Your Employee Benefits

Benefit Plans Effective January 1–December 31, 2025

IMPORTANT NOTICE

This Benefits Guide includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From EyeCare Partners LLC About Your Prescription Drug Coverage and Medicare."

Welcome to our 2025 Employee Benefits Guide!

At EyeCare Partners, we understand the importance of a well-rounded benefits program and are dedicated to providing you with unique benefits that meet the needs of you and your family. In this benefits guide, you'll find details for all of the benefits we offer to help protect you and your family.

Enclosed you will find:

- Step-by-step instructions for how to enroll.
- Summary information about each medical, dental, and vision benefit option.
- Additional benefits such as life insurance, the employee assistance program (EAP), and more.
- Directory and contact information, in case you have questions.
- And much more!

Thank you for your dedication to EyeCare Partners and our mission to Enhance Vision, Advance Eye Care, and Improve Lives.

Did You Know?

EyeCare Partners Funds your Healthcare Costs

As part of a "self-funding" healthcare model, EyeCare Partners not only subsidizes your monthly premiums but also assumes the financial responsibility for providing your healthcare benefits. This reflects our mission to **enhance vision, advance eye care, and improve lives**—not just through patient care, but by supporting our team members' overall health and wellbeing.

For example, after visiting your doctor, a claim is generated for the office visit. While you contribute through a copay or as part of your deductible, what happens if your healthcare bills exceed your deductible? Who pays the remaining costs—Anthem?

Actually, no.

Anthem offers a strong national network of healthcare providers and handles the processing of your claims to determine your portion of the costs. However, **EyeCare Partners** covers your hospital bills and healthcare expenses above your deductible and out-of-pocket maximums.

That's right—the organization you work for is covering those high-dollar claim costs for surgeries and procedures, not Anthem. This same organization that funds wage increases, headcount expansion, and other vital resources is also committed to ensuring your healthcare needs are met.

We deeply care about your wellbeing, as it aligns with our mission to improve lives. We encourage you to take full advantage of your healthcare benefits by being a smart healthcare consumer. By making choices that reduce overall healthcare costs, you are contributing to the financial health of our organization, which ultimately enhances our ability to support you and your colleagues.

Sincerely,

Billy Parsons, Chief Human Resources Officer

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WHO IS ELIGIBLE

If you are scheduled to work at least 30 hours per week, you are eligible for benefits on the first day of the month following 60 days of employment.

Many of the plans allow you to cover your eligible dependents, which include:

- Your legal spouse or domestic partner*.
- Your children to age 26, regardless of student, marital, or tax-dependent status (including a stepchild, legally-adopted child, a child placed with you for adoption, or a child for whom you are the legal guardian).
- Your dependent children of any age who are physically or mentally unable to care for themselves.

*DOMESTIC PARTNER IMPUTED INCOME: Under federal law, domestic partners do not share the same status and corresponding tax benefits as those of a legal spouse. The imputed income associated with your domestic partner's coverage will be added to your pay for tax purposes, and any additional taxes you owe as a result will be withheld from your paycheck. If your qualified domestic partner is an IRS tax code tax-dependent, coverage may be deducted pre-tax.

WHEN TO ENROLL

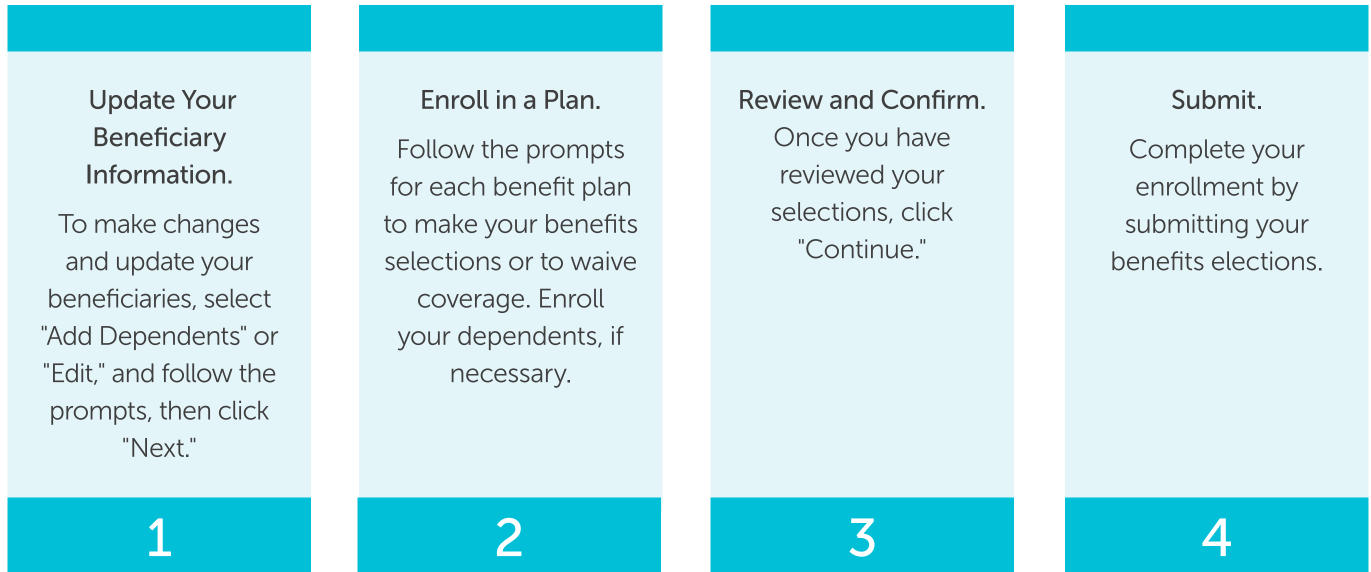
You can only sign up for benefits or change your benefits at the following times.

- Within 30 days of joining EyeCare Partners as a new employee: Complete the new hire paperwork.
- During the annual benefits enrollment period: See page 4.
- Within 60 days of a qualifying life event: Contact ECP Benefits email inbox.

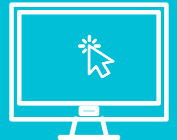
The choices you make at this time will remain in place from January 1, 2025, through December 31, 2025, unless you experience a qualifying life event as described on page 4. If you do not sign up for benefits during your initial eligibility period, you will not be able to elect coverage until the next open enrollment period.

HOW TO ENROLL

To enroll in benefits, log into dayforcehcm.com and log into your employee portal (Company: Eyecare). Click on the Menu icon (three horizontal lines) in the upper left-hand corner, then click "Benefits," then click "Overview," and select "Start Enrollment."



