

# RETIREE VOLUNTARY GROUP VISION PLAN EVIDENCE OF COVERAGE

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3333 Quality Drive, Rancho Cordova, CA 95670

Customer Service: 800.400.4569

Website: [www.vsp.com](http://www.vsp.com) or [csuretirees.vspforme.com](http://csuretirees.vspforme.com)

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This evidence of coverage (EOC) provides the terms and conditions of coverage. Please read the EOC completely and carefully.

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Group Plan Number:

#30059425

CSU Retirees Basic Plan

Effective January 1, 2022

**CSU** The California State University



Welcome to VSP® Vision Care! We're so glad you're a member. Your eyes are amazing, and we'll treat them amazingly well. To keep your eyes healthy and your vision clear, utilize your VSP coverage.

## Getting started is a breeze.

- **Find the right VSP Network doctor for you.** You'll find plenty to choose from at [csuretirees.vspforme.com](http://csuretirees.vspforme.com) or by calling us at **800.400.4569**.
- **Already have a VSP Network doctor?** Make an appointment today and tell them you're a VSP member.
- **Check out your coverage.** Visit [vsp.com](http://vsp.com) to see your benefits anytime.

That's it! We'll handle the rest—no ID card necessary or claim forms to complete when you see a VSP Network doctor.

## You'll get more than the basics and at a great price.

Our WellVision Exam® is more than a quick eye check. Our doctors take their time and look for eye problems and signs of other health conditions too.

Thanks for letting us help you see well, stay healthy, and get the most out of life. Get the personalized eyecare you deserve and make your vision appointment today.

Sincerely,

A handwritten signature in black ink that reads 'Kate'.

Kate Renwick-Espinosa  
President and CEO  
VSP Vision Care

**P.S. Satisfaction guaranteed. You'll be 100% happy or we'll make it right.**

Contact us.

[csuretirees.vspforme.com](http://csuretirees.vspforme.com) | **800.400.4569**

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THIS EVIDENCE OF COVERAGE (EOC) IS AN ADDENDUM OF THE GROUP PLAN CONTRACT AND CONSTITUTES ONLY A SUMMARY OF THE TERMS AND CONDITIONS OF COVERAGE. IF THERE'S A CONFLICT BETWEEN THE EVIDENCE OF COVERAGE AND THE GROUP PLAN CONTRACT, THE GROUP PLAN CONTRACT WILL PREVAIL.

| <b>Definitions</b>       |   |
|--------------------------|---|
| Anisometropia            | A condition of unequal refractive state for the two eyes, with one eye requiring a different lens correction than the other.  |
| Benefit Authorization    | Authorization issued by VSP identifying the individual named as a Covered Person of VSP and identifying those Plan Benefits to which a Covered Person is entitled.  |
| Coordination of Coverage | Coordination of coverage is a contract provision that provides dual coverage for the same allowable expense(s) if an Enrollee and/or any covered dependent(s) are enrolled in more than one vision plan.  |
| Copay                    | Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.  |
| Covered Person           | An Enrollee or Eligible Dependent who meets CSU's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.  |
| Domestic Partner         | An individual with whom the Enrollee has completed a declaration of domestic partnership with the Secretary of the State of California, filed for public record if required by law, and submitted to the Group. Domestic partnership is defined as specified domestic partnerships between persons who are both at least 18 years of age who are not legally married. A same-sex legal union other than marriage validly formed in another jurisdiction that is substantially equivalent to a registered domestic partner in California may also be recognized. |
| Eligible Dependent       | Any dependent of an Enrollee of Group who meets the criteria for eligibility specified herein under Eligibility for Coverage.   |
| Emergency Condition      | A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care; or an unforeseen occurrence requiring immediate, non-medical action.  |
| Enrollee                 | An employee or member of Group who meets the criteria for eligibility specified under Section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator.   |
| Experimental Nature      | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.   |

