

GROUP VISION PLAN

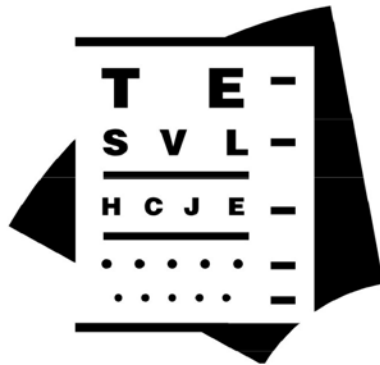
EVIDENCE OF COVERAGE

Provided by



3333 Quality Drive, Rancho Cordova, CA 95670
Customer Service: (800) 877-7195
Website: www.vsp.com

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



Group Plan Number:
#12292796

Effective January 1, 2007

CSU The California State University

GROUP VISION PLAN - EVIDENCE OF COVERAGE BOOKLET
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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 IS A CONFLICT BETWEEN THE EVIDENCE OF COVERAGE AND THE GROUP PLAN CONTRACT, THE GROUP PLAN CONTRACT WILL PREVAIL.

DEFINITIONS:

| | |
|---------------------------------|---|
| ANISOMETROPIA | A condition of unequal refractive state for the two eyes, 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 same-sex domestic partnerships between persons who are both at least 18 years of age; and specified opposite sex domestic partnerships when one or both persons is/are the age of 62, 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 person who who meets the criteria for eligibility specified herein under Eligibility for Coverage, or is eligible for and chooses to pay for optional Continuation of Coverage. |
| EXPERIMENTAL NATURE | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP. |
| 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. |
| 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 coneshaped 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 who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP. |
| NON-MEMBER | Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has |

| | |
|--|--|
| PROVIDER | 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 COVERAGE

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

- 1) Currently active employee, and
- 2) appointed half-time or more for more than six month, or
- 3) appointed as an academic year lecturer or coach appointed for at least six (6) weighted teaching units or more for at least one semester or two or more consecutive quarter terms.

Dependents: the persons eligible for coverage as dependents shall include:

- 1) the legal spouse, or
- 2) registered Domestic Partner of any Enrollee, and
- 3) any unmarried child under 23 years of age. An unmarried child includes any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, Enrollees step-child, child living with the 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.

A dependent, unmarried 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.

EFFECTIVE DATE OF COVERAGE

Your enrollment will be effective on the later of:

- 1) the first day of the month coinciding with or following the date of eligibility; or
- 2) the date Enrollee resumes active work, if not actively at work on the day Enrollee became eligible.

TERMINATION OF COVERAGE: Your coverage will terminate on the earliest of:

- 1) the date this Plan is terminated;
- 2) the last day of the last month for which premium payment is made on your behalf;
- 3) the date you cease to be eligible for coverage under this Plan;
- 4) the date you enter the armed services of any state or country unless you are on paid status ; or
- 5) the last day of the month following the month in which your employment with the Group terminates. Ceasing active work will be deemed termination of employment, and will result in termination of coverage except as follows:
 - A) If you are on approved leave of absence, coverage may be continued with payments made directly to VSP.

CONTINUATION OF INSURANCE DURING A LABOR DISPUTE

You may continue coverage for up to six months when:

- 1) your employer's premium contributions are required by a collective bargaining agreement; and
- 2) your eligibility ends because your employment ceases due to a labor dispute. To continue insurance during a labor dispute, you must send VSP a written request to continue insurance, and pay the first monthly premium payment.

Insurance continued during a labor dispute will end on the earlier of:

- 1) the date coverage has been continued for six months;
- 2) the date you begin full-time employment with another employer;
- 3) the date fewer than 75% of the eligible employees for this continuation are continuing their coverage;
- 4) the end of the period for which the last premium was paid; or
- 5) the date coverage would otherwise terminate, had you remained an active half-time employee.

During a labor dispute, you must continue to pay VSP the required monthly premium on or before its due date. A grace period of 31 days from the due date will be allowed for the payment of each premium. The monthly premium will be calculated using the same rate VSP would have charged for your coverage, if you had remained an active half-time employee. VSP retains the right to adjust the rates during the continuation period.

PREMIUMS

CSU is responsible for payments to VSP of the monthly charges for your coverage. Currently, the entire cost of the program is paid to VSP by CSU.

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.

1. 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) 877-7195, or write VSP to obtain one that does.
2. 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.
3. 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.
4. 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.

5. 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.

6. 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 VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

- A. **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.
- B. **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 VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's 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.

1. **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.
2. **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.
3. **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.

4. 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 Visually Necessary contact lenses from a Member Doctor, professional fees and materials will be covered as indicated on the enclosed insert with prior authorization from VSP. **Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider is subject to review and authorization from VSP's optometric consultants.**

If you select contact lenses for other than Visually Necessary circumstances, they will be considered Elective contact lenses. 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 exam, evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. 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.