Open Enrollment is October 28 through November 15, 2024. Your current benefit elections **WILL NOT** carry over. If you wish to have benefits in 2025, you must log into Dayforce to make your elections by November 15, 2024.



CHANGING YOUR BENEFITS

Due to IRS regulations, once you have made your elections for 2025, you cannot change your benefits until the next annual open enrollment period.

The only exception is if you experience a qualifying life event. Election changes must be consistent with your life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation.
- Birth or adoption of an eligible child.
- Change in your spouse's work status that affects his or her benefits.
- Death of your spouse or covered child.
- Change in your child's eligibility for benefits.
- Qualified Medical Child Support Order.

To request a benefits change, notify the Benefits Department within 60 days of the qualifying life event. Change requests submitted after 60 days cannot be accepted. You will need to provide proof of the event, such as a marriage license or birth certificate.

MEDICAL INSURANCE

EyeCare Partners offers three medical plan options through Anthem/AmeriBen.

You have the freedom to choose any medical provider. However, you will maximize the plan benefits when you choose a network provider. Locate an Anthem provider at eyecarepartnershealthcare.com/auth/login-credential.

Before you enroll in medical coverage, take some time to fully understand how each plan works. Refer to page 6 for an overview of the plan benefits.

WHEN CHOOSING A PLAN, CONSIDER THIS:

Who is my medical carrier?

Your medical plans will be offered through Anthem Blue Cross Blue Shield. This means that you will want to utilize Anthem BCBS providers to maximize your benefit and minimize unnecessary out-of-network costs.

Who will administer my medical claims?

Anthem works closely with Ameriben to help administer your benefits. AmeriBen will be the claims administrator. AmeriBen will be working behind the scenes processing your claims, explanation of benefits, and managing your medical plan. You will receive your ID cards and explanation of benefits from AmeriBen. The ID cards will be sent by AmeriBen and include information about your medical and pharmacy benefits.

Who is Quantum Health?

Quantum Health Care Coordinators can provide you with personalized support and guidance when you need help on your health care journey and they work in tandem with Anthem and AmeriBen. Quantum Health Care Coordinators are here to simplify your health care experience by replacing ID cards, finding in-network providers, and more. From medical claims to check-ups and even pre-certifications, your Care Coordinators help organize and simplify your medical, dental, vision, and prescription benefits to provide you with a better care experience. See page 7 for more information.

MEDICAL COSTS

Listed below are the **biweekly** costs* for medical insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis. For post-tax domestic partner rates, please see Dayforce.

LEVEL OF COVERAGE	Standard HDHP Plan (biweekly rates)	Premium HDHP Plan (biweekly rates)	Premium PPO Plan (biweekly rates)
Employee Only	$52.83	$106.57	$94.53
Employee + Spouse	$234.45	$342.24	$339.14
Employee + Child(ren)	$166.69	$257.33	$252.95
Employee + Family	$332.45	$480.91	$473.13

*Your premiums may vary based on your payroll frequency.

MEDICAL INSURANCE

The table below summarizes the benefits of each medical plan.

The coinsurance amounts listed reflect the amount you pay. **Please refer to the official plan documents for additional information on coverage and exclusions.**

Summary of Covered Benefits	Standard HDHP Plan		Premium HDHP Plan		Premium PPO Plan	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Calendar Year Deductible Individual/Family	$4,000/$8,000	$4,500/$9,000	$2,000/$4,000	$2,500/$5,000	$1,500/$3,000	$2,000/$4,000
The amount that EyeCare Partners contributes to help you pay for out-of-pocket expenses	Health savings account eligible. EyeCare Partners will match your contributions up to $500 per year. See page 13 for more information.		Health savings account eligible. EyeCare Partners will match your contributions up to $500 per year. See page 13 for more information.		N/A	
Calendar Year Out-of-Pocket Maximum Individual/Family	Includes deductible, copays, and coinsurance $7,500/$9,200	$10,000/$20,000	$5,000/$8,500	$10,000/$20,000	$4,000/$8,000	$7,000/$14,000
Preventive Care	Plan pays 100%	40% after ded.	Plan pays 100%	40% after ded.	Plan pays 100%	40% after ded.
Physician Services						
Primary Care Physician	20% after ded.	40% after ded.	20% after ded.	40% after ded.	$25 copay	40% after ded.
Specialist	20% after ded.	40% after ded.	20% after ded.	40% after ded.	$60 copay	40% after ded.
Telemedicine	20% after ded.	Not covered	20% after ded.	Not covered	$15 copay	Not covered
Urgent Care	20% after ded.	40% after ded.	20% after ded.	40% after ded.	$60 copay	40% after ded.
Lab/X-Ray						
Diagnostic Lab/X-Ray	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
High-Tech Services (MRI, CT, PET)	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Hospital Services						
Inpatient	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Outpatient	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Emergency Room	20% after ded.		20% after ded.		$250 copay	
Behavioral Health	20% after ded.	40% after ded.	20% after ded.	40% after ded.	$25 copay	40% after ded.
Prescription Drugs	Ded. then,	Not covered	Ded. then,	Not covered		Not covered
Generic	$10 copay		$10 copay		$10 copay	
Formulary Brand	$35 copay		$35 copay		$35 copay	
Non-Formulary Brand	$60 copay		$60 copay		$60 copay	
Specialty	$35/$60 copay		$35/$60 copay		$150 copay	
Mail Order (Up to a 90-day supply)	2.5x retail copay		2.5x retail copay		2.5x retail copay	

ARE YOU COVERING YOUR SPOUSE /DOMESTIC PARTNER AND/OR CHILDREN?

- HDHP plans: The family deductible and out-of-pocket (OOP) maximums are non-embedded. The cost shares of all family members apply to one shared family deductible and OOP. There is no individual deductible or OOP except for those enrolled in employee only coverage.
- PPO plan: The family deductible and OOP maximum are embedded. The amounts for all covered family members apply to both the individual and family. No one member will pay more than the per person deductible or per person OOP maximum.

For personalized support and guidance when you need help with your medical benefits, please visit eyecarepartnershealthcare.com or contact a Quantum Health Care Coordinator at 855-497-1222.

MEDICAL INSURANCE

QUANTUM HEALTH

Whenever you have questions about your health care, your Quantum Care Coordinators are here to help. Get personalized support and guidance when you need help with medical claims, health benefits, prescriptions, and so much more—at no additional cost to you.

To get started, call 855-497-1222, visit eyecarepartnershealthcare.com, or scan the QR code.