## Definitions

|                                   |   |
|-----------------------------------|---|
| Group                             | The California State University (“CSU”) which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.  |
| Group Plan Number                 | The Group Plan Number is #30059425.   |
| Interim Benefits                  | New prescription lenses will be approved and replaced every calendar year if certain criteria is met.   |
| Keratoconus                       | A development 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.   |
| Member Doctor                     | An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials and has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP. |
| Non-Member Provider               | Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.                                      |
| Plan Benefits                     | The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan, as defined on the enclosed insert.  |
| Premiums                          | The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.   |
| Renewal Date                      | The date on which this plan shall renew or terminate if proper notice is given.   |
| Schedule of Benefits              | List of vision care services and vision care materials described herein which a Covered Person is entitled to receive by virtue of this plan.   |
| Visually Necessary or Appropriate | Services and materials medically or visually necessary to restore or maintain a patient’s visual acuity and health and for which there is no less expensive professionally acceptable alternative.  |

## Eligibility for CSU Retiree Voluntary Vision Coverage

Enrollees: To be eligible for coverage, a person must meet the following eligibility criteria:

- Currently be a CalPERS benefits eligible annuitant or an eligible survivor who is receiving a retirement warrant from either the retirement system; or
- A CSU benefits-eligible employee who meets vesting requirements and subsequently retires from the CSU within 120 days of separation from CSU, is eligible to enroll in either COBRA and/or the CSU Voluntary Retiree Vision Plan in order to continue vision benefits into retirement.
- **Dependents:** the persons eligible for coverage as dependents shall include:
  - **the legal spouse;** or
  - **Domestic partner** of any Enrollee; and
  - **Dependent children:** Dependent children are covered through the end of the month in which they turn age 26, child includes any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, Enrollee's step-child, child living with Enrollee in the Enrollee's household in a parent child relationship and depends on the Enrollee for principal support, or other child for whom a court holds the Enrollee responsible.

If either of the eligibility criteria has been met, the individual has the option to enroll in the CSU Voluntary Vision Plan at retirement, or within sixty (60) days of retirement, or within 60 days of loss of coverage on another vision plan, or during any future open enrollment period.

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

### Coordination of Coverage Restrictions

- A married couple retired from this company may not receive duplicate coverage; therefore, coordination of benefits is not allowed.
- A retiree's dependent child who works for this company may not receive duplicate coverage; therefore, coordination of benefits is not allowed.
- A retiree for this company may not receive duplicate coverage; therefore, coordination of benefits is not allowed.
- Dependent children are covered under only one parent's plan when both parents retire from this company.

## Effective Date of Coverage

Enrollment in the CSU Retiree Vision Plan is based on the calendar year (January 1-December 31). Therefore, enrollment in this Plan will be no earlier than January 1.

Any enrollment processed after January 1, will be effective the first of the month following receipt of the VSP enrollment form by VSP. The sixty (60) day time limits for enrollment based on the appropriate permitting event(s) (e.g., retirement, survivorship, adding/deleting dependents) apply also to this Plan.

## Termination of Coverage

Your coverage will terminate on the earliest of:

- the date this Plan is terminated
- the last day of the last month for which premium payment is made on your behalf
- the date you cease to be eligible for coverage under this Plan
- the last day of the month following the month in which your status with the Group terminates

## Enrollment Options and Terms

Upon retirement from the CSU, an employee who was enrolled in the CSU Group Vision Plan during active employment can elect to enroll in either COBRA or the CSU Retiree Voluntary Vision Plan. The retiree cannot be enrolled in both plans.

Retirees enrolling in the CSU Retiree Voluntary Vision Plan will be required to maintain enrollment for a minimum period of 12 months. The length of the required enrollment period may be greater depending upon enrollment in the Plan. A plan year runs from January 1 of any year through December 31 of the same calendar year. Employees retiring and enrolling into this program will be required to maintain their enrollment for the balance of the plan year in which they enroll and for 12 months in the following plan year, unless a permitting event occurs to change their enrollment. Permitting event policy is established by the plan administrator, the California State University Human Resources Administration.

## Monthly Premium Cost of Enrollment

Retirees are responsible for payments to VSP of the monthly charges for coverage, which may be deducted from the retirement warrant. Due to processing constraints, some retirees will be billed directly for payment.

