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IMPORTANT NOTICE ABOUT CHANGES TO THE OHIO BRICKLAYERS' HEALTH & WELFARE SUMMARY PLAN DESCRIPTION

May 2025

This Notice explains important changes that are being made to the Summary Plan Description of the Ohio Bricklayers Health and Welfare Plan. You are urged to carefully review this Notice and address any questions to the Benefit Office. Enclosed with this Notice is a Welcome Letter and Summary flyer from VSP. Please keep these documents with your records of Plan activities.

New Vison Care Benefits

The Board of Trustees have hired Vision Services Plan (VSP) to provide a new vision benefit to Active Employees, Non-Medicare Retirees and their covered Dependents receiving vision benefits under the Plan. Medicare Eligible Retirees and Non-Bargained Employees do not currently have vision benefits, so they will not be impacted by this benefit change.

The benefits provided by a VSP Choice Network provider will be greater than the benefits provided if you get your vision care exams and glasses from a provider that does not participate in the VSP Choice Network. To find a VSP Choice Network provider, you can log onto www.vsp.com.

All eligible Participants and their covered Dependents will receive the following vision benefits offered by the Plan once every 12 months instead of the prior $100.00 per year per calendar year benefit.

	VSP Choice Network Providers	Out –of –Network
Examinations	100%	Up to $45.00
Frames -**subject to Allowance	$100**	Up to $70.00
Lenses		
Single Vision	100%	Up to $30.00
Lined Bifocals	100%	Up to $50.00
Lined Trifocals	100%	Up to $65.00
Progressive Lenses		
Standard Progressives	100%	Up to $50.00
Premium Progressives	100% after $95 -$105 copayment	n/a
Custom Progressives	100% after $150 - $175 copayment	n/a
Other Lens Enhancements	30% savings on average	n/a

Elective Contact Lenses (in lieu of glasses)	Up to $100.00 allowance	Up to $85.00
Sunglasses	20% savings on additional glasses or sunglasses	
Benefit Period	12 Months	
**Allowance varies depending upon type of frame and provider: $100 is the general frame allowance with $120 featured frame brands/ $55 Walmart, Sams Club & Costco		

What is Included in Your Vision Coverage

The specific vision services covered by the Plan and the various levels of payment are shown in the "Schedule of Benefits" above. Vision Benefits are available to Active Employees, Non-Medicare Retirees and their Covered Dependents. Eligibility rules for vision benefits are the same as those for other benefits under the Fund. Benefits will be paid only for services which are performed while you are eligible.

The Plan will provide the following general vision benefits to eligible participants and their dependents:

Vision Examinations: A complete initial vision analysis which includes an appropriate examination of visual functions, including routine retinal screening along with the prescription of corrective eyewear where indicated.

Lenses and Frames: To correct vision problems – lenses may be plastic or impact resistant glass. Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

The Plan offers a wide selection of frames; however, if you select a frame which costs more than the amount allowed, you will be responsible to pay the additional cost. The frame allowance is based upon the type of frame and provider. Additionally, if you use a VSP network provider, you will be eligible for additional discounts to help reduce your out of pocket costs further.

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

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

Contact Lenses: The Plan will cover Elective Contacts once in a twelve-month period in lieu of glasses up to an allowance of $100.00. The exam and contact fitting received from a VSP network provider will be covered at 100% after a $20.00 copayment. Necessary Contacts will be covered in full once in a twelve-month period in lieu of glasses without the copayment when prescribed as medically necessary and received from a VSP network provider.

If you see a non-VSP network provider, the Plan will reimburse you up to $85 for Elective Contacts exam and materials and up to $210 for Necessary Contacts exam and materials.

Low Vision Benefits: The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses. Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids are covered where indicated. Supplemental tests received from a VSP provider are covered at 100% subject to two per every two years. This benefit is subject to a 25% coinsurance and limited to $1,000 maximum every two years. If you use a non-VSP network provider, the Plan will reimburse you the amount they would have paid if the services were received from a VSP provider which may not equal 100% or 25% of the billed charges.

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

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

Vision exams needed for the diagnosis or treatment of a medical condition will be covered under the VSP vision benefit when received by VSP network providers after a $20.00 co-payment. These may include second vision exams within the 12-month period or exams for sudden changes in vision. Additionally, retinal exams needed for participants with diabetes will be covered under this Supplemental Vision Benefit.

Urgent/Emergency Care and Special Ophthalmological Services are covered in full not subject to the copayment. Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid. Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

Other Lens Enhancements - Participant Options: This Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and you will pay the additional costs for the options. If these are received from a VSP network provider, there may be discounts available to reduce some of the out of pocket costs.

- 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.

How to use this Benefit

When you receive this notice, please follow the instructions in the attached VSP Welcome Letter to register. Once registered, you can use the VSP website to view your benefits, find a VSP Network provider and schedule an appointment. Go to www.vsp.com or call 800.877.7195 for assistance. No claim forms are required if you use a network provider. All you need to do is let the VSP Network provider know you have VSP along with your Participant ID information. As long as you utilize a network provider, you will receive the higher in-network vision benefits.

As always, the choice of your vision is up to you. If you choose to use a non-network provider, your benefit will be paid at the out-of-network benefit level. You will generally have to pay for the service and then seek

reimbursement from the vendor. In order to file a claim for benefits received from a non-network provider, you will need to do the following:

- Pay 100% of the costs at the time of the services
- Obtain an itemized bill from the service provider
- Obtain a claim form from the vision vendor or Fund Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

The itemized bill must include the following information in order to be processed:

- Name and ID Number of the Participant
- Name and address of the provider of the service
- Patient's full name and relationship to the Participant
- Date of the service
- Description of the services performed on each date or description of the item
- Amount charged for each service/item

The vendor will then reimburse you the non-network amount directly once the completed claim form and proof of claim are received and processed for payment. If you register on the Vendor's website, you will be able to submit a claim through their online system for payment.

Excluded Vision Expenses

The vision Plan benefit does not cover certain vision care expenses, such as (but not limited to) the following:

- 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 the Schedule above as covered Plan Benefits.

Thank you for your participation in the Plan and please feel free to contact the Benefit Office with any questions.

Sincerely,

Board of Trustees

Make Eye Health a Priority with VSP!

Your health comes first with VSP and Ohio Bricklayers. Take a look at your VSP vision care coverage.

vsp vision care

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during and eye exam.*

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

VSP gives you thousands of in-network choices, including private practice doctors, regional and national optical retail chains, or online at **eyeconic.com**®. You'll get the most out of your benefits at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Provider Network: VSP Choice

Effective Date: 05/01/2025

Create an account today.
Questions?
http://www.vsp.com or **800.877.7195**

Scan QR code or visit **vsp.com** to learn more.

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP DOCTOR		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$0 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		
FRAME+	• $100 Frame allowance • $120 Featured Frame Brands allowance • 20% savings on the amount over your allowance • $55 Walmart/Sam's Club/Costco frame allowance • Every 12 months	$0
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	$0
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $100 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $20
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam	up to $45	Lined Trifocal Lenses	up to $65
Frame	up to $70	Progressive Lenses	up to $50
Single Vision Lenses	up to $30	Contacts	up to $85
Lined Bifocal Lenses	up to $50		

*Full Picture of Eye Health, American Optometric Association, 2020.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Eyeconic is a VSP-affiliated company.

Classification: Restricted