EQUITABLE

Vision

Benefit Summary

San Jose State University Research Foundation **Effective Date:** January 01, 2019

Policy Number: 004201

Class Definition: Class 1: All Active Full Time Employees working at least 30 hours per week

An extensive vision coverage network that offers convenience and cost savings

Maintaining healthy eyes gives us the opportunity to see the important things in life - graduations, weddings, births, and everything in between. One of the best ways to protect your eye health is to visit an eye doctor regularly. Vision insurance can make those visits more convenient and less costly. We've partnered with a vision network, VSP ® Vision Care, to give you the freedom to choose from 37,000 unique providers at 78,000 locations.

What your benefits cover:

Coverage Type	In-Network Benefit	In-Network Copay	Out-of-Network Benefit	Frequency
Benefit Plan and Features				
Eye Examination	Covered in full	$5	Up to $45	Every 12 months
Prescription Eyeglasses		$5		
Frames	$150	Included in Prescription Eyeglasses Copay	Up to $70	Every 24 months
Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered in full	Included	Up to $30 Up to $50 Up to $65 Up to $100	Every 12 months
	Standard Progressive Premium Progressive			

Coverage Type	In-Network Benefit	In-Network Copay	Out-of-Network Benefit	Frequency
Lens Enhancements	Custom Progressive	$55 $95-$105 $150-$175	N/A	Every 12 months
Elective Contact Lenses	$150	$0	Up to $105	Every 12 months
	Contact Lens Exam (fitting and evaluation)	Up to $60		
Necessary Contact Lenses	Covered in Full	$5	Up to $210	Every 12 months

Manage Your Benefits

Go to www.equitable.com/employeebenefits and log on to **EB360®** to view your account details.

Find A Vision Provider

Visit www.equitable.com/findvision

Choose from 37,000 unique providers at 78,000 locations.

If you have any questions, please don't hesitate to contact us at 1-866-274-9887.

We look forward to helping you manage your benefits with confidence and ease.

More about your Vision coverage

If you are working for your employer on the effective date - the waiting period is the first of the month following 3 continuous days.
If you start working for your employer after the effective date - the waiting period is the first of the month following 0 continuous days.

An Employee who is employed on the effective date of the policy will receive credit towards satisfying the waiting period for time employed with the employer provided he or she was employed on the day prior to the effective date of the policy.

What is not covered?

Limitations: Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. You can find details regarding frame brand availability by calling the information number shown on your certificate information page.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Services provided without a benefit authorization or after expiration of a benefit authorization;
2. Services and/or materials not specifically included in the schedule of benefits;

3. Services received outside of the United States;
4. Orthoptics or vision training and any associated supplemental testing;
5. Plano lenses (less than a ±.38 diopter power);
6. Two pair of glasses in lieu of bifocals;
7. Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available;
8. Plano contact lenses to change eye color cosmetically;
9. Artistically-painted contact lenses;
10. Contact lens insurance policies or service contracts;
11. Additional office visits associated with contact lens pathology;
12. Contact lens modification, polishing or cleaning;
13. Costs for covered services and/or materials above the in-network or out-of-network benefit allowance;
14. Services or materials of a cosmetic nature;
15. Services and/or materials not indicated in this certificate as covered services;
16. Pathological treatment;
17. Laser or any other form of refractive surgery;
18. Pre- and post-operative services;
19. Local, state and/or federal taxes, except where we are required by law to pay;
20. Corrective vision treatment of an experimental nature.

This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Equitable is not affiliated with VSP®.

*Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company with main administrative headquarters in Jersey City, NJ; Equitable Advisors, LLC (member FINRA, SIPC); and Equitable Distributors, LLC. The obligations of Equitable Financial and Equitable America are backed solely by their claims-paying abilities.

All group insurance products are issued either by Equitable Financial or Equitable America, which have sole responsibility for their respective insurance and claims-paying obligations. Some products are not available in all states.

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GE-2839751 (6/20) (Exp. 6/22)

EQUITABLE

Vision

Benefit Summary

San Jose State University Research Foundation **Effective Date:** January 01, 2019

Policy Number: 004201

Class Definition: Class 2: All Active Retirees working at least 0 hours per week

An extensive vision coverage network that offers convenience and cost savings

Maintaining healthy eyes gives us the opportunity to see the important things in life - graduations, weddings, births, and everything in between. One of the best ways to protect your eye health is to visit an eye doctor regularly. Vision insurance can make those visits more convenient and less costly. We've partnered with a vision network, VSP ® Vision Care, to give you the freedom to choose from 37,000 unique providers at 78,000 locations.

What your benefits cover:

Coverage Type	In-Network Benefit	In-Network Copay	Out-of-Network Benefit	Frequency
Benefit Plan and Features				
Eye Examination	Covered in full	$5	Up to $45	Every 12 months
Prescription Eyeglasses		$5		
Frames	$150	Included in Prescription Eyeglasses Copay	Up to $70	Every 24 months
Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered in full	Included	Up to $30 Up to $50 Up to $65 Up to $100	Every 12 months
	Standard Progressive Premium Progressive			

Coverage Type	In-Network Benefit	In-Network Copay	Out-of-Network Benefit	Frequency
Lens Enhancements	Custom Progressive	$55 $95-$105 $150-$175	N/A	Every 12 months
Elective Contact Lenses	$150	$0	Up to $105	Every 12 months
	Contact Lens Exam (fitting and evaluation)	Up to $60		
Necessary Contact Lenses	Covered in Full	$5	Up to $210	Every 12 months

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If you have any questions, please don't hesitate to contact us at 1-866-274-9887.

We look forward to helping you manage your benefits with confidence and ease.

More about your Vision coverage

If you are working for your employer on the effective date - the waiting period is 0 continuous days.
If you start working for your employer after the effective date - the waiting period is 0 continuous days.

An Employee who is employed on the effective date of the policy will receive credit towards satisfying the waiting period for time employed with the employer provided he or she was employed on the day prior to the effective date of the policy.

What is not covered?

Limitations: Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. You can find details regarding frame brand availability by calling the information number shown on your certificate information page.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Services provided without a benefit authorization or after expiration of a benefit authorization;
2. Services and/or materials not specifically included in the schedule of benefits;

3. Services received outside of the United States;
4. Orthoptics or vision training and any associated supplemental testing;
5. Plano lenses (less than a ±.38 diopter power);
6. Two pair of glasses in lieu of bifocals;
7. Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available;
8. Plano contact lenses to change eye color cosmetically;
9. Artistically-painted contact lenses;
10. Contact lens insurance policies or service contracts;
11. Additional office visits associated with contact lens pathology;
12. Contact lens modification, polishing or cleaning;
13. Costs for covered services and/or materials above the in-network or out-of-network benefit allowance;
14. Services or materials of a cosmetic nature;
15. Services and/or materials not indicated in this certificate as covered services;
16. Pathological treatment;
17. Laser or any other form of refractive surgery;
18. Pre- and post-operative services;
19. Local, state and/or federal taxes, except where we are required by law to pay;
20. Corrective vision treatment of an experimental nature.

This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Equitable is not affiliated with VSP®.

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