

**VSP**  
**Disclosure Statement**  
**and**  
**Evidence of Coverage**

Contract Number 00101923

January 2008

**UNIVERSITY OF CALIFORNIA**  
**Plan Administrator**

UNIVERSITY OF CALIFORNIA  
Office of the President  
Employee Benefits Plan Administration  
300 Lakeside Drive, 5th Floor  
Oakland, CA 94612-3557

Provided by:



3333 Quality Drive  
Rancho Cordova, CA 95670  
800-877-7195  
vsp.com

T.D.D. for the hearing impaired  
800-428-4833

## FOREWORD

The University of California sponsored vision plan from VSP provides vision care coverage for eligible employees and their eligible family members.

This Disclosure Statement and Evidence of Coverage constitutes only a summary. The University's vision plan is fully governed by the terms and conditions of the contract between The Regents of the University of California and VSP, and by the University's Group Insurance Regulations. Those terms and conditions apply if information in this publication is not the same. Some provisions of the program may not apply to employees in certain exclusively represented bargaining units.

## TABLE OF CONTENTS

Foreword.....	1
Eligibility, Enrollment, Termination and Plan Administration Provisions .....	R1 - R10
Summary of Benefits.....	3 - 5
VSP Network Doctor and Non-VSP Provider Copay Schedule .....	5 - 6
Provisions for a Non-VSP Provider .....	6
Provisions for a VSP Network Doctor .....	6
Filing a Claim for Non-VSP Provider Services.....	6 - 7
Out-of-Network Reimbursement Schedule.....	7 - 8
Exclusions and Limitations.....	8
Procedure for Using the Plan .....	8 - 9
Request for Appeals .....	9 - 10
Complaints and Grievances .....	10 - 11
Liability in Event of Non-Payment.....	11
Terms and Cancellations.....	11
Definitions .....	11 - 12

**University of California  
Eligibility, Enrollment,  
Termination and  
Plan Administration Provisions  
Plan Year 2008**

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own health and welfare plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"). Portions of these Regulations are summarized below.

**ELIGIBILITY**

The following individuals are eligible to enroll in this Plan:

**Subscriber**

Employee: You are eligible if you have an appointment type which is eligible for benefits, and are a member of a UC-sponsored retirement plan. Generally, there are two ways to qualify for UCRP membership:

1. you are appointed to work at least 50% time for a year or more or
2. you worked 1,000\* hours in a rolling twelve-month period in a position eligible for UCRP membership. To remain eligible, you must maintain an average regular paid time\*\* of at least 17.5 hours per week and continue in an eligible appointment.

\* Lecturers - see your Benefits Office for eligibility.

\*\* Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

## Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the specific Participation Terms and Conditions outlined on the form and the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return or other official documentation.

Spouse:

Your legal spouse

Child:

All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% their support and are your or your spouse's dependents for income tax purposes;
- (c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
- (d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- (a) the incapacity began before age 23, the child was enrolled in a group vision plan

- before age 23 and coverage is continuous;
- (b) the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
  - (c) the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored health plan are eligible for continued coverage under any other University-sponsored vision plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group vision coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

### **Other Eligible Dependents (Family Members):**

You may enroll a same-sex domestic partner (and the same-sex domestic partner's children grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security

benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

### **Additional Requirements**

If you enroll your eligible domestic partner and/or your partner's eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, the UC/employer contribution for their medical and/or dental and/or vision coverage may be considered your taxable income, subject to FICA (Social Security and Medicare and federal and California state income tax withholding).

### **No Dual Coverage**

Eligible individuals may be covered under only one of the following categories: as an Employee, or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or same-sex domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or domestic partner's coverage but not under both.

### **More Information**

For more information on who qualifies for vision coverage, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the Web site: <http://atyourservice.ucop.edu>.

## **ENROLLMENT**

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. Enrollment

transactions may be completed by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

### **During a Period of Initial Eligibility (PIE)**

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in:

- (a) For a spouse, on the date of marriage
- (b) For a natural child, on the child's date of birth
- (c) For an adopted child, the earlier of:
  - (i) the date you or your Spouse has the legal right to control the child's health care, or
  - (ii) the date the child is placed in your physical custody.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

- (d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group



plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your family members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

### **At Other Times**

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

### **Effective Date**

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

An employee already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE.

Retroactive coverage is limited to the later of:

- (a) the date the child becomes eligible, or
- (b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

### **Change in Coverage**

In order to change from single to adult plus child(ren) coverage, or two-adult coverage, or family coverage or to add another Family Member to existing family coverage, contact the person who handles benefits at your location.

## **TERMINATION OF COVERAGE**

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described

below. Additional Plan provisions apply and are described elsewhere in the document.