Who are Quantum Care Coordinators?

Quantum Care Coordinators are nurses, clinicians, and benefit specialists who advocate for members' care.

They also:

- Serve as personal health care guides who get to know members' unique health and wellness needs and work with their providers to ensure members receive high-quality, safe, and cost effective care.
- Know EyeCare Partners benefits from top to bottom so they can help with any questions.
- Bring personalized health care solutions to members.

When do I contact my Quantum Care Coordinator?

Here are some common issues Quantum Care Coordinators help solve:

- Receiving ID cards.
- Answering claims, billing, and benefit questions.
- Managing a health condition.
- Saving money on out-of-pocket costs.
- Understanding how to get the most out of benefits.
- Learning simple steps to improving health.
- Helping with medical needs—anything that can make the health care process easier.

Visit eyecarepartnershealthcare.com for more information.

CONTACT YOUR QUANTUM CARE COORDINATOR

855-497-1222

Monday–Friday, 8:30 a.m.–10 p.m. ET

eyecarepartnershealthcare.com

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KEY TERMS TO KNOW

Copay

A fixed dollar amount you may pay for certain covered services. Typically, your copay is due at the time of service.

Deductible

The amount you must pay each year for certain covered health services before your insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay coinsurance, which is your share of the costs of a covered service.

OOP Maximum

This includes copays, deductibles, and coinsurance. Once you meet this amount, the plan pays 100% of covered services the rest of the year.

MEDICAL INSURANCE

IN-NETWORK PREVENTIVE CARE IS FREE FOR MEDICAL PLAN MEMBERS.

The cost of your preventive care is covered 100% by the EyeCare Partners medical plans. This means you won't have to pay anything out of your pocket. For all questions about your preventive health care, please contact a Quantum Health Care Coordinator at eyecarepartnershealthcare.com or call 855-497-1222.

WHAT IS PREVENTIVE CARE?

Preventive health care is meant to DETECT issues at an early stage when treatment is likely to work best and PREVENT future health problems.

WHY IS PREVENTIVE CARE IMPORTANT?

It is important that you have a preventive health exam each year—even if you feel healthy and are symptom free—in order to IDENTIFY FUTURE HEALTH RISKS.

WHAT'S COVERED?

Covered preventive services vary by age and gender. Talk with your provider to determine which SCREENINGS, TESTS, AND VACCINES will be covered and that are right for you.

Save money on your health care.

Choose an in-network provider.

Choose an in-network provider and you'll pay less out of your pocket. Why? Because in-network doctors and facilities contract with the insurance company and agree to charge a lower price for services. For help finding an in-network provider, contact a Quantum Health Care Coordinator at eyecarepartnershealthcare.com or call 855-497-1222.

Request an in-network lab.

When your doctor orders a test, confirm that an in-network lab will be used. If your tests are sent to an out-of-network lab, you may incur additional out-of-pocket expenses. For help finding an in-network lab, contact a Quantum Health Care Coordinator at eyecarepartnershealthcare.com or call 855-497-1222.

Call Lantern.

EyeCare Partners has partnered with Lantern (formerly known as SurgeryPlus) to help you find a board-certified surgeon for many different surgeries. If you are planning a procedure, please call Lantern and a dedicated Care Advocate will manage the entire process for you. Visit lanterncare.com to learn more!

Note: Some services are generally not considered preventive if you get them as part of a visit to diagnose, monitor, or treat an illness or injury. Please be aware that you will be responsible for the cost of any non-preventive care services you receive at your preventive care exam based on your plan design. Learn more about preventive care at eyecarepartnershealthcare.com.

MEDICAL INSURANCE

TELEHEALTH

You have access to telehealth through LiveHealth Online. Get the care you need when and wherever you need it. Whether you're on the go, at home, or at the office, care comes to you in the form of telehealth.

Get care for non-emergency conditions.

Telehealth can connect you to a doctor from your phone, computer, or tablet. Receive care for common health issues like allergies, asthma, sore throat, fever, headache, and much more.

Receive mental health support and counseling.

Licensed therapists can help diagnose and treat depression and anxiety, substance abuse and panic disorders, PTSD, grief and loss, and more. To schedule an appointment, call 888-548-3432 from 7 a.m. to 7 p.m. or visit livehealthonline.com.

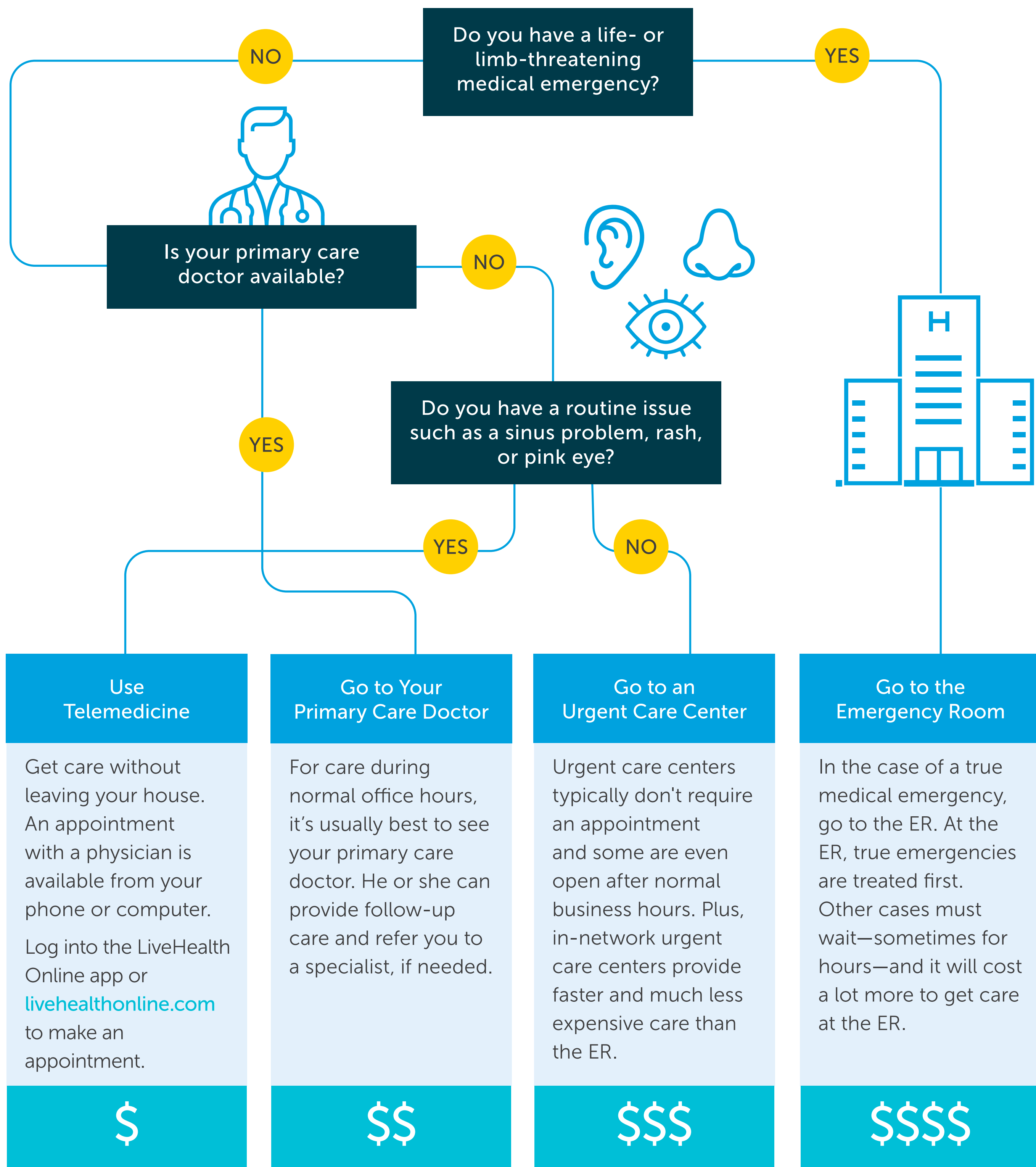
Talk with a doctor by phone or video, 24/7.