The Plan is based on a three-tier rate structure, based on the number of dependents covered. The monthly premium cost is as follows:

|  |         |
|--|---------|
| Retiree Only (One Party).....            | \$5.13  |
| Retiree + One Dependent (Two Party)..... | \$9.40  |
| Retiree + Family (Three Party).....      | \$10.08 |

## COBRA Option for Enrollees Under CSU Group Vision Plan Who Retire

Upon retirement from the CSU, employees who were enrolled in a vision plan during active employment can elect to maintain vision coverage through COBRA for an 18-month period, rather than enrolling in the CSU Retiree Voluntary Vision Plan. The retiree cannot be enrolled in both plans.

Retirees that choose to enroll in COBRA may enroll in the CSU Retiree Voluntary Vision Plan during any subsequent open enrollment period following his/her COBRA eligibility end date or COBRA cancellation due to non-payment.

The following events qualify eligible qualified beneficiaries enrolled in COBRA under CSU Group Plan for continued coverage for up to a maximum of 36 months:

- **Death of covered retiree;**
- **Divorce of a spouse or dissolution of domestic partnership from a covered retiree;**
- **Termination of a child's dependent status (e.g., dependent reaches age 26, marries, etc.).**

If the retiree dies while on COBRA, eligible survivors can either be enrolled in the CSU Retiree Voluntary Vision Plan at the time of death or during any subsequent enrollment period, or the survivor(s) may opt to choose COBRA continuation. If, however, the survivor wishes to remain enrolled in COBRA, the survivor would be eligible for COBRA for a period of 36 months.

## COBRA Option for CSU Retiree Voluntary Vision Plan – Qualified Beneficiaries

The following events qualify eligible qualified beneficiaries enrolled in the CSU Retiree Vision Plan for continued coverage for up to a maximum of 36 months:

- Divorce of a spouse or dissolution of domestic partnership from a covered retiree;
- Termination of a child’s dependent status (e.g., dependent reaches age 26, marries, etc.).

The monthly cost of COBRA enrollment is as follows:

|  |         |
|--|---------|
| Qualified Beneficiary Only (One Party). .....            | \$5.23  |
| Qualified Beneficiary + One Dependent (Two Party). ..... | \$9.58  |
| Qualified Beneficiary + Family (Three Party). .....      | \$10.28 |

## Death of Retiree

A retiree’s vision coverage ceases at midnight on the date of death. Upon the death of a retiree, enrollment in the CSU Retiree Voluntary Vision Plan may continue for a surviving spouse or domestic partner and underage dependents deemed eligible for a CalPERS or CalSTRS monthly retirement allowance. Eligible survivors may continue enrolled coverage, or can enroll within 60 days of the death, or during any subsequent open enrollment. If the survivor subsequently remarries or obtains another domestic partner, the vision benefit will not apply to the new spouse or domestic partner. Vision coverage for surviving spouses or domestic partners ineligible for a monthly retirement allowance as a survivor will cease at midnight on the last day of the month following the retiree’s death. In this case, surviving family members may opt to continue vision coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

## Procedures for Using This Plan

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED.

- **To obtain Plan Benefits from a Member Doctor**, you should contact a Member Doctor or VSP. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from CSU or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call (800)400-4569, or write VSP to obtain one that does.
- **If you are eligible for Plan Benefits**, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member, so the doctor knows to obtain Benefit Authorization from VSP.
- When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against this plan, in spite of your termination of coverage or the termination of this plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
- You pay only the Copayment to the Member Doctor for the services covered by this plan. You are responsible for payment of any services not covered by VSP, including, but not limited to, frames and lenses that exceed the covered limits established by this plan. VSP will pay the Member Doctor directly, according to their agreement with the doctor. VSP reimburses its Member Doctors on a fee-for-service basis. There are no incentives or financial bonuses paid to Member Doctors for services covered under this plan.



Note: If you obtain Plan Benefits from a Non-Member Provider, you must pay the provider the full fee. LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

- A Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken, or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

- In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

## **Benefit Authorization Process**

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided in this Plan.

### **Prior Authorization**

Certain Plan Benefits require prior authorization by VSP before such Plan Benefits are covered. Prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by the VSP Utilization Management Committee and Board of Directors.

- Initial Determination: VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
- Appeals: If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second-level appeal, and other remedies as described below, is also available. VSP shall resolve any second-level appeal within thirty (30) calendar days. Covered Person may designate any person, including the provider, as Covered Person's authorized representative.