### **De-enrollment Due to Loss of Eligible Status**

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on de-enrollment procedures, contact the person who handles benefits at your location.

### **De-Enrollment Due to Misuse**

Coverage for you or your Family Members may be terminated for misuse of the Plan, including but not limited to such actions as fraud or deception in the use of the services of the Plan, knowingly permitting such fraud or deception by another, or threats or abusive behavior towards Plan providers or representatives. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who misuses the Plan will be permanently de-enrolled while any other Family Member and the Subscriber will be de-enrolled for 12 months. If a Subscriber misuses the Plan, the Subscriber and any Family Members will be de-enrolled for 12 months.

### **Leave of Absence or Layoff**

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence or layoff.

### **Optional Continuation of Coverage**

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended

and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UC benefits Web site (<http://atyourservice.ucop.edu>). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center.

## **PLAN ADMINISTRATION**

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the insurance contract. What is written in this document does not constitute a guarantee of plan coverage or benefits - particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

### **Sponsorship and Administration of the Plan**

The University of California is the Plan sponsor for

the Plan described in this booklet. If you have a question, you may direct it to:

University of California  
Human Resources and Benefits  
Health & Welfare Administration  
300 Lakeside Drive, 12th Floor  
Oakland, CA 94612-3557  
(800) 888-8267

Claims under the Plan are processed by VSP at the following address and phone number:

VSP  
3333 Quality Drive  
Rancho Cordova, California 95670  
(800) 877-7195

### **Group Contract Number**

The Group Contract Number for this Plan is:  
00101923

### **Type of Plan**

This Plan is a health and welfare plan that provides group vision benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

### **Plan Year**

The plan year is January 1 through December 31.

### **Continuation of the Plan**

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, and what portion of the premiums you and the University will pay. The portion of the premiums that the University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

## **Financial Arrangements**

The benefits under the Plan are provided by VSP under an insurance contract. The cost of the premiums is currently paid entirely by the University of California.

## **Agent for Serving of Legal Process**

Legal process may be served on VSP, at the address listed above.

## **Your Rights under the Plan**

As a participant in a University of California health plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Insurance contract, at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

## **Nondiscrimination Statement**

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

## SUMMARY OF BENEFITS

The benefits described herein are available to you from any VSP network doctor or non-VSP provider.

If you choose to visit a VSP network doctor, there is a copay amount payable by you to the VSP network doctor at the time of the exam and a separate copay when frames and lenses are ordered. Note: The copays do not apply to the exam/materials for contact lenses.

1. **Exam:** You are entitled to a comprehensive eye exam to determine the presence of vision problems or other abnormalities. Services shall be provided once every calendar year.
2. **Lenses:** The VSP network doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Tinted and polycarbonate lenses are covered in full when dispensed by a VSP network doctor. Lenses shall be provided once every calendar year.
3. **Frame:** VSP covers a frame allowance of up to \$130. The frame benefit provides you the choice to select a frame that fits your lifestyle. If you choose a frame valued at more than your allowance, you will save 20% on your out-of-pocket costs. Have your doctor help you choose the best frame for you based on your VSP coverage. Frames shall be provided once every other calendar year. For information on how your eligibility for frames may be affected if you receive contact lenses, please see "Contact Lenses" below.

VSP offers even more value by providing a 20% discount on additional pairs of prescription and non-prescription glasses including sunglasses.

4. **Contact Lenses:** Elective contact lenses are covered up to \$110.00. This allowance includes the cost of the eye exam, the contact lens fitting and evaluation exam and the contact lenses. The contact lens exam is a separate exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. The contact lens exam is covered only when billed with contact lenses. Contact lenses are in lieu of all other benefits (exam, lenses and frames) for that eligibility period. Copays do not apply.  
Note: If you get contact lenses, you cannot

receive lenses for glasses or contact lenses until the next calendar year. You will not be eligible to receive frames again until the second calendar year. For example, if you get contact lenses in July 2007, the earliest you would be eligible to receive frames again would be January 2009 (this assumes you do not receive contacts in 2008).

Medically necessary contact lenses may be prescribed by a VSP network doctor for certain conditions. A VSP network doctor must receive prior approval from VSP for medically necessary contact lenses. When the VSP network doctor receives prior approval for such cases, they are fully covered by VSP and are in lieu of all benefits for that eligibility time period. If you receive medically necessary contact lenses through a non-VSP provider, you will be reimbursed according to a provider schedule (see page 7).

VSP's additional value is also extended to include 15% discount on contact lens fitting and evaluation services. The discount does not apply to the cost of the materials. This benefit is available in conjunction with your VSP contact lens allowance or you can use it to purchase contacts in addition to glasses.

