as well as comprehensive information about laser vision correction surgery can be found on the VSP Web site (vsp.com) or by contacting VSP toll-free at 1-800-877-7195.

Sunglasses Following Laser Vision Surgery: Members who have had laser vision surgery can use their frame allowance to buy nonprescription sunglasses instead of a pair of prescription glasses or contacts from their VSP Provider.

B. VSP Network Provider and Non-VSP Provider Copay Schedule

There shall be a copay for the exam, payable by You, to the VSP network Provider at the time of the exam; however, if materials (lenses and/or frames) are provided, You must pay an additional copay at the time the materials are ordered as noted below:

	FREQUENCY	**IN-NETWORK COVERAGE**
Well Vision Exam	• *Focuses on your eyes and overall wellness* • *Every 12 months*	$10 Copay Adults and Children Over Age 19. No Charge Children under Age 19.
Prescription Glasses		$25 Copay Adults and Children Over Age 19. No Charge Children under Age 19.
FRAME	*Every 12 months (retail allowance)*	**Adults and Children over Age 19 and Children Under Age 19** • $150 frame allowance • $170 featured frame brands allowance • 20% savings on the amount over your allowance
LENSES		
Glass or plastic, Single Vision, Lined Bifocal and Lined Trifocal Lenses or Lenticular	*Every 12 months*	**Adults and Children over Age 19 and Children Under Age 19** Included in Prescription Glasses
LENS ENHANCEMENTS		
Impact-resistant Lenses	*Every 12 months*	Covered in Full for Children under age 19 only. 40% average savings for Adults and Children over 19
Scratch-Resistant Coating and UV Coating		Covered in Full for Children under age 19 only. 40% average savings for Adults and Children over 19
		40% average savings for Adults and Children over 19
		40% average savings for Adults and Children over 19
Standard Progressives		No Charge (Adults and All Dependent Children)
Premium Progressives		$80-$90 Adults & All Dependent Children
Custom Progressives		$120- $160 Adults & All Dependent Children
CONTACTS (INSTEAD OF GLASSES)		
Contacts (in lieu of glasses) Contact Lens Exam (fitting and evaluation) Medically Necessary Contacts	*Every 12 months*	$150 allowance copay does not apply (Adults & All Dependent Children) Covered in full after copay after not to exceed $60 copay (Adults & All Dependent Children). 15% off contact lens exam services at VSP doctors only. Covered in full after $25 copay
DIABETIC EYECARE PLUS PROGRAM		
Retinal Screening for members with Diabetes	*As needed*	No Charge (Adults and All Dependent Children)
Additional exams and services for diabetic eye disease, glaucoma, or age-related macular degeneration.	*Limitations and coordination with your medical coverage may apply. Ask VSP doctor for details*	$20 per exam (Adults and All Dependent Children)

Any additional care, service and/or material, not covered by this Plan, may be arranged between You and the Doctor.

C. Provisions for a VSP Network Doctor

The vision benefits provided through VSP provide You with a choice. Selecting a VSP network Doctor assures direct payment to the Doctor and a guarantee of quality and cost control.

D. Provisions for a Non-VSP Provider

If You choose to go to a non-VSP Provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This Plan then becomes an indemnity Plan reimbursing according to a schedule of allowances. You should pay the Provider the full fee and copays still apply.

E. Filing a Claim for Non-VSP Provider Services

Following these steps to file a claim if You obtain services and/or materials from a non-VSP Provider:

1. Pay the Provider the full amount of the bill and request an itemized copy of the bill that shows the amount of the eye exam, lens type and frame.

2. Send a copy of the itemized bill(s) to VSP. The following information must also be included in Your documentation:

   - Member's name and mailing address;
   - Member's ID number;
   - Member's Employer or group name; and
   - Patient's name, relationship to member, and date of birth.

Claims must be submitted within twelve months of completion of services. VSP will reimburse in accordance with the schedule below. There is no assurance that the schedule will be sufficient to pay for the exam or the materials. In order to receive reimbursement, please mail Your itemized bill(s) and above documentation to the following address:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Availability of services under this reimbursement schedule is subject to the same time limits and copays as those described on pages 59 through 60. Services obtained from a non-VSP Provider are in lieu of obtaining service from a VSP network Doctor.

F. Out-Of-Network Reimbursement Schedule

Maximum Reimbursement for services from an Out-Of-Network Provider. Please call member services for out-of-network plan details. Copays still apply.

OPEN ACCESS SCHEDULE (OUT-OF-NETWORK)

PROFESSIONAL FEES- $10 copay for Adults and Children over 19, $0 copay for Dependent Children under 19	
Exam	Up to $50 Adult & All Dependent Children

MATERIALS - $25 copay Adults and Children over 19; $0 copay for Dependent Children under 19	
Single Vision Lenses	Up to $ 50 (Adult & All Dependent Children)
Bifocal Lenses	Up to $ 75 (Adult & All Dependent Children)
Trifocal Lenses	Up to $100 (Adult & All Dependent Children)
Lenticular Lenses	Up to $125 (Adult & All Dependent Children)
Progressive Lenses	Up to $75 (Adult & All Dependent Children)
Frame	Up to $70 (Adult & All Dependent Children)

CONTACT LENSES *	
Elective contact lenses and contact lens (fitting and evaluation) exam	Up to $105 (Adult & All Dependent Children)
Medically Necessary contact lenses	Up to $210 after $25 copay (Adult & All Dependent Children)

***** Determination of necessary versus elective contact lenses under the non-VSP Provider reimbursement schedule will be consistent with VSP network Doctor services. Reimbursement for medically necessary and elective contact lenses is in lieu of all prescription lenses and frame materials for the periods stated.