For more information regarding criteria for authorizing or denying Plan Benefits, please contact VSP Customer Service.

## Benefits and Coverages

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

**IMPORTANT:** The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

- **Eye Examination:** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Covered Person is entitled to an Eye Examination as indicated on the enclosed insert.
- **Lenses:** The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Covered Person is entitled to new lenses as indicated on the enclosed insert.
- **Frames:** The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Covered Person is entitled to new frames as indicated on the enclosed insert.
- **Contact lenses:** Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein.

When you obtain Necessary contact lenses from a Member Doctor, professional fees and materials will be covered as indicated on the enclosed insert.

When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

- If you elect to receive vision care services from one of the Member Doctors, Plan Benefits are provided subject only to your payment of any applicable Copayment. If you choose to obtain Plan Benefits from a Non-Member Provider, you must pay the Non-Member Provider the full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAM OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.
- **Additional Discount:** Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off Member Doctor professional fees for elective contact lens exam, evaluations and fittings. The Covered Person pays the Member Doctor the difference between the Plan Benefit Allowance and the Member Doctor's discounted usual and customary fees, plus any Copays and charges for services or materials not covered under this Plan. Contact lens materials are provided at the doctor's usual and customary charges.

Discounts are applied to the Member Doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye exam from the Member Doctor who provided the covered eye exam. Additional discounts noted on this schedule are subject to change as deemed appropriate by VSP with prior notification to the Group.

## **Discounts Do Not Apply to Vision Care Benefits Obtained from Non-Member Providers**

- **Low Vision Services and Materials:** The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

## **Copay**

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

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

To file a claim, you must send your itemized statement of charges to VSP. To be reimbursed, submit your claim within six months of the date of service to the following address:

VSP  
P.O. Box 385018  
Birmingham, AL 35238-5018

VSP will reimburse you in accordance with the following reimbursement schedule. There is no assurance that the reimbursement schedule will be sufficient to pay for the exam or eyewear and VSP cannot guarantee patient satisfaction.

**NON-VSP PROVIDER REIMBURSEMENT SCHEDULE** Availability of services under the reimbursement schedule is subject to the same time limits and copays as those described for VSP network doctor services. Services obtained from a non-VSP provider are in lieu of obtaining services from a VSP network doctor. Reimbursement benefits are not assignable.

## Exclusion and Limitations of Benefits

This Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, this Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional costs of the options, unless the option is defined as a Plan Benefit in the enclosed Schedule of Benefits insert.

- **Optional cosmetic processes**
- **Anti-reflective coating**
- **Color coating**
- **Mirror coating**
- **Scratch coating**
- **Blended lenses**
- **Cosmetic lenses**
- **Laminated lenses**
- **Oversize lenses**
- **Progressive multifocal lenses**
- **Certain limitations on low vision care**

## Services and/or Materials Not Covered

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

- Orthoptics or vision training and any associated supplemental testing
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia)
- Refitting of contact lenses after the initial (90-day) fitting period
- Plano contact lenses (lenses with refractive correction of less than .50 diopter)
- Two pairs of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an Experimental Nature
- Plano contact lenses to change eye color cosmetically
- Costs for services and/or materials exceeding Plan Benefit allowances
- Artistically-painted contact lenses
- Contact lens modification, polishing, or cleaning
- Additional office visits associated with contact lens pathology
- Contact lens insurance policies or service agreements
- Computer Vision Care (CVC) benefits, lenses, etc., or supplemental eye examination associated with CVC benefits
- Services and/or materials not indicated on this Schedule as covered Plan Benefits

### LIABILITY IN EVENT OF NONPAYMENT

IN THE EVENT VSP FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE FOR ANY SUMS OWED BY VSP OTHER THAN THOSE NOT COVERED BY THE POLICY.

## Complaints and Grievances

If Covered Person ever has a question or problem, Covered Person's first step is to call the VSP Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained, upon request, from the Customer Service Department. Complaints and grievances include disagreements regarding access to care or the quality of care, treatment, or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in review by VSP. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after receipt by VSP of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate the expected resolution date by VSP. Upon final resolution, the Covered Person will be notified of the outcome in writing.