6. 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.**

EXCLUSIONS 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.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

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

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

LIABILITY IN EVENT OF NON-PAYMENT

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 VSP's 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 VSP's review. 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 VSP's receipt 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 VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. 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.

B. 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) 877-7195**

VSP's determination, 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 VSP's determination, 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.

C. 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) 877-7195** 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 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site <http://www.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.

VSP

**3333 Quality Drive
Rancho Cordova, CA 95670**

*California State University
VISION CARE PLAN EVIDENCE OF COVERAGE*

PLAN AND SCHEDULE:

| | |
|----------------|---------------------------------------|
| <i>EXAM:</i> | <i>ONCE EVERY CALENDAR YEAR</i> |
| <i>LENSES:</i> | <i>ONCE EVERY OTHER CALENDAR YEAR</i> |
| <i>FRAMES:</i> | <i>ONCE EVERY OTHER CALENDAR YEAR</i> |

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:

*VSP
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670*

SCHEDULE OF BENEFITS

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of Vision Service Plan Insurance Company ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Evidence of Coverage to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Select Network. When Plan Benefits are received from Member Doctors, benefits appearing in the Member Doctor Benefit column below are applicable subject to any Copayments and other conditions, limitations and/or exclusions as stated below.

When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-Member Provider Benefit column below less any applicable Copayment. The Covered Person pays the provider's full fee at the time of service and submits an itemized bill and a completed Out-of-Network Reimbursement form to VSP for reimbursement.

PLAN BENEFITS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

VISION CARE SERVICES

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

VISION CARE MATERIALS

Lenses (per Pair)

| | | | |
|---------------|-----------------|-------|----------|
| 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 Options

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

| | | | |
|--------|-----------------------|-------|---------|
| Frames | Covered up to \$95.00 | Up to | \$60.00 |
|--------|-----------------------|-------|---------|

CONTACT LENSES

| | | | |
|--|------------------|-------|-----------|
| Visually 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 |
|--|-----------------|-------|----------|

VDT

This supplemental benefit is offered only to employees whose job requires use of a Video Display Terminal on a regular basis. Employee must obtain a VDT form from their campus Benefits Office and present to the VSP Select Network doctor to receive services. Supplemental exam included which entails additional tests to determine employee's visual needs in relation to VDT. Single vision, lined bifocal and lined trifocal lenses covered in full, if obtained from an in-network provider. Interim benefits apply to the lenses. Frame covered up to \$95, if obtained from an in-network provider. If services and/or materials are obtained from a non-network provider, reimbursement will be based on the schedule of allowances for non-network providers.

For more information regarding this Additional Benefit, please see the VDT Benefit Rider attached hereto.

Bills for services and materials from non-VSP providers should be paid in full, then copies submitted to VSP for reimbursement up to the amounts shown. The VDT form must be included if you receive services for the supplemental benefit. Mail paperwork to the following address:

*VSP
PO Box 997105
Sacramento, CA 95899-7105
Attn: Out-of-Network Claims*

ADDENDUM

VSP ADDITIONAL BENEFIT RIDER - VDT EYECARE PLAN (ENROLLEES ONLY)

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copays and other conditions, limitations and/or exclusions stated herein. This Schedule forms a part of the Evidence of Certificate to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS AND WHO UTILIZE A VIDEO DISPLAY TERMINAL SHALL BE ELIGIBLE FOR THE VDT PROGRAM.

This supplemental benefit is offered only to employees whose job requires use of a Video Display Terminal at least four hours per day. Employee must obtain a VDT form from their campus Benefits Office and present to the VSP Select Network doctor to receive services. Supplemental exam included which entails additional tests to determine employee's visual needs in relation to VDT. Single vision, lined bifocal and lined trifocal lenses covered in full. Frame covered up to \$95 if services are provided by a member doctor. Interim benefits apply to the lenses.

SERVICES FROM VSP DOCTORS

EYE EXAM

A complete initial analysis which includes an appropriate examination of visual functions to determine the presence of vision problems or other abnormalities is covered through the base plan's exam benefit.

A supplemental vision analysis of the eyes and related structures will be provided to determine visual needs specific to VDT EyeCare requirements.

Each Covered Person shall be entitled to a supplemental eye exam based on the frequency as indicated in the **VDT SCHEDULE OF BENEFITS**.

MATERIALS

A. **LENSES** - *The VSP Doctor will order proper lenses necessary for the VDT user's visual welfare.*

Each Covered Person is entitled to new lenses based on the frequency as indicated on the attached **VDT SCHEDULE OF BENEFITS**.