NOTE: The amounts shown are maximums. The actual reimbursement to You shall be either the amount shown in the "Maximum Reimbursement for Services from a Non-VSP Provider," or the above amount charged by the Provider of such services, whichever is the least amount.

G. Exclusions and Limitations of Vision 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 toll-free at 1-800-877-7195.

PATIENT OPTIONS

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

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.

- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

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

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

H. Procedure for Using the Plan

1. When You are ready to obtain vision care services, call Your VSP network Doctor. If You need to locate a VSP network Doctor, call VSP toll-free at 1-800-877-7195 or visit the VSP Web site at **www.vsp.com**.

2. When making an appointment, identify Yourself as a VSP member. The VSP network Doctor will also need the covered member's identification number and covered member's group name (IBEW / NECA Sound and Communications Health and Welfare Trust). The VSP network Doctor will contact VSP to verify Your eligibility and Plan coverage. The VSP network Doctor will also obtain authorization for services and materials. If You are not eligible, the VSP network Doctor will notify You.

3. The VSP network Doctor will provide an eye exam and determine if eyewear is necessary. If so, the VSP network Doctor will coordinate the prescription with a VSP-approved, contract laboratory. The VSP network Doctor will itemize any non-covered charges and have You sign a form to document that You received services. VSP will pay the VSP network Doctor directly for covered services and materials. You are responsible for paying the Doctor a $10 copay for the eye exam and a $25 copay for lenses and/or frames. There is No copay for Dependent Children (ages newborn to 19). Adult Dependent children (ages 19 to 26) are subject to the same applicable copayment as Adults. The copays will not apply toward elective contact lenses but there may be a copay for contact lens exam. You are responsible for any additional costs resulting from cosmetic options, or non-covered services and materials You have selected. Selecting a VSP network Doctor from VSP's network assures direct payment to the Doctor and guarantees quality services and materials. However, if you decide to use the services of a Doctor who is not a VSP network Doctor, you should pay the doctor his or her fee.

I. Coordination of Benefits

If You have dual coverage and are covered by more than one vision plan (whether it be another carrier or another VSP plan), You may:

(a) Use each plan individually (based on what each plan offers) for either two separate exams and/or materials from each plan. For example, contact lenses from one plan and glasses from the other plan or two sets of glasses (one pair from each plan); **Or**

(b) Choose to have both plans pay for one set of services to offset plan copayment(s), lens options and/or frame overage, up to, but not more than the billed amount.

NOTE: Check with Your VSP Doctor for coordination of benefit details.

Determine Primary and Secondary Plan

- The plan that covers You as an Employee is primary.
- The plan that covers You as a Dependent is secondary.
- If the patient is a Dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

J. Request for Appeals

If Your claim for benefits is denied by VSP, in whole or in part, VSP will notify You 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, You may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied including the name of the VSP enrollee, member identification number of the VSP enrollee, Your name, date of birth, and the name of the Provider of services. You may state the reasons You believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give You 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. You or Your authorized representative should submit all requests for appeals to the address below or may be filed online at www.vsp.com :

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670-7985
Phone: 1-800-877-7195

K. Complaints and Grievances

If You have a complaint or grievance regarding VSP service or claim payment, You may communicate Your complaint or grievance to VSP by using a complaint form, which may be obtained by calling the VSP Customer Services Department's toll-free number at 1-800-877-7195 Monday through Friday, 5:00 AM – 6:00 PM (PST), Saturday and Sunday 7 AM- 5 PM (PST). The completed form should be sent to the address shown above. VSP shall acknowledge receipt of Your grievance within five (5) business days of receipt by VSP. VSP shall also provide a written response to our grievance as required by VSP's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. There shall be no discrimination against a member on the basis of filing a complaint or grievance. If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures section of this booklet.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 800-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688- 9891 (TDD) to contact the Department. Health plan complaint forms and instructions are available online at the Department's website, ***http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.***

If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than sixty (60) days, You may call the Health Plan Division for assistance. **NOTE:** The Plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to You. Your failure to use these procedures does not preclude

Your use of any other remedy provided by law.

L. Liability in Event of Non-Payment

In the event VSP fails to pay the VSP Doctor, You shall not be liable to the Doctor for any sums owed by VSP, other than those not covered by the Plan.

M. Terms and Cancellations

The contract between the Plan and VSP will continue until terminated by either party giving the other party sixty (60) days prior written notice. VSP reserves the right to reject any and all claims for services or benefits which are filed more than one hundred eighty (180) days after completion of services.

N. Vision Benefit Definitions

Coated Lenses – A substance is added to a finished lens on one or both surfaces.

Covered Person – The Employee, and their eligible and enrolled Dependents, of the Employer participating in this program.

Group – The entity that contracts with VSP on behalf of its members.

Materials – Lenses, frame, low vision aids, and contact lenses.

Orthoptics – The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Oversize Lenses – Larger than standard lens blank.

Photochromic Lenses – Lenses that change color with intensity of sunlight.

Plan Administrator – United Administrative Services.

Plano Lenses – Lenses with no refractive power.

Polycarbonate Lenses – The most impact-resistant lens. Thinner than regular plastic lenses. Appropriate for active lifestyles, especially kids.

Professional Service – Exam, material selection, fitting of glasses, and related adjustments.

Progressive Lenses – A multifocal lens with no distinct lines. Changes from distance correction in the top half of the lens to reading correction in the bottom half of the lens.
Tinted Lenses – Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, and blue).

IN ACCORDANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS SUMMARY OF MATERIAL MODIFICATIONS SUPPLEMENTS THE SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT.

Respectfully submitted,
Plan Administrator
On Behalf of the Board of Trustees