The additional discounts are available from any VSP doctor within 12 months of your last eye exam.

5. **Laser VisionCare<sup>SM</sup>:** VSP has contracted with many of the nation's finest laser surgery facilities and doctors offering you access to laser vision correction surgery for hundreds of dollars less than what you might pay privately. Details about VSP's Laser VisionCare program as well as comprehensive information about laser vision correction surgery can be found on the VSP Web site ([vsp.com](http://vsp.com)) or by contacting VSP at 800-877-7195.

**Sunglasses following Laser Vision Surgery:** Beginning January 1, 2008, members who

have had laser vision surgery can use their frame allowance to buy non-prescription sunglasses from their VSP doctor.

6. **Low Vision:** The Low Vision benefit is available if you have severe visual problems that are not correctable with regular lenses. This benefit is subject to the following limitations:
- a. **Prior Authorization** - When a VSP network doctor suspects a low vision condition, the doctor requests advance approval prior to beginning service. VSP consultants may authorize supplementary testing by the doctor to determine the nature of the problem and to allow the doctor to gather enough facts to propose a treatment plan. The supplementary testing is paid by the Plan with no copay by you.
  - b. **Copay** - After supplementary testing, the doctor submits the treatment plan to VSP consultants for review. If the Plan is approved, the VSP consultants will authorize benefits on a copay basis with 75% of the cost being paid by VSP and 25% of the cost being paid by you.
  - c. **Maximum Benefit** - VSP will pay a maximum of \$1,000 (excluding copays) every two (2) calendar years for approved Low Vision care. The maximum includes the Supplementary Testing.

Low Vision benefits secured from a non-VSP provider are subject to the same time limits and copay arrangements as described herein for a VSP network doctor. You should pay the non-VSP provider the full fee. You will be reimbursed up to \$1,000 every two years. You will be responsible for amounts in excess of this limit.

## **VSP NETWORK DOCTOR AND NON-VSP PROVIDER COPAY SCHEDULE**

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



Exam.....	\$10.00
Lenses and/or frames.....	\$25.00

Any additional care, service and/or material not covered by this plan may be arranged between you and the doctor.

The copays will not apply toward elective contact lens evaluation/exam and materials.

## **PROVISIONS FOR A VSP NETWORK DOCTOR**

The VSP Plan provides you with a choice. If you elect to receive vision care services from one of the VSP network doctors, covered services as described herein, are provided at no out-of-pocket cost after any applicable copays. Selecting a VSP network doctor assures direct payment to the doctor and a guarantee of quality and cost control.

## **PROVISIONS FOR A NON-VSP DOCTOR**

If you choose to go to a non-VSP provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This plan then becomes an indemnity plan reimbursing according to a schedule of allowances. You should pay the doctor his full fee.

## **FILING A CLAIM FOR NON-VSP PROVIDER SERVICES**

Follow these steps to file a claim if you obtain services and/or materials from a non-VSP provider.

1. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye exam, lens type and frame.
2. Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:
  - Member's name and mailing address
  - Member's ID number
  - Member's employer or group name
  - Patient's name, relationship to member and date of birth

Claims must be submitted within six months of completion of services. VSP will reimburse in accordance with the schedule below. There is no

assurance that the schedule will be sufficient to pay for the exam or the materials. In order to receive reimbursement, please mail your itemized bill(s) and above documentation to the following address:

VSP  
P. O. Box 997105  
Sacramento, CA 95899-7105

Availability of services under this reimbursement schedule is subject to the same time limits and copays as those described on pages 3 through 6. Services obtained from a non-VSP provider are in lieu of obtaining service from a VSP network doctor.

## **OUT-OF-NETWORK REIMBURSEMENT SCHEDULE**

### **MAXIMUM REIMBURSEMENT FOR SERVICES FROM AN OUT-OF-NETWORK PROVIDER**

#### **PROFESSIONAL FEES**

Exam covered up to.....\$40.00

#### **MATERIALS**

Single Vision Lenses .....\$40.00

Bifocal Lenses.....60.00

Trifocal Lenses.....80.00

Lenticular Lenses.....125.00

Frame.....45.00

Tints and Polycarbonate Lenses.....5.00

#### **CONTACT LENSES\***

Necessary .....\$250.00

Elective .....110.00

\* Determination of necessary versus elective contact lenses under the non-VSP provider reimbursement schedule will be consistent with VSP network doctor services. Reimbursement for necessary and elective contact lenses is in lieu of all other benefits, including exam and materials for the periods stated.

Note: The amounts shown are maximums. The actual reimbursement to you shall be either the amount shown in the Maximum Reimbursement for Services from a non-VSP Provider or the amount

charged by the provider of such services, whichever is the least amount.

