

VSP[®] Disclosure Statement and Evidence of Coverage

UNIVERSITY OF CALIFORNIA

Plan Administrator

Contract Numbers:
Active Employees - 00101923
Retirees - 12334445

Effective January 2012

UNIVERSITY OF CALIFORNIA

Human Resources
300 Lakeside Drive
Oakland, CA 94612



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 – R14
Summary of Benefits.....	3
VSP Network Doctor and Non-VSP Provider Copay Schedule.....	6
Provisions for a VSP Network Doctor	6
Provisions for a Non-VSP Provider	7
Filing a Claim for Non-VSP Provider Services.....	7
Out-of-Network Reimbursement Schedule.....	7
Exclusions and Limitations.....	8
Procedure for Using the Plan	9
Coordination of Benefits.....	10
Request for Appeals	10
Complaints and Grievances	11
Liability in Event of Non-Payment.....	12
Terms and Cancellations.....	12
Definitions	13

**UNIVERSITY OF CALIFORNIA
ELIGIBILITY, ENROLLMENT, TERMINATION,
AND PLAN ADMINISTRATION PROVISIONS
January 1, 2012**

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 medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. 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 are appointment type which is eligible for benefits and are a member of the 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 twelve months or more or 2) you have 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.

Retiree: A former University Employee receiving monthly benefits from a University benefit plan.

You may continue University medical-plan coverage as a Retiree when you start collecting retirement

or disability benefits from a University-sponsored defined benefit Plan provided that you also meet the following requirements:

- (a) you meet the University's service credit requirements for Retiree medical eligibility;
- (b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and
- (c) you elect to continue vision coverage at the time of retirement.

A Survivor: A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University—sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the *UC Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members or the Survivor and Beneficiary Handbook*.

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 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), domestic partner verification, adoption records, court documentation confirming a child's status as a legal ward, Federal Income Tax Return, or other official documentation.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself.

Spouse: Your legal spouse.

Domestic Partner: You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered

to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Your domestic partner (same-sex or opposite sex) must be at least 18 years of age.

Note: An adult dependent relative is not eligible for coverage in UC plans [unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date (e.g., continues to be ineligible for Medicare PartA)].

Child: All eligible children must be under the limiting age of 26 (18 for legal wards), except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness, or condition. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your spouse's natural or legally adopted children (your stepchildren);
- (c) your eligible domestic partner's natural or legally adopted children;
- (d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
- (e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
- (f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

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 26, provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;

- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner for support and maintenance (50% or more); and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, 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.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee. See *At Your Service* online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor, or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and 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 eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored vision plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* 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. If you are a Retiree, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, 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 UC

Customer Service Center by the last business day within the applicable enrollment period. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1. (d) below). Also see, "At Other Times for Employees and Retirees," below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

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 in which you are enrolled.

- (a) For a spouse, on the date of marriage.
- (b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.
- (c) For a natural child, on the child's date of birth.
- (d) For an adopted child, the earlier of:
 - (i) the date the child is placed for adoption with the Employee/Retiree, or
 - (ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

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.

- (e) For a legal ward, the effective date of the legal guardianship.
- (f) Where there is more than one eligibility requirement, the date all requirements are satisfied.

At Other Times for Employees and Retirees

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

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - (a) You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
 - (b) You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan, as stated above.
 - (c) Coverage under another health plan for

you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, coverage under COBRA or CalCOBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.

- (d) You properly file an application with the University during the PIE which starts on the day after the other coverage ends.

Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.

2. You or your eligible Family Members are not currently enrolled in UC-sponsored vision coverage and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.
3. A court has ordered coverage be provided for a dependent child under your UC-sponsored vision plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.
4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
 - (a) If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership, provided you enroll during the PIE.
 - (b) If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also

enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan. If you are a Survivor, you may not enroll your legal spouse or domestic partner.

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.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

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

An Employee or Retiree 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 your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

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.

Deenrollment 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 for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your monthly retirement payments covered by a University-sponsored defined benefit plan terminate, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

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 deenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

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

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyour.service.ucop.edu/employees/health_welfare/cobra.html

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document.

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, 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 applicable 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 group insurance contracts. 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.

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 and the President of the University (or his/her delegates) is the Plan Administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
800.888.8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by VSP. If you have a question about benefits under the Plan or about a specific claim, please contact VSP at the following address and phone number:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670
800.877.7195

Group Contract Number

The Group Contract Number for this Plan is:

Active employees - 00101923

Retirees - 12334445.

Type of Plan

This plan provides group vision benefits. This plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

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, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The portion of the premiums that 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 a Group Service Agreement.

For Employees, the cost of the premiums is currently paid entirely by the University of California.

For Retirees, the cost of the premiums is currently paid by plan participants.

Agent for Serving of Legal Process

Legal process may be served on VSP at the address listed on R-11.

Your Rights under the Plan

As a participant in a University of California medical 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 Group Service Agreement, 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.