Use telehealth to prioritize your health by getting the care you need when you need it. Visit livehealthonline.com or download the LiveHealth Online app to get started.

MEDICAL INSURANCE

Know where to go for your health care.

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. Use the chart below to help you choose where to go for care.



For personalized support and guidance when you need help with your medical benefits, please visit eyecarepartnershealthcare.com or contact Quantum Health Care Coordinators at 855-497-1222.

DENTAL INSURANCE

EyeCare Partners offers a dental insurance plan through Delta Dental of MO.

You have the freedom to choose any dental provider. However, you will maximize the plan benefits when you choose a network provider. Locate a Delta Dental of MO PPO network provider at deltadentalmo.com. Members living outside of Missouri will also need to access deltadentalmo.com in order to find a network provider.

The table below summarizes key features of the dental plan. The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	Delta Dental of MO Dental Plan		
	In Network	Premier*	Out of Network*
Calendar Year Deductible Individual/Family	$50/$150	$50/$150	$50/$150
Calendar Year Benefit Maximum	$1,000		
Preventive Care (Oral exams, cleanings, x-rays)	Plan pays 100%		
Basic Services (Periodontal services, endodontic services, oral surgery, fillings)	20% after ded.	20% after ded.	20% after ded.
Major Services (Bridges, crowns [inlays/onlays], dentures [full/partial])	50% after ded.	50% after ded.	50% after ded.
Orthodontia Services (Children to age 19)	50%		
Orthodontia Lifetime Maximum	$1,000		

*Please note! By utilizing a Premier or out-of-network provider, you run the risk of being balance-billed by your provider, even for preventive care services. This means that you may be charged for the difference between the maximum allowable charge, allowed by Delta Dental, and the actual billed charges.

Your dentist can tell a lot about your overall health during your dental visit, including whether or not you may be developing diabetes, heart disease, kidney disease, and even some forms of cancer.

DENTAL COSTS

Listed below are the **biweekly** costs for dental insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis. For post-tax domestic partner rates, please see Dayforce.

LEVEL OF COVERAGE	Delta Dental of MO Dental Plan (biweekly rates)
Employee Only	$12.35
Employee + Spouse	$24.34
Employee + Child(ren)	$27.71
Employee + Family	$39.70

VISION INSURANCE

EyeCare Partners offers a vision insurance plan through VSP.

You have the freedom to choose any vision provider. However, you will maximize the plan benefits when you choose a network provider. Locate a VSP network provider at vsp.com.

The table below summarizes key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	VSP Vision Plan In Network	VSP Vision Plan Out of Network
Eye Exam (Every 12 months)	$20 copay	$45 allowance
Standard Plastic Lenses (Every 12 months)		
Single/Bifocal/Trifocal	$20 copay	$30/$50/$65 allowance
Frames (Every 12 months)	$200 allowance + 20% off balance	$70 allowance
Contact Lenses (Every 12 months in lieu of standard plastic lenses)		
Elective	$150 allowance	$105 allowance
Medically Necessary	Covered in full	$210 allowance

Even if you have perfect vision, an annual eye exam is important. Just by examining your eyes, a doctor can find warning signs of high blood pressure, diabetes, and more than 200 other major diseases.

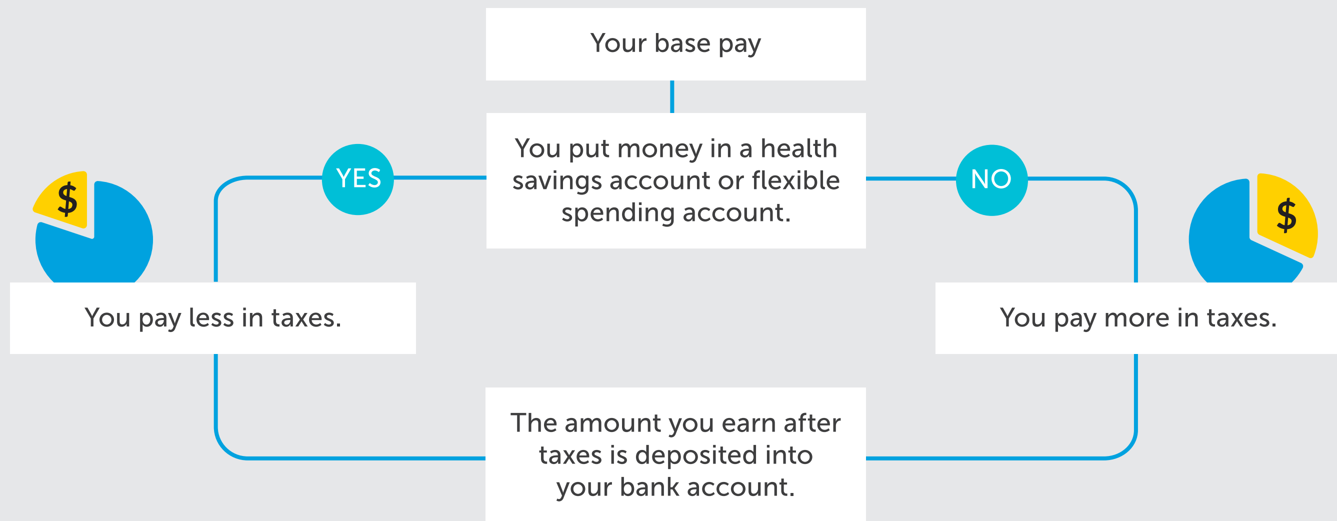
Your Vision Perks benefit can be used to supplement your vision coverage. You do not have to be enrolled in the vision plan to be eligible for Vision Perks. **See page 20 for details.**

VISION COSTS

Listed below are the **biweekly** costs for vision insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis.

