

# Group Vision Care Plan



## EVIDENCE OF COVERAGE & DISCLOSURE FORM

Provided by:

3333 Quality Drive, Rancho Cordova, CA 95670  
(916) 851-5000 (800) 877-7195

THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM DISCLOSES THE TERMS AND CONDITIONS OF COVERAGE. PLEASE READ THE FORM COMPLETELY AND CAREFULLY. INDIVIDUALS WITH SPECIAL HEALTHCARE NEEDS SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THEM. ALL APPLICANTS HAVE A RIGHT TO REVIEW THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT.

**To be filled in by employer in the event this document is used to develop a Summary Plan Description:**

NAME OF EMPLOYER:  
NAME OF PLAN:  
PRINCIPAL ADDRESS:

This page does not need to be completed as the City of Palo is a public entity and not bound by the Department of Labor requirements.

EMPLOYER I.D.#:

PLAN #:

PLAN ADMINISTRATOR:  
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

**THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE TERMS AND CONDITIONS OF COVERAGE. THE PLAN CONTRACT ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING TERMS AND CONDITIONS OF COVERAGE.**

**DEFINITIONS:**

- |                                 |  |
|---------------------------------|--|
| <b>ADDITIONAL BENEFIT RIDER</b> | The document attached to this Evidence of Coverage,, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.  |
| <b>ANISOMETROPIA</b>            | A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.  |
| <b>BENEFIT AUTHORIZATION</b>    | 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.  |
| <b>COPAYMENTS</b>               | Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.   |
| <b>COVERED PERSON</b>           | An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.   |
| <b>ELIGIBLE DEPENDENT</b>       | Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator under which such Enrollee is covered. |
| <b>EMERGENCY CONDITION</b>      | 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.   |
| <b>ENROLLEE</b>                 | 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.  |
| <b>EXPERIMENTAL NATURE</b>      | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.  |
| <b>GROUP</b>                    | An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.   |

<b>KERATOCONUS</b>	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.
<b>MEMBER DOCTOR</b>	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.
<b>NON-MEMBER PROVIDER</b>	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.
<b>PLAN BENEFITS</b>	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 or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.
<b>PREMIUMS</b>	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.
<b>RENEWAL DATE</b>	The date on which this plan shall renew or terminate if proper notice is given.
<b>SCHEDULE OF BENEFITS</b>	The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.
<b>SCHEDULE OF PREMIUMS</b>	The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

## **ELIGIBILITY FOR COVERAGE**

Enrollees: To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any child of an Enrollee who has not attained the limiting age as shown on the enclosed insert, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

A dependent, unmarried child over the limiting age as shown on the enclosed insert 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.

## **ANNUAL ENROLLMENT/DISENROLLMENT**

Except for new Enrollees joining this plan, Enrollees and Eligible Dependents shall have the right to become covered or cancel coverage once each year during the thirty (30) day period beginning sixty (60) days prior to the anniversary of the effective date of this plan (or as may otherwise be allowed by mutual agreement between the Group and VSP). Any such coverage or cancellation of coverage may be accomplished only by Group giving VSP written notice thereof on behalf of the Enrollee or Eligible Dependent before the end of the prescribed thirty (30) day period and will take effect on the anniversary date following receipt of such notice.

## **PREMIUMS**

Your Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by your Group.

## PROCEDURES FOR USING THIS PLAN

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

1. When you desire 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 your Group, Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one which 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 (if any) to the Member Doctor for the services covered 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 are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his full fee. 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. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, 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 to Covered Person by Group.

- A. **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 Department.

## **BENEFITS AND COVERAGES**

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, 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 a 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 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.

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 your Plan includes Non-Member Provider coverage and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his 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 EXAMINATION 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.
6. **Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert):** 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.

## **COPAYMENT**

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

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

This Plan is designed to cover *visual* needs rather than *cosmetic* materials. If you select any of the following extras, this Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra 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.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- 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:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than  $\pm .50$  diopter power); or 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.
- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
- Services/materials not indicated as covered Plan Benefits on the enclosed insert.

## 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.

### 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.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 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. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

**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 VSP, you should first telephone VSP at (800) 877-7195 and use VSP's health plan 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 any grievance involving an emergency, a grievance that has not been satisfactorily resolved by VSP, 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 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 (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's 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.



## **TERMINATION OF BENEFITS**

Terms and cancellation conditions of this plan are shown on the enclosed insert. 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.

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

Group Name: CITY OF PALO ALTO

Plan Number: 00102584

Effective Date: JANUARY 1, 2015

Plan Term: THIRTY-SIX (36) MONTHS

**VISION CARE PLAN  
DISCLOSURE FORM AND EVIDENCE OF COVERAGE**

**PLAN ADMINISTRATOR:** Brenna Rowe  
(Name)  
Po Box 10250  
(Address)  
Palo Alto, CA 94303-0862  
(City, State, Zip)

**MONTHLY PREMIUM:** YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

**ELIGIBILITY:** ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **SIGNATURE PLAN \$20 Copay**

**EXAMINATION:** ONCE EVERY 12 MONTHS\*  
**LENSES:** ONCE EVERY 24 MONTHS\*  
**FRAMES:** ONCE EVERY 24 MONTHS\*

\*Beginning with the first date of service

**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 SIXTY (60) 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

## **SCHEDULE OF BENEFITS**

### **GENERAL**

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any 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 services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

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.

<b><u>PLAN BENEFITS</u></b>	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
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### **VISION CARE SERVICES**

Vision Examination	Covered in Full*	Up to \$	50.00*
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### **VISION CARE MATERIALS**

Lenses			
Single Vision	Covered in Full*	Up to \$	50.00*
Bifocal	Covered in Full*	Up to \$	75.00*
Trifocal	Covered in Full*	Up to \$	100.00*
Lenticular	Covered in Full*	Up to \$	125.00*

Frames	Covered up to Plan Allowance*	Up to \$	70.00*
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

### **CONTACT LENSES**

Necessary			
Professional Fees and Materials	Covered in Full*	Up to \$	210.00*

Elective			
Professional Fees** and Materials	Up to \$ 105.00	Up to \$	105.00

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

**\*\*15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.**

### **COPAYMENT**

A Copayment amount of \$20.00 shall be payable by the Covered Person to the Member Doctor or Non-Member Doctor at the time services are rendered.

**LOW VISION**

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

<i>Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)</i>	<i>Covered in Full</i>	<i>Up to \$125.00</i>
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<i>Supplemental Aids</i>	<i>75% of cost</i>	<i>75% of cost</i>
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*Maximum allowable for all Low Vision benefits of \$1000.00 every two (2) years.*

***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.***

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Plan Number: 00102584

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**PLAN ADMINISTRATOR:** Brenna Rowe  
(Name)  
Po Box 10250  
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Palo Alto, CA 94303-0862  
(City, State, Zip)

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**ELIGIBILITY:** ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

**PLAN AND SCHEDULE:** **SIGNATURE PLAN