## Claim Payments and Denials

- **Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
- **Request for Appeals:** If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person 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, Covered Person 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; the Covered Person's name and date of birth; the name of the provider of services; and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person 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. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670  
800.400.4569

Determination by VSP, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative. If Covered Person disagrees with the determination by VSP, he/she may request a second-level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second-level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U.S. Department of Labor or the State insurance regulatory agency for details.

- **Review by the Department of Managed Health Care:** The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800)400-4569 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HM0-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site <http://hmoHELP.ca.gov> has complaint forms, IMR application forms, and instructions online.

## Arbitration

Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration. The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

## Second Medical Opinions

- All requests for a second medical opinion shall be directed, in writing, to:  
  
VSP  
Clinical Consultant  
Health Care Services Division  
3333 Quality Drive  
Rancho Cordova, CA 95670
- The Clinical Consultant will review each request and respond within twenty (20) days of receipt of the written request.
- The requesting patient shall provide all evidence supporting the request for a second medical opinion when requested by the Clinical Consultant.
- A request for a second medical opinion shall be granted when it is determined by the Clinical Consultant, based on information provided by the Enrollee and the original examining Member Doctor, that the initial examination was insufficient to ascertain the visual health problems of the patient.
- In no circumstance will a second medical opinion be granted if the Enrollee's initial vision examination was performed by a Non-Member Provider.

## **Termination of Benefits**

Plan Benefits will cease on the date of cancellation of this plan, whether the cancellation is by Group or by VSP, due to non-payment of Premium. If service is being rendered to you as of the termination date of this plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this plan.

## **Individual Continuation of Benefits**

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

## **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.



# VISION SERVICE PLAN

3333 Quality Drive  
Rancho Cordova, CA 95670

Group Name: THE CALIFORNIA STATE UNIVERSITY - RETIREES BASIC

Plan Number: 30059425

Effective Date: JANUARY 1, 2022

Plan Term: TWELVE (12-MONTHS)

## VISION CARE PLAN DISCLOSURE FORM AND EVIDENCE OF COVERAGE

**PLAN ADMINISTRATOR:** HRM BENEFITS  
(NAME)  
401 GOLDEN SHORE FL 4  
(ADDRESS)  
LONG BEACH, CA 90802-4210  
(CITY, STATE, ZIP)

**MONTHLY PREMIUM:** REFER TO PAGES 9-10 FOR PREMIUM INFORMATION.

**ELIGIBILITY:** ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO THE END OF THE MONTH IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **VSP ADVANTAGE PLAN<sup>SM</sup>**

**EXAM:** ONCE EVERY PLAN YEAR\*  
**LENSES** ONCE EVERY OTHER PLAN YEAR\*  
**FRAMES:** ONCE EVERY OTHER PLAN YEAR\*  
\*PLAN YEAR BEGINS JANUARY 1ST.

**TERM, TERMINATION AND RENEWAL:** AFTER THE PLAN TERM, THIS PLAN WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER THIRTY (30) DAYS PRIOR WRITTEN NOTICE.

**TYPE OF ADMINISTRATION:** BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

**VSP'S ADDRESS IS:** VISION SERVICE PLAN  
3333 QUALITY DRIVE  
RANCHO CORDOVA, CA 95670



## **BASIC SCHEDULE OF BENEFITS**

### **GENERAL**

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached. Member Doctors are those doctors who have agreed to participate in VSP's Advantage Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

### **PLAN BENEFITS**

### **MEMBER PROVIDER BENEFIT**

### **NON-MEMBER PROVIDER BENEFIT**

#### **VISION CARE SERVICES**

|                    |                  |          |        |
|--------------------|------------------|----------|--------|
| Vision Examination | Covered in Full* | Up to \$ | 50.00* |
|--------------------|------------------|----------|--------|

Comprehensive examination of visual functions and prescription of corrective eyewear.