Claims under the Plan

To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California 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 covered persons (You) from any VSP network doctor or non-VSP provider.

VSP network.....Choice

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. The plan covers lenses 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. The plan covers frames 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. This allowance includes 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 plan covers a contact lens exam only when billed with the purchase of 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 2010, the earliest you would be eligible to receive frames again would be January 2012 (this assumes you do not receive contacts in 2011).

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 PROVISIONS FOR A NON-VSP PROVIDER Section).

Discounted Contact Lens Services: The additional value of VSP is also extended to include a 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 twelve months of your last eye exam.

5. **Extra Discounts and Savings:**
 - Average 20–25% savings on lens options, such as scratch resistance, anti-reflective coatings and Progressives.
 - A 20% discount off unlimited additional pairs of glasses valid through any VSP doctor within 12 months of the last covered eye exam.

6. **Retinal Screening:** Guaranteed in network member pricing of \$39 as an enhancement to your WellVision exam. Use of retinal imaging, which takes a picture of the back of your eye, helps your VSP doctor find and track possible signs of eye disease.
7. **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 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.
8. **Diabetic Eyecare Program (DEP):** The Diabetic Eyecare Program provides additional coverage through medical diagnosis and procedure codes if you have Type 1 diabetes and specific ophthalmological conditions, with \$20 copay. This benefit provides a diabetic exam for diagnostic services in addition to

the routine vision examination covered under this plan. Additional services, such as retinal photography and other diabetes-related vision tests may apply. Follow-up diabetic eyecare services would be provided by the VSP doctor.

9. **Laser VisionCare Program:** 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) or by contacting VSP at (800) 877-7195.

Sunglasses Following Laser Vision Surgery: Members who have had laser vision surgery can use their frame allowance to buy nonprescription sunglasses from their VSP doctor.

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
Lenses and/or frames.....	\$25

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 PROVIDER

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 the 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 three through six. 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

MATERIALS

Single Vision Lenses\$40

Bifocal Lenses\$60

Trifocal Lenses\$80

Lenticular Lenses\$125

Frame\$45

Tints and Polycarbonate Lenses\$5

CONTACT LENSES*

Necessary\$250

Elective\$110

* 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 above 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:

- (a) Blended lenses
- (b) Contact lenses (see SUMMARY OF BENEFITS for provisions)
- (c) Oversize lenses
- (d) Progressive multifocal lenses
- (e) Coating of a lens or lenses
- (f) Laminating of a lens or lenses
- (g) Frame that costing more than the plan allowance
- (h) Certain limitations on low vision care
- (i) Cosmetic lenses
- (j) Optional cosmetic processes

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

- (a) Orthoptics; vision training; any associate supplemental testing

- (b) Plano lenses (non-prescription)
- (c) Two pairs of glasses, in lieu of bifocals
- (d) Lost, broken, or stolen lenses and frames (furnished under this plan)*
- (e) Medical or surgical treatment of the eyes
- (f) Services and/or materials in excess of those provided under this plan needed because of a job requirement
- (g) Protective eyewear

* These will not be replaced except at the normal intervals when services are otherwise available

PROCEDURE FOR USING THE PLAN

1. 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.
2. 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 (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.
3. 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 copay for the eye exam and a \$25 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.

COORDINATION OF BENEFITS

If you have dual coverage and are covered by more than one vision plan, (whether it be another carrier or another VSP plan), you may:

Use each plan individually (based on what each plan offers) for either two separate exams and/or materials from each plan. For example, contact lenses from one plan and glasses from the other plan or two sets of glasses (one pair from each plan).

or

Choose to have both plans pay for one set of services to offset plan copayment(s), lens options and/or frame coverage, up to, but not more than the billed amount.

Note: Check with your VSP Doctor for coordination of benefits details.

Determine Primary and Secondary Plan

- The plan that covers you an employee is primary.
- The plan that covers you as a dependent is secondary.
- If the patient is a dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Coverage

The primary plan pays as if the secondary plan does not exist. If a VSP plan is the secondary plan, you may receive allowances (examination, lenses and frame) that will be used to pay up to, but not more than, your out-of-pocket expenses.

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 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, 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, 5:00 a.m. - 7:00 p.m., (PST) and Saturday, 6:00 a.m. - 2:30 p.m., (PST). 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 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 Web site (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 sixty 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. 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 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 days after completion of services.

DEFINITIONS

Affiliate Provider — While affiliate providers are not VSP network providers, they must undergo license verification and meet NCQA standards and may provide a covered-in-full experience to VSP members.

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

Covered Person — The employee/retiree and their eligible and enrolled dependents, 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, and 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.

Photochromic Lenses — Lenses that change color with intensity of sunlight.

Plan Administrator — University of California.

Plano Lenses — Lenses with no refractive power.

Polycarbonate Lenses — The most impact-resistant lens. Thinner than regular plastic lenses. Appropriate for active lifestyles, especially kids.

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

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, and blue).

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