LEVEL OF COVERAGE	VSP Vision Plan (biweekly rates)
Employee Only	$7.18
Employee + Spouse	$11.49
Employee + Child(ren)	$11.72
Employee + Family	$18.90

BUDGETING FOR YOUR CARE



When you put money into a health savings account or flexible spending account, you can save about 20%[1] on your care. This is because you don't pay taxes on your contributions.

COMPARE YOUR OPTIONS

	Health Savings Account More Info on Page 14	Health Care FSA[2] More Info on Page 15	Limited Purpose Health Care FSA[2] More Info on Page 15	Dependent Care FSA[2] More Info on Page 15
Eligible plans	Standard HDHP Plan or Premium HDHP Plan	Premium PPO Plan	All plans	All plans
Eligible expenses	Medical, dental, vision	Medical, dental, vision	Dental and vision only	Dependent care
EyeCare Partners contribution	Yes, contribution evenly distributed across 26 pay periods	No	No	No
Your contribution	Yes, contribution evenly distributed across 26 pay periods	Yes, available in full on January 1, 2025	Yes, available in full on January 1, 2025	Yes
You can change your election throughout the year	Yes	No	No	No
You can take income tax deductions for expenses you pay with your account	No	No	No	No
Annual IRS contribution maximum	Individual: $4,300 All other tiers: $8,550	$3,300	$3,300	Married and file separately: $2,500 Single and head of household or married and file jointly: $5,000
Funds roll over from one year to the next	Yes, unlimited	Yes, up to $660	Yes, up to $660	No

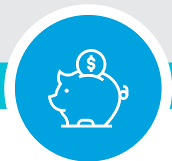
(1) Percentage varies based on your tax bracket. (2) Please note: Domestic partners and dependents of domestic partners are not eligible to participate in these accounts.

HEALTH SAVINGS ACCOUNT

MAXIMIZE YOUR TAX SAVINGS WITH AN HSA

SPEND

Use your HSA dollars today to pay for eligible health care expenses such as: deductibles, copays, dental expenses, eye exams, and prescriptions.



SAVE

Save your HSA funds for the future. An HSA allows you to save and roll over money year to year. The money in the account is always yours, even if you change health plans or even jobs.

INVEST

The money in your HSA can be invested and grows tax free—including interest and investment earnings. After you reach age 65, you can spend your HSA dollars penalty free on any expense.

If you enroll in the Standard or Premium HDHP Plan offered by EyeCare Partners, you may be eligible to open and fund a health savings account (HSA) through Rocky Mountain Reserve.

An HSA is a savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars.

EYECARE PARTNERS CONTRIBUTION

If you enroll in the Standard HDHP Plan or Premium HDHP Plan, EyeCare Partners will help you save by matching your contributions up to $500 per year (dollar for dollar).

Note: The matching contribution is deposited into your HSA every pay period.

2025 IRS HSA CONTRIBUTION MAXIMUMS

Contributions to an HSA cannot exceed the IRS allowed annual maximums.

- Individuals: $4,300
- All other coverage levels: $8,550

If you are age 55+ by December 31, 2025, you may contribute an additional $1,000.

HSA ELIGIBILITY

You are eligible to fund an HSA if you are enrolled in the Standard HDHP Plan or Premium HDHP Plan.

You are NOT eligible to fund an HSA if:

- If you are enrolled in the Premium PPO Plan
- You are covered by a non-HSA eligible medical plan, health care FSA, or health reimbursement arrangement.
- You are eligible to be claimed as a dependent on someone else's tax return.
- You are enrolled in Medicare, TRICARE, or TRICARE for Life.

Refer to IRS Publication 969 for eligibility details. If you are over age 65, contact the ECP Benefits email inbox.

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FLEXIBLE SPENDING ACCOUNTS

EyeCare Partners offers three flexible spending account (FSA) options administered by Rocky Mountain Reserve.

Log into your account at rockymountainreserve.com or download the RMR Benefits Mobile app to: view your account balance(s), calculate tax savings, view eligible expenses, download forms, view transaction history, and more.

HEALTH CARE FSA (NOT ALLOWED IF YOU FUND AN HSA)

Pay for eligible out-of-pocket medical, dental, and vision expenses with pre-tax dollars. Please note, if you are enrolled in either of the EyeCare Partners medical plans and you contribute to an HSA, you are not eligible to fund a health care FSA.

The health care FSA maximum contribution is $3,300 for the 2025 calendar year.

LIMITED PURPOSE HEALTH CARE FSA (IF YOU FUND AN HSA)

If you fund an HSA, you can also fund a limited purpose health care FSA. The limited purpose health care FSA can only be used for dental and vision expenses.

- At the end of the plan year, you can roll over $660 from your limited purpose health care FSA to use in future years. Any amount in excess of $660 will be forfeited.

The limited purpose health care FSA maximum contribution is $3,300 for the 2025 calendar year.

DEPENDENT CARE FSA

The dependent care FSA allows you to pay for eligible dependent day care expenses with pre-tax dollars. Eligible dependents are children under 13 years of age, or spouse, a child over 13, or elderly parent residing in your home who is physically or mentally unable to care for him or herself.

- Dependent care FSA dollars are use it or lose it (no roll over allowed). However, you have an additional 90 days after the end of the plan year to submit expenses for reimbursement.

You may contribute up to $5,000 to the dependent care FSA for the 2025 calendar year if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect $2,500 for the 2025 calendar year.

When you fund a dependent care FSA to the maximum amount ($5,000), you will save $1,000 per year.* This is because you don't pay taxes on your FSA contributions.

*Amount varies based on your tax bracket.

Please note: Domestic partners and dependents of domestic partners are not eligible to participate in these accounts.