#### **VISION CARE MATERIALS**

##### *Lenses*

|               |                  |          |         |
|---------------|------------------|----------|---------|
| Single Vision | Covered in Full* | Up to \$ | 45.00*  |
| Bifocal       | Covered in Full* | Up to \$ | 65.00*  |
| Trifocal      | Covered in Full* | Up to \$ | 85.00*  |
| Lenticular    | Covered in Full* | Up to \$ | 125.00* |

##### *Lens Enhancements*

|  |                  |          |        |
|--|------------------|----------|--------|
| Polycarbonate Lenses (for children only) | Covered in Full* | Up to \$ | 65.00* |
| UV Protection                            | Covered in Full* | Up to \$ | 0.00   |

|        |   |          |        |
|--------|---|----------|--------|
| Frames | Covered up to \$110 Retail Frame Allowance* | Up to \$ | 60.00* |
|--------|---|----------|--------|

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

### **INTERIM BENEFITS**

New lenses will be approved and replaced every calendar year if at least one of the following criteria is met:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
- There is a difference in vertical prism greater than one prism diopter.
- There is a change in the axis of 15 degrees or more.

### **CONTACT LENSES**

#### *Necessary*

|                                 |                  |          |         |
|---------------------------------|------------------|----------|---------|
| Professional Fees and Materials | Covered in Full* | Up to \$ | 250.00* |
|---------------------------------|------------------|----------|---------|

#### *Elective*

|                                 |                 |          |        |
|---------------------------------|-----------------|----------|--------|
| Professional Fees and Materials | Up to \$ 120.00 | Up to \$ | 110.00 |
|---------------------------------|-----------------|----------|--------|

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for two plan years.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Provider or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

\*Subject to Copayment, if any.

### **COPAYMENT**

There shall be a Copayment of \$10.00 payable by the Covered Person to the Member Doctor toward the eye examination.

**THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.**

### **LOW VISION (IN-NETWORK ONLY)**

Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

Supplemental Testing          Covered in Full  
(includes evaluation, diagnosis and prescription of vision aids where indicated)

Supplemental Aids              75% of cost

Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) calendar years.

### PATIENT OPTIONS

This vision service plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

Optional cosmetic processes.

- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses,
- Tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere herein)

### NOT COVERED

There are no benefits for professional services or materials connected with:

- Subnormal vision aids.
- Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer.
- Corneal Refractive Therapy (CRT).
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano contact lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Plano lenses.
- Costs for services and/or materials exceeding Plan Benefit allowances
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Additional office visits associated with contact lens pathology.
- Contact lens insurance policies or service agreements.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

## PLAN BENEFITS

### AFFILIATE PROVIDERS

#### GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

#### BENEFIT PERIOD

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

#### COPAYMENT

There shall be a Copayment of \$10.00 payable by the Covered Person to the Member Doctor toward the eye examination.

#### COVERED SERVICES AND MATERIALS

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

**Comprehensive examination of visual functions and prescription of corrective eyewear.**

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

**Spectacle Lenses (Single, Lined Bifocal, or Lined Trifocal)**

##### **LENS ENHANCEMENTS-**

Polycarbonate Lenses for Dependent Children

UV Protection

##### **FRAMES - Covered up to plan allowance\* once every 24 months\*\***

#### CONTACT LENSES

##### **ELECTIVE**

**Elective Contact Lenses are covered up to \$ 120.00 once every 24 months\*\***

The Elective Contact Lens allowance applies to materials only.

##### **NECESSARY**

**Necessary Contact Lenses are covered up to \$ 250.00\* once every 24 months\*\***

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

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

\*Less any applicable Copayment.

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

## **EXCLUSIONS AND LIMITATIONS OF BENEFITS**

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

## **ADDENDUM**

### **ADDITIONAL BENEFIT RIDER SUPPLEMENTAL PRIMARY EYECARE PLAN**

#### **GENERAL**

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary Eyecare Plan is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary Eyecare also involves management of conditions that require monitoring to prevent future vision loss. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

#### **ELIGIBILITY**

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

- Enrollee.
- Legal spouse of Enrollee.
- Domestic partner
- Dependent children

Dependent children are covered through the end of the month in which they turn age 26, child includes any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, Enrollee's step-child, child living with Enrollee in the Enrollee's household in a parent child relationship and depends on the Enrollee for principal support, or other child for whom a court holds the Enrollee responsible.

