

Client Vision Care Plan



Client Name: WORTHINGTON STEEL, INC.
Client Number: 40156274
Effective Date: JANUARY 1, 2024

EVIDENCE OF COVERAGE

VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
(916) 851-5000 (800) 877-7195

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

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

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

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

ELIGIBILITY FOR COVERAGE

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

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

HOW TO USE THIS PLAN

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

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

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

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

TO OBTAIN FURTHER INFORMATION

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

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

URGENT VISION CARE

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

HOLD HARMLESS

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

COMPLAINTS AND GRIEVANCES

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

CLAIM PAYMENTS AND DENIALS

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

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

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

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

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

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

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

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

DEFINITIONS:

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

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan® Plan B

GENERAL

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

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

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

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

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

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

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

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

FRAMES - Covered up to the Plan allowance* once every 24 months**

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

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of \$50.00 once every 24 months**.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$120.00 once every 12 months**

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

NECESSARY

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

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

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

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology

**REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS**

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

FRAMES: Covered up to \$ 70.00* once every 24 months**

CONTACT LENSES

Elective

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

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

Necessary

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

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

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

*Less any applicable Copayment.

**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to \$125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee, up to \$1,000.00*

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

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

*Less any applicable Copayment.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

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

EXHIBIT A

SCHEDULE OF BENEFITS VSP Choice Plan® Plan C

GENERAL

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

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

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

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

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

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

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

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Standard Progressive Lenses covered in full.

LENS OPTIONS

Anti-reflective coating covered in full¹ once every 12 months.**

Polycarbonate Lenses covered in full once every 12 months.**

Premium and Custom Progressive lenses covered in full² once every 12 months.**

Tinted/Photochromic covered in full once every 12 months.**

¹After \$40.00 Copayment.

²After \$50.00 Copayment.

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

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

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of \$50.00 once every 12 months**.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to \$120.00 once every 12 months**

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

NECESSARY

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

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

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

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology

**REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS**

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to \$ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to \$ 30.00* once every 12 months**

Bifocal Up to \$ 50.00* once every 12 months**

Trifocal Up to \$ 65.00* once every 12 months**

Lenticular Up to \$100.00* once every 12 months**

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

CONTACT LENSES

Elective

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

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

Necessary

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

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

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

*Less any applicable Copayment.

**beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to \$125.00*.

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

Supplemental Aids: 75% of Open Access Provider's fee, up to \$1,000.00*

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

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

*Less any applicable Copayment.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

OPEN ACCESS PROVIDERS

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

EXHIBIT C

ADDITIONAL BENEFIT RIDER SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

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

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

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

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

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

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

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

**PLAN BENEFITS
VSP PREFERRED PROVIDERS**

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of \$20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

EXHIBIT C

ADDITIONAL BENEFIT RIDER ProTec Safety®

GENERAL

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

ELIGIBILITY

The Enrollee shall be the Covered Person under this Plan.

COVERED PERSONS WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE PROTEC SAFETY PLAN.

PLAN BENEFITS

VSP PREFERRED PROVIDERS

COPAYMENT

There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of \$65.00 payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

LENSES- Covered in full* once every 24 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

VSP Preferred Providers shall ensure that lenses provided under ProTec Safety meet all current standards established by the American National Standards Institute (ANSI).

PROTEC EYEWEAR® FRAMES† - Covered in full* once every 24 months**

VSP Preferred Providers shall ensure that frames provided under ProTec Safety meet all current ANSI standards.

†Frames available under ProTec Safety are those included in the ProTec Safety Eyewear frame kit.

Should Covered Person choose a frame outside of the ProTec Eyewear frame kit, Covered Person may incur out-of-pocket expenses.

LENS OPTIONS

Polycarbonate Lenses covered in full once every 24 months.**

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
- Two pair of glasses instead of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lenses, contact lens services, contact lens insurance policies or service agreements.
- Replacement of lost or damaged contact lenses.
- Refitting of contact lenses.
- Contact lens modifications, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- No coordination of benefits.
- No dependent coverage.
- Everyday eyewear lenses instead of safety materials.
- Eye examinations, unless specifically noted in this ProTec Safety Rider as a covered benefit.

Summary of Benefits and Coverage

VSP Choice Plan

Plan B

Prepared for: WORTHINGTON STEEL, INC.

Group ID: 40156274

Effective Date: JANUARY 1, 2024

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

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

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations and Exceptions |
|--|----------------------------|--|--|--|
| | | In-Network Provider | Out-of-Network Provider | |
| If you or your dependents (if applicable) need eyecare | Eye Exam | \$20.00 Copay | Reimbursed up to \$45.00 | Exam covered in full every 12 months** |
| | Frames, Lenses or Contacts | Glasses: \$25.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam | Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00 | Frames covered every 24 months** Lenses covered every 12 months** |
| | Fees | | | |

** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage

VSP Choice Plan

Plan C

Prepared for: WORTHINGTON STEEL, INC.

Group ID: 40156274

Effective Date: JANUARY 1, 2024

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

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

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations and Exceptions |
|--|----------------------------|---|--|--|
| | | In-Network Provider | Out-of-Network Provider | |
| If you or your dependents (if applicable) need eyecare | Eye Exam | \$20.00 Copay | Reimbursed up to \$45.00 | Exam covered in full every 12 months** |
| | Frames, Lenses or Contacts | Glasses: \$25.00 Copay (lenses and/or frames only); Up to \$60.00 copay for Contact Lens Exam | Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 30.00 Bi-Focal Lenses reimbursed up to \$ 50.00 Tri-Focal Lenses reimbursed up to \$ 65.00 Lenticular Lenses reimbursed up to \$100.00 ECL reimbursed up to \$105.00 | Frames covered every 12 months** Lenses covered every 12 months** |
| | Fees | | | |

** Beginning with the first day of the Benefit Period.

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