B. **FRAMES** - *New frames will be provided based on the frequency as indicated on the attached **VDT SCHEDULE OF BENEFITS**.*

VSP reserves the right to limit the cost of the frames provided by VSP Doctors under the Plan. The current allowance shall be published periodically by VSP to its VSP Doctors and will be set at a level to cover a sufficient number of frames in common use.

C. **LENS OPTIONS** - *Lens options will be provided based on the frequency and allowances as indicated on the attached **VDT SCHEDULE OF BENEFITS**.*

ASSOCIATED VISION THERAPY

This benefit is limited to Covered Persons who are eligible for VDT coverage who have one of the following diagnoses:

- **Accommodative Infacility** - The inability (or inefficiency) to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at things up close).
- **Convergence Insufficiency** - The occasional problem with the eye muscle's ability to point the eyes straight when working up close.

The maximum annual benefit is \$200.00. A Copay is not required from the Covered Person.

COPAY

The benefits described herein are available to each Covered Person from any participating VSP Doctor at no cost to the Covered Person, provided Covered Person follows the proper procedures by obtaining Benefit Authorization.

A COPAYMENT AMOUNT AS INDICATED ON THE ATTACHED **VDT SCHEDULE OF BENEFITS** SHALL BE PAYABLE BY THE COVERED PERSON TO THE VSP DOCTOR AT THE TIME OF SERVICES.

VDT EYECARE SCHEDULE OF BENEFITS

SERVICES FROM VSP DOCTORS

| <u>SERVICES</u> | <u>FREQUENCY</u> | <u>MEMBER DOCTOR BENEFIT</u> |
|------------------------|---|-------------------------------------|
| Eye Exam | Every other CALENDAR year beginning January 1st | Covered in full |
| Lenses* | Every other CALENDAR year beginning January 1st | Covered in full |
| Frame | Every other CALENDAR year beginning January 1st | Covered up To \$ 95.00 |

COPAY

| | |
|------|---------|
| Exam | \$10.00 |
|------|---------|

INTERIM BENEFITS FOR LENSES*

New lenses will be approved and replaced every calendar year if at least one of the following criteria is met: (1) the new prescription differs from the original by at least a .50 diopter sphere or cylinder; (2) there is a change in the axis of 15 degrees or more; and (3) a difference in vertical prism greater than one prism diopter.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS

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

- *Optional cosmetic processes.*
- *Anti-reflective coating.*
- *Color coating.*
- *Mirror coating.*
- *Scratch coating.*
- *Cosmetic lenses.*
- *Laminated lenses.*
- *Oversize lenses.*
- *Progressive multifocal lenses.*
- *Photochromic lenses.*
- *Tinted lenses.*
- *UV (ultraviolet) protected 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 is no benefit 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 $\pm.50$ 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.*
- *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.*
- *Services and/or materials not indicated on this Schedule as covered Plan Benefits.*

VSP may, at its discretion, waive any of the plan limitations if, in the opinion of our optometric consultants, this is necessary for the visual welfare of the Covered Person.

VDT EYECARE SCHEDULE OF BENEFITS (CONTINUED)

SERVICES FROM OUT-OF-NETWORK PROVIDER

LIABILITY OF COVERED PERSONS FOR PAYMENT

REIMBURSEMENT PROVISIONS

When a Covered Person chooses 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. The Covered Person should pay the doctor his full fee. VSP will reimburse in accordance with the following schedule. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAM OR THE MATERIALS.

AVAILABILITY OF SERVICES UNDER THIS REIMBURSEMENT SCHEDULE IS SUBJECT TO THE SAME TIME LIMITS AND COPAY AS THOSE DESCRIBED FOR MEMBER SERVICES. SERVICES OBTAINED FROM A NON-MEMBER PROVIDER ARE IN LIEU OF OBTAINING SERVICES FROM A MEMBER DOCTOR OF VSP.

VSP IS UNABLE TO REQUIRE NON-MEMBER PROVIDERS TO UPHOLD VSP'S QUALITY STANDARDS.

MAXIMUM REIMBURSEMENT FOR SERVICES

FROM NON-MEMBER PROVIDER

| MATERIALS | PAIR |
|------------------------------------|----------|
| Eye Examination, up to | \$ 50.00 |
| Single Vision Lenses (PAIR), up to | \$ 45.00 |
| Bifocal Lenses (PAIR), up to | \$ 65.00 |
| Trifocal Lenses (PAIR), up to | \$ 85.00 |
| FRAME, UP TO | \$ 60.00 |

Bills for services and materials from non-VSP providers should be paid in full by the Enrollee, then copies submitted to VSP for reimbursement up to the amounts shown. The VDT form must be included if you receive services for the supplemental benefit. Mail paperwork, including a completed Out-of-Network Reimbursement form to the following address:

VSP
PO Box 997105
Sacramento, CA 95899-7105
Attn: Out-of-Network Claims