LIFE AND AD&D INSURANCE

EyeCare Partners provides basic life and AD&D insurance to all benefits-eligible employees AT NO COST. You have the option to purchase supplemental life and AD&D insurance.

BASIC LIFE AND AD&D INSURANCE

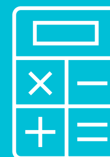
EyeCare Partners automatically provides basic life and AD&D insurance through Lincoln Financial to all benefits-eligible employees AT NO COST. If you die as a result of an accident, your beneficiary would receive both the life benefit and the AD&D benefit. **Please be sure to keep your beneficiary designations up to date.**

- Employee life benefit: 1x annual salary up to a maximum of $200,000
- Employee AD&D benefit: 1x annual salary up to a maximum of $200,000

Under Section 79 of the Internal Revenue Code, the cost of employee group term life insurance coverage provided by an employer in excess of $50,000 is includable in the gross income of active employees and reported on an employee's W-2 Form.

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. To protect those who depend on you for financial security, you may want to purchase supplemental coverage.

Use the calculator at lfg.com to find the right amount for you.



SUPPLEMENTAL LIFE AND AD&D INSURANCE

EyeCare Partners provides you the option to purchase supplemental life and AD&D insurance for yourself, your spouse/domestic partner, and your dependent children through Lincoln Financial.

You must purchase supplemental coverage for yourself in order to purchase coverage for your spouse/domestic partner and/or dependents. Supplemental life rates are age-banded. Benefits will reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75. Please refer to the official plan documents for additional information.

- Employee: $10,000 increments up to $500,000 or 5x annual salary, whichever is less—guarantee issue: $300,000
- Spouse/domestic partner: $5,000 increments up to $250,000 or 50% of the employee elected amount—guarantee issue: $50,000
- Dependent children: Birth to 14 days: $1,000; 14 days to age 26: $1,000, $5,000, or $10,000

If you elect supplemental coverage when you're first eligible to enroll, you may purchase up to the guarantee issue amount(s) without completing a statement of health (evidence of insurability).

If you have coverage and would like to increase your coverage at open enrollment, you may elect up to two increments for employees (one for spouses) up to the guarantee issue amount(s) without completing a statement of health (evidence of insurability).

If you do not enroll when first eligible, and choose to enroll during a subsequent annual open enrollment period, you will be required to submit evidence of insurability for any amount of coverage. Coverage will not take effect until approved by Lincoln Financial.

DISABILITY INSURANCE

Disability insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury.

SHORT-TERM DISABILITY

EyeCare Partners offers you the option to purchase short-term disability insurance (STD) through Lincoln Financial. STD insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury. Benefits will be reduced by other income, including state-mandated STD plans. Please refer to the official plan documents for additional information.

- Benefit: 60% of base weekly pay up to $600
- Elimination period: 7 days
- Benefit duration: Up to 13 weeks
- Pre-Existing condition: You will be subject to the pre-existing condition exclusion if your total disability begins in the first 12 consecutive months after your effective date and you have received medical treatment, consultation, care services, or medication for a sickness or injury during the first three months immediately prior to your effective date.

LONG-TERM DISABILITY

EyeCare Partners offers you the option to purchase long-term disability (LTD) insurance through Lincoln Financial. LTD insurance is designed to help you meet your financial needs if your disability extends beyond the STD period. Please refer to the official plan documents for additional information.

- Benefit: 60% of base monthly pay up to $7,500
- Elimination period: 90 days
- Benefit duration: Social Security normal retirement age

EXECUTIVE/PHYSICIAN BUY-UP LTD

- Benefit: 60% of base monthly pay up to $20,000
- Elimination period: 90 days
- Benefit duration: Social Security normal retirement age

MATERNITY LEAVE BENEFIT

Short-term disability (STD) is administered in combination with the Maternity Leave Benefit. Employees electing STD will not exceed 100% of normal pay, but will receive a coordination of STD and Maternity Leave Pay for the initial five weeks of leave. If employees enrolled in STD and are approved for this coverage, they will receive 40% (up to $6,000 weekly) of their normal pay through the maternity benefit on their regular pay cycle and 60% through Lincoln Financial (up to $600 weekly).

There is a one week "elimination period" when employees have started their leave of absence and their STD coverage begins. If employees begin their leave of absence immediately following the birth of their baby, employees will receive 100% of their normal pay (up to $6,000 weekly) from the maternity benefit for one week.

Employees are eligible for the maternity benefit after 180 days of service with EyeCare Partners. If an employee meets their 6-month anniversary date during the five weeks their maternity benefit would be paying out, the benefit will pay for the remaining time left in the 5 weeks since the birth event. Employees will not receive the full maternity benefit after reaching six months of service if the five weeks since the baby's date of birth has concluded.

Proof of birth from the hospital should be sent to the Leave of Absence email address (leaveofabsence@eyecare-partners.com) and Lincoln Financial (if the employee is FMLA eligible) for FMLA approval. This will ensure time out is excused.

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ACCIDENT INSURANCE

EyeCare Partners provides you the option to purchase accident insurance through Voya.

Accident insurance helps protect against the financial burden that accident-related costs can create. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Claims payments are made in flat amounts based on services incurred during an accident.

A health screening benefit of $50 per insured individual ($25 per child up to a maximum of $100 for all children) is included in this plan. Please refer to the official plan documents for additional information.

CRITICAL ILLNESS INSURANCE

EyeCare Partners provides you the option to purchase critical illness insurance through Voya.

Critical illness insurance provides a financial, lump-sum benefit upon diagnosis of a covered illness. These covered illnesses are typically very severe and likely to render the affected person incapable of working. Because of the financial strain these illnesses can place on individuals and families, critical illness insurance is designed to help you pay your mortgage, seek experimental treatment, or handle unexpected medical expenses. Please refer to the plan documents for additional information.

- **Employee benefit:** $10,000, $20,000, or $30,000
- **Spouse/domestic partner benefit:** $5,000, $10,000, or $15,000
- **Dependent children benefit:** $5,000, $10,000, or $15,000
- **Health screening benefit*:** $50 ($25 per child up to a maximum of $100 for all children)

*Voya will pay you to get your preventive screenings each year. Contact Voya at 877-236-7564 for more information about your wellness benefit.

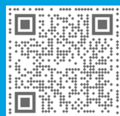
HOSPITAL INDEMNITY INSURANCE

EyeCare Partners provides you the option to purchase hospital indemnity insurance through Voya.

Hospital indemnity insurance pays a daily benefit if you have a covered stay in a hospital, critical care unit, or rehabilitation facility. The benefit amount is determined by the type of facility and the number of days you stay.