## **EXCLUSIONS AND LIMITATIONS**

The Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following, the Plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for the options.

1. Blended lenses
2. Contact lenses (see pages 3-4 for provisions)
3. Oversize lenses
4. Progressive multifocal lenses
5. The coating of a lens or lenses
6. The laminating of a lens or lenses
7. A frame that costs more than the plan allowance
8. Certain limitations on Low Vision care
9. Cosmetic lenses
10. Optional cosmetic processes

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

1. Orthoptics or vision training and any associate supplemental testing
2. Plano lenses (non-prescription)
3. Two pairs of glasses in lieu of bifocals
4. Lenses and frames furnished under this plan which are lost, broken or stolen (these will not be replaced except at the normal intervals when services are otherwise available)
5. Medical or surgical treatment of the eyes
6. Services and/or materials in excess of those provided under this plan needed because of a job requirement
7. Protective eyewear

## **PROCEDURE FOR USING THE PLAN**

**STEP ONE:** When you are ready to obtain vision care services, call your VSP network doctor. If you need to locate a VSP network doctor, call VSP at 800-877-7195 or visit the VSP Web site at [vsp.com](http://vsp.com).

**STEP TWO:** When making an appointment, identify yourself as a VSP member. The VSP network doctor will also need the covered member's identification number and the covered member's group name (The University of California). The VSP network doctor will contact VSP to verify your eligibility and plan coverage. The VSP network doctor will also obtain authorization for services and materials. If you are not eligible, the VSP network doctor will notify you.

**STEP THREE:** The VSP network doctor will provide an eye exam and determine if eyewear is necessary. If so, the VSP network doctor will coordinate the prescription with a VSP-approved, contract laboratory. The VSP network doctor will itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the VSP network doctor directly for covered services and materials. You are responsible for paying the doctor a \$10.00 copay for the eye exam and a \$25.00 copay for lenses and/or frames. The copays will not apply toward an elective contact lens exam and materials. You are responsible for any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a VSP network doctor from VSP's network assures direct payment to the doctor and guarantees quality services and materials.

## **REQUEST FOR APPEALS**

If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied including the name of the VSP enrollee, member identification number of the VSP enrollee, your name and date of birth and the name of the provider of services. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit

any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all requests for appeals to:

VSP  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670  
800-877-7195

## **COMPLAINTS AND GRIEVANCES**

If you have a complaint or grievance regarding VSP service or claim payment, you may communicate your complaint or grievance to VSP by using a complaint form which may be obtained by calling the VSP Member Services Department's toll-free number at 800-877-7195 Monday through Friday, 6:00 a.m. - 6:00 p.m., Pacific Standard Time. The completed form should be sent to the address shown on the front of this booklet.

VSP shall acknowledge receipt of your grievance within five (5) business days of receipt by VSP.

VSP shall also provide a written response to your grievances as required by VSP's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. There shall be no discrimination against a member on the basis of filing a complaint or grievance.

The California Department of Managed Health Care is responsible for regulating health service plans. The department's Health Plan Division has a toll-free telephone number 800-400-0815 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers 800-735-2929 (TTY) or 888-877-5378 (TTY) to contact the department. The department's internet website ([hmohelp.ca.gov](http://hmohelp.ca.gov)) has complaint forms and instructions online. If you have a grievance against the health plan, you should first contact your plan at 800-877-7195 and use the plan's grievance process before contacting the Health Plan Division.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the plan, or a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you and your failure to use these procedures does not preclude your use of any other remedy provided by law.

## **LIABILITY IN EVENT OF NON-PAYMENT**

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

## **TERMS AND CANCELLATIONS**

This contract will continue until terminated by either party giving the other sixty (60) days prior written notice.

VSP reserves the right to reject any and all claims for services or benefits which are filed more than one hundred eighty (180) days after completion of services.

## **DEFINITIONS**

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

**Covered Person** — The employee (and eligible and enrolled spouse and unmarried child(ren) if dependent coverage is provided) of the employer participating in this program.

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

**Materials** — Lenses, frame, low vision aids, contact lenses.

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

**Oversize Lenses** — Larger than standard lens blank to accommodate prescriptions.

**Photochromic Lenses** — Lenses which change color with intensity of sunlight.

**Plan Administrator** — The University of California.

**Plano Lenses** — Lenses which have no refractive power.

**Polycarbonate Lenses** — The most impact-resistant lens which is also thinner than regular plastic lenses; appropriate for active lifestyles, especially kids.

**Professional Service** — Exam, material selection, fitting of glasses, related adjustments, etc.

**Progressive Lenses** — A multifocal lens with no distinct lines; changes from distance correction in the top half of the lens to reading correction in the bottom half of the lens.

**Tinted Lenses** — Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

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