

VSP
Disclosure Statement
and
Evidence of Coverage
Contract Number 00101923

January 2002

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

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(800) 877-7195
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T.D.D. for the hearing impaired
(800) 428-4833

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FOREWORD

The University of California sponsored vision service plan 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 service 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.

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**University of California
Regulations Insert
for VSP Plan Booklet
Plan Year 2002
Effective Date: 01/01/02**

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.

* For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked

by you in the preceding twelve (12) month period.

- (a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.
- (b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

- (a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.
- (b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

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. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return

(IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

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 handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group vision plan before age 23 and coverage is continuous,
- the child is dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, and
- 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 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 an adult dependent relative or same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations. For information on who

qualifies and how to enroll, contact your local Benefits-Office or the University of California's Customer Service Center.

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 both husband and wife are 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 coverage but not under both.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. Enrollment transactions may be 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 vision plan coverage and you lose that coverage involuntarily, 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.

If you or your eligible Family Members fail to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date your enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family Member at any time. See “Effective Date”.

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.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

When you already have two or more Family Members enrolled and enroll another Family Member, coverage may be retroactive with the effective date limited to the later of:

- (a) the date the newly added Family Member 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 individual to two-party coverage and from two-party to 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.

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 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 deenrollment procedures, contact the person who handles benefits at your location.

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. 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

commits fraud or deception will be permanently disenrolled while any other Family Member and the Subscriber will be disenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be disenrolled for 18 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 UCbencom website (www.ucop.edu/bencom). 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 and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th 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. The plan is not a vested plan. 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 premium the University pays is subject to state appropriation which may change or be discontinued in the future.

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 Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, 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 doctor or out-of-network provider.

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

- 1. Exam:** You are entitled to a comprehensive exam, including a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. Services shall be provided once in every calendar year period.
- 2. Lenses:** The VSP 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 doctor. Lenses shall be provided once in every calendar year period.
- 3. Frames:** VSP fully covers a wide selection of frames. The frame benefit provides you choice to select the frame that fits your lifestyle. Therefore, if you choose a frame that exceeds the plan allowance, you will pay the difference based on VSP's discounted member pricing. Have your doctor help you choose the best frame for you based on your VSP coverage. Frames shall be provided once in every other calendar year period. For information on how your eligibility for frames may be affected if you receive contact lenses, please see "Contact Lenses" below.

VSP offers you even more value by providing a 20% discount on non-covered pairs of prescription glasses.

- 4. Contact Lenses:** For **elective** contact lenses, obtained through either a VSP doctor or out-of-network provider, VSP has established an allowance of up to \$110.00. This allowance includes the cost of the exam. Contact lenses are in lieu of all other benefits (exam, lenses and frames),

for that eligibility period. Copayments do not apply. Note: If you get contact lenses, you cannot receive spectacle 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 2002, the earliest you would be eligible to receive frames again would be January 2004 (this assumes you have not received contact lenses in 2003).

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

VSP's additional value is also extended to include a 15% discount on elective, non-covered and replacement contact lens services which includes evaluation, design, fitting and subsequent follow-up 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.

You may use these discounts for 12 months following the date of the covered eye examination. Also, these discounts are only offered through a VSP doctor who provided the last covered eye examination.

5. Laser VisionCareSM - 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 in the WellVision Learning Source[®] area of VSP's website (www.vsp.com) or by contacting VSP at (888) 354-4434.

6. Low Vision - Limitations

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.

1. **PRIOR AUTHORIZATION** - When a VSP 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 copayment by you.
2. **COPAYMENT** - After supplementary testing, the doctor submits the treatment plan to the VSP consultants. The consultants will review the Plan and, if the Plan is approved, will authorize benefits on a copayment basis with 75% of the cost being paid by VSP and 25% of the cost being paid by you.
3. **MAXIMUM BENEFIT** - VSP will pay a maximum of \$1000 (excluding copayments) every two (2) calendar years for approved Low Vision care. The maximum includes the Supplementary Testing.

Low Vision benefits secured from an out-of-network provider are subject to the same time limits and copayment arrangements as described herein for a VSP doctor. You should pay the out-of-network provider his 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 Doctor and Out-of-Network Provider Copayment Schedule

There shall be a copayment for the exam payable by you to the VSP doctor at the time of the exam; however, if materials (Lenses and/or Frames) are provided, you must pay an addi-

tional copayment 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 copayments will not apply toward elective contact lens evaluation/examination and materials.

Provisions for a VSP Doctor

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

Provisions for an Out-of-Network Provider

If you choose to go to an out-of-network 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 Out-of-Network Provider Services

To file a claim, follow these steps if you obtain services and/or materials from an out-of-network 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 identification number (usually the employee's social security 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 found 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 copayments as those described on pages 3 through 6. Services obtained from an out-of-network provider are in lieu of obtaining service from a VSP doctor.

Out-of-Network Provider Reimbursement Schedule

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

PROFESSIONAL FEES

Exam, up to \$40.00

MATERIALS

PAIR

Single Vision Lenses, up to \$40.00

Bifocal Lenses, up to 60.00

Trifocal Lenses, up to 80.00

Lenticular Lenses, up to 125.00

Frame, up to 45.00

Tints and Polycarbonate Lenses, up to 5.00

CONTACT LENSES*

Necessary, up to \$250.00

Elective, up to 110.00

*Determination of **necessary** versus **elective** contact lenses under the out-of-network provider reimbursement schedule will be consistent with VSP 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 maximum shown in the Maximum Reimbursement

for Services from an Out-Of-Network provider, the amount charged, or the amount usually charged by the provider of such services to his private patients, whichever is determined by VSP to be 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 associated supplemental testing; plano lenses; or two pairs of glasses in lieu of bifocals.
2. 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.
3. Medical or surgical treatment of the eyes.
4. Services and/or materials in excess of those provided under this Plan needed because of a job requirement.
5. Protective eye wear.

EMERGENCY SERVICES

In emergency cases when immediate vision care is necessary, you may obtain covered services by contacting a VSP Member Service Representative at 800-877-7195.

PROCEDURE FOR USING THE PLAN

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

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

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

CLAIMS APPEAL PROCEDURE

VSP shall notify you in writing if a claim is denied in whole or part, of the reason or reasons for the denial. Within sixty (60) days after receipt of such notice, you may make a written request for review of such denial, by addressing such request to VSP, whose

address is shown on the front of this booklet. You may state the reason you believe that the denial of the claim was in error and may provide any pertinent documents that you wish 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. The determination of VSP, including specific reasons for the decision, shall be provided and communicated to you in writing within thirty (30) days after receipt of a request for review unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but no later than one hundred twenty (120) days after receipt of a request for review.

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 ten (10) 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 (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the

department. The department's internet website (www.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.

FACILITIES

This vision care plan is an agreement among various state vision service corporations throughout the United States. Through these service plans and their extensive nationwide network of doctors, VSP provides professional vision care to employees and their dependents covered under group vision care plans.

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

ACTIVELY-AT-WORK — is based on your normally scheduled workday and means you are working full-time for one full day (not merely on pay status) and have completed a full day's work at the University or at other locations to which the University requires you to travel.

ANISOMETROPIA — A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

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.

KERATOCONUS — A developmental or dystrophic deformity of the cornea in which it becomes cone-shaped, due to a thinning and stretching of the tissue in its central area.

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

PROFESSIONAL SERVICE — Examination, material selection, fitting of glasses, related adjustments, etc.

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



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