A health screening benefit is automatically included in the plan. This plan will pay $100 per insured individual per calendar year when a covered health screening test is performed. The benefit for child coverage is 50% of your benefit amount with an annual maximum of $200 for all children.

Please refer to the official plan documents for additional information.



Scan the QR code to learn more!

WHEN HELP IS NEEDED

ECP CARES—CRISIS AID RELIEF FOR EMPLOYEES

At EyeCare Partners, we are a team. Coming together to support each other allows us to continue to grow and best serve our patients.

The ECP Crisis Aid Relief for Employees (CAREs) Foundation is our 501(c)(3) nonprofit organization that allows ECP teammates to support their coworkers in times of need. By making a tax-deductible donation, team members can help others who are experiencing significant hardships, including health concerns, unexpected medical expenses, home/property damage due to natural disasters, domestic violence, and expenses to assist with the loss of a family member. 100% of the funds donated to the ECP CAREs Foundation go to fellow ECP team members.

You can help by electing to donate through payroll deductions in Dayforce. Elections can be made during open enrollment and changed throughout the year.

To learn more about how to donate or apply for assistance, visit eyecare-partners.com/ecpcares.

EMPLOYEE ASSISTANCE PROGRAM

Employee assistance program (EAP) services are provided AT NO COST to you and your household through Lincoln Financial Group.

Your EAP is a free, strictly confidential service that includes 24/7 online and telephonic counseling and up to **5 free sessions with a counselor** per person, per issue, per year.

The EAP provides unlimited phone access and assistance with the following every day issues:

- Depression, stress, and anxiety
- Parenting and child care
- Senior care
- Financial consultations
- Legal concerns
- Family or marital conflicts
- Major life changes
- Emotional and work-life balance

Additional services include:

- Unlimited phone access to a financial expert.
- Unlimited phone access an attorney; includes one free 30-minute face-to-face consultation per legal issue and 25% discount off published fees with a network attorney

Access your EAP by calling 888-628-4824 or visiting guidanceresources.com (username: LFGSupport; password: LFGSupport1).

Feeling burnt out or stretched thin?

Need help finding care for your child or loved one?

Want to talk with someone for 24/7 support when it's convenient for you?

The free EAP can support you. Call 888-628-482 or visit guidanceresources.com.

401(k) RETIREMENT SAVINGS PLAN

EyeCare Partners offers a 401(k) retirement savings plan, which is administered by Vanguard.

The 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. All employees are eligible to participate in the plan on the first of the month following two months of service.

ENROLLMENT AND ACCOUNT ACCESS

To enroll in the 401(k) plan, please visit vanguard.com/retirementplans or download the Vanguard app to enroll online or contact Vanguard at 800-523-1188 to receive your enrollment forms. Your plan number to register is 092337. **Note: New employees that do not take any action will be enrolled in the plan at 3% once eligibility is met on a pre-tax basis. New employees will be automatically enrolled 30 days after becoming eligible to participate in the plan.**

You can opt out of contributing, change the contribution amount, check your 401(k) account balance, select different investments at any time and more by visiting vanguard.com/retirementplans. You can even utilize the financial wellness calculators to calculate how much to expect for retirement based on your current contributions. For login or password assistance, please contact Vanguard at 800-523-1188.

EMPLOYER MATCH

EyeCare Partners will match 50% of the employee's contribution up to a maximum of 6% on a per pay period basis. The below schedule represents a 5-year vesting schedule for the employer match. For example, after you have worked for the company for 3 years, 60% of the employer match will be vested (your money).

To maximize your employer match consider spreading out your contributions throughout the year. When front-loading your 401(k) contributions, you may risk in missing potential employer match opportunities.

401(k) EMPLOYER MATCH VESTING SCHEDULE

- Less than 1 year of service: 0% employer match
- 1 year of service: 20% employer match
- 2 years of service: 40% employer match
- 3 years of service: 60% employer match
- 4 years of service: 80% employer match
- 5 years of service: 100% employer match

EMPLOYEE DEFERRAL 2025

Employee deferrals are always 100% vested.

- Employee Compensation Deferral: Between 1% and 100%, but no more than $22,500.*
- Employee 50 years +: $7,500* additional contribution.
- Investments: Over 31 funds from a variety of fund managers provided by Vanguard.
- Changes in Deferral: You may enroll, change, or cancel your salary contributions at any time online by visiting vanguard.com/retirementplans or by calling 800-523-1188. Changes will be effective in payroll as soon as administratively feasible following the date of change.
- Deferral/Investment: Changes to your future savings as well as transferring funds among investment options can be done any time via my.vanguardplan.com or by calling 800-523-1188.

*Amount subject to change. 2025 maximums not yet released at time of publication.

PAID TIME OFF

(NON-DOCTORS)

Paid time off is available so you can relax, maintain your health, and take care of yourself or your family.

EyeCare Partners values your time and we also recognize the importance of taking time away from work to rest and recharge, or attend to your health and family obligations.

Paid time off (PTO) benefits are available to full-time team members regularly working 30 or more hours per week to use after PTO has been accrued as set forth in the chart below. Part-time team members are not eligible for this benefit.

PTO accrues each pay period during the calendar year and is calculated on the total number of PTO hours for the year, divided across all 26 payroll periods. PTO accruals increase on January 1 in the year in which a milestone anniversary occurs.

New hires start accruing PTO on their first paycheck. In the first year of employment, total PTO accrual is prorated based on hire date and remaining payroll periods for the year (e.g., per payroll accrual amount times remaining payroll periods from the hire date). New hire team members are eligible to begin using PTO after it is accrued. Team members are able to carry over 60 hours of PTO per year.

PTO is accrued as shown below. Please refer to the Team Member Handbook for additional information.

YEARS OF SERVICE	PTO Accrual					
	Level 1		Level 2		Level 3	
	Days	Hours	Days	Hours	Days	Hours
0–2	12	96	15	120	17	136
3–4	14	112	17	136	20	160
5–6	17	136	19	152	20	160
7–10	19	152	21	168	21	168
11–14	21	168	22	176	22	176
15+	22	176	22	176	22	176

Level 1—Field & Center Staff, and Corporate Staff, Assistant Manager/Lead
Level 2—Office & Center Managers; Corporate Supervisors
Level 3—District, Practice & Region Managers; Corporate Managers, Practice Administrators

VISION PERKS BENEFIT

Full-time and part-time team members receive a $200 benefit amount ($100 for employees under 1 year of service) for immediate access to EyeCare Partners products and services. Vision Perks funds can be used on product and service purchases for team members and eligible family members at any EyeCare Partners location. The funds in your virtual account can be used toward the employee price for frames, lenses, lens options, medical services, or contacts and LASIK.