Plan Benefits under the Supplemental Primary Eyecare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

## **SYMPTOMS**

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

- Ocular discomfort or pain
- Transient loss of vision
- Flashes or floaters
- Ocular trauma
- Diplopia
- Recent onset of eye muscle dysfunction
- Ocular foreign body sensation
- Pain in or around the eyes
- Swollen lids
- Red eyes

## **CONDITIONS**

Examples of conditions that may require management under the PEC Plan may include, but are not limited to:

- Ocular hypertension
- Retinal nevus
- Glaucoma
- Cataract
- Pink-eye
- Macular degeneration
- Corneal dystrophy
- Corneal abrasion
- Blepharitis
- Sty

## **PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES**

### **COVERED PERSON HAS A GROUP MEDICAL PLAN**

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

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

### **COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN**

When Covered Person does not have a group medical plan, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

## **REFERRALS**

If Covered Services cannot be provided by Covered Person's Member Doctor, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the Member Doctor will refer the Covered Person back to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition, **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

**PLAN BENEFITS  
MEMBER DOCTORS**

**COVERED SERVICES**

**Eye Examinations, Consultations, Urgent/Emergency Care:** Covered in Full after a Copayment of \$20.00.

**Special Ophthalmological Services:** Covered in Full

**Eye and Ocular Adnexa Services:** Covered in Full

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

**NOT COVERED**

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where VSP is required by law to pay.



## SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

|                          |  |
|--------------------------|--|
| Blepharitis              | Inflammation of the eyelids.   |
| Cataract                 | A cloudiness of the lens of the eye obstructing vision.  |
| Conjunctiva              | The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.                     |
| Conjunctivitis           | See Pink Eye.  |
| Corneal Abrasion         | Irritation of the transparent, outermost layer of the eye.   |
| Corneal Dystrophy        | A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.                                   |
| Diplopia                 | The observance by a person of seeing double images of an object.   |
| Eyecare Professional     | Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).          |
| Eye Muscle Dysfunction   | A disorder or weakness of the muscles that control the eye movement.   |
| Flashes or Floaters      | The observance by a person of seeing flashing lights and/or spots.   |
| Glaucoma                 | A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision. |
| Macula                   | The small, sensitive area of the central retina, which provides vision for fine work and reading.                                  |
| Macular Degeneration     | An acquired degenerative disease which affects the central retina.   |
| Ocular                   | Of or pertaining to the eye or the eyesight.   |
| Ocular Conditions        | Any condition, problem or complaint relating to the eyes or eyesight.  |
| Ocular Hypertension      | Unusually high blood pressure within the eye.  |
| Ocular Trauma            | A forceful injury to the eye due to a foreign object.  |
| Pink Eye                 | An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.   |
| Retinal Nevus            | A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.                          |
| Systemic Condition       | Any condition of problem relating to a person's general health.  |
| Sty                      | An inflamed swelling of the fatty material at the margin of the eyelid.  |
| Transient Loss of Vision | Temporary loss of vision.  |

**Summary of Benefits and Coverage**  
**ADVANTAGE PLAN**

**Prepared for:** THE CALIFORNIA STATE UNIVERSITY - RETIREES BASIC PLAN  
**Group ID:** 30059425  
**Effective Date:** JANUARY 1, 2022

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

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

| Common Medical Event                                   | Services You May Need      | Your cost if you use an                            |   | Limitations and Exceptions   |
|--|----------------------------|--|---|--|
|  |                            | In-Network Provider                                | Out-of-Network Provider   |  |
| If you or your dependents (if applicable) need eyecare | Eye Exam                   | \$10.00 Copay                                      | Reimbursed up to \$50.00  | Exam covered in full every 12 months**                               |
|  | Frames, Lenses or Contacts | Glasses: \$0.00 Copay (lenses and/or frames only); | Frames reimbursed up to \$ 60.00<br>SV Lenses reimbursed up to \$ 45.00<br>Bi-Focal Lenses reimbursed up to \$ 65.00<br>Tri-Focal Lenses reimbursed up to \$85.00<br>Lenticular Lenses reimbursed up to \$125.00<br>ECL reimbursed up to \$110.00 | Frames covered every 24 months**<br>Lenses covered every 24 months** |
|  | Fees                       |  |   |  |

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

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800.400.4569.