Eligible team members will receive the $200 benefit amount in April each year. New hires will be eligible for their funds at the start of the quarter following 60 days of employment. More details about your Vision Perks benefit can be found on the ECP intranet.

TRAVEL ASSISTANCE

EyeCare Partners provides access to travel assistance services to all benefits-eligible employees AT NO COST through Lincoln Financial Group.

The TravelConnect® program offers help, comfort, and reassurance—helping make travel less stressful. You and your loved ones can count on TravelConnect services 24 hours a day, seven days a week.

- Emergency travel arrangements.
- Assistance in replacing lost or stolen travel documents.
- Referrals to medical or dental providers worldwide.
- Emergency translation services.
- Assistance with the monitoring of medical treatment, hospital payment, and transfer of insurance information.
- Emergency medical travel and more.

Visit mysearchlightportal.com (group ID: LFGTravel123) to learn more.

EMPLOYEE DISCOUNTS

TICKETSATWORK

This cost-free benefit provides you access to thousands of exclusive travel and entertainment discounts. Register at ticketsatwork.com, click "Become a Member," and enter the company code: EYECAREPERKS.

RENTAL CAR DISCOUNTS

- Hertz: Varying discounts on leisure and professional travel rates and benefits. Visit hertz.com or call 800-654-3131. Enter or mention 1789573 as your Hertz CDP-ID when making your reservation.

MOBILE CARRIER DISCOUNTS

- AT&T: 25% off eligible voice and data plans. Register at att.com/wireless/premiergpo (FAN Code: 07741468). An email address will be required to register.
- Verizon: Up to 22% off eligible voice and text plans. Register at verizonwireless.com/discount and enter your work email address or upload a copy of your current pay stub, or visit a local Verizon Wireless store with proof of employment.

CORESTREAM VOLUNTARY BENEFITS

EyeCare Partners provides the following money-saving benefits and discounts through Corestream.

- Legal services: Access to experienced attorneys to help with legal matters such as wills, traffic tickets, and more.
- Discount shopping: Shop the brands you love with exclusive discounts you can't get anywhere else.
- ID theft protection: Protect your financial and social wellness from identity thieves.
- Pet insurance: Two plans available to protect your pet and your wallet with exceptional savings on veterinary bills.
- Auto and home insurance: Quickly shop your auto and home Insurance with multiple providers to find the best fit for your lifestyle and your wallet.

Visit eyecare.corestream.com or call 636-213-3310 to learn more.

EyeCare Partners LLC

HEALTH PLAN NOTICES

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1. Medicare Part D Creditable Coverage Notice
2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Women's Health and Cancer Rights Notice

IMPORTANT NOTICE
This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From EyeCare Partners LLC About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM EYECARE PARTNERS LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with EyeCare Partners LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. EyeCare Partners LLC has determined that the prescription drug coverage offered by the EyeCare Partners LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the EyeCare Partners LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the EyeCare Partners LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the EyeCare Partners LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your EyeCare Partners LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 636-227-2600. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through EyeCare Partners LLC changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Ann Buscavage
Contact—Position/Office:	Senior Director, Total Rewards
Address:	15933 Clayton Rd, Ste. 210 Ballwin, MO 63011
Phone Number:	636-227-2600

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

IMPORTANT NOTICES

EYECARE PARTNERS LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

EyeCare Partners LLC Health and Welfare Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this
notice, EyeCare Partners LLC is referred to as Company.

IMPORTANT NOTICES

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you

choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official

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Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Ann Buscavage
Senior Director, Total Rewards
636-227-2600

Effective Date

The effective date of this notice is: January 1, 2025.

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

NOTICE OF SPECIAL ENROLLMENT RIGHTS

EYECARE PARTNERS LLC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Ann Buscavage
Senior Director, Total Rewards
636-227-2600

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Ann Buscavage
Senior Director, Total Rewards
15933 Clayton Rd, Ste. 210
Ballwin, MO 63011
636-227-2600

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

EyeCare Partners LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The EyeCare Partners LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Standard HDHP Plan	In-Network	Out-of-Network
Individual Deductible	$4,000	$4,500
Family Deductible	$8,000	$9,000
Coinsurance	20%	40%
Premium HDHP Plan	In-Network	Out-of-Network
Individual Deductible	$2,000	$2,500
Family Deductible	$4,000	$5,000
Coinsurance	20%	40%

Premium PPO Plan	In-Network	Out-of-Network
Individual Deductible	$1,500	$2,000
Family Deductible	$3,000	$4,000
Coinsurance	20%	40%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Ann Buscavage
Senior Director, Total Rewards
636-227-2600

CONTACT INFORMATION

If you have any questions regarding your benefits or the material contained in this guide, please contact EyeCare Partners Benefits Department by emailing benefits@eyecare-partners.com.

Provider/Plan	Policy Number	Contact Number	Website
Medical—Quantum Health Care Coordinators	0121016	855-497-1222	eyecarepartnershealthcare.com
Healthcare Navigation—Quantum Health Care Coordinators	0121016	855-497-1222	eyecarepartnershealthcare.com
Surgery Assistance—Lantern	N/A	833-469-2021	lanterncare.com
Dental—Delta Dental of MO	22681000	800-335-8266	deltadentalmo.com
Vision—VSP	30046581	800-877-7195	vsp.com
Health Savings Account—Rocky Mountain Reserve	N/A	888-722-1223	rockymountainreserve.com
Flexible Spending Accounts—Rocky Mountain Reserve	N/A	888-722-1223	rockymountainreserve.com
Life and Disability Insurance—Lincoln Financial Group	09-LF0515	800-320-7585	lfg.com
Accident, Critical Illness, and Hospital Indemnity Insurance—Voya	69722-2	877-236-7564 Claims: 888-238-4840	voya.com
Employee Assistance Program—EmployeeConnect	N/A	888-628-4824	guidanceresources.com (username: LFGSupport; password: LFGSupport1)
401(k) Retirement Savings Plan—Vanguard	092337	800-523-1188	vanguard.com/retirementplans
Corestream Voluntary Benefits	N/A	636-213-3310	eyecare.corestream.com

This summary of benefits is not intended to be a complete description of the terms and EyeCare Partners insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although EyeCare Partners maintains its benefit plans on an ongoing basis, EyeCare Partners reserves the right to terminate or amend each plan, in its entirety or in any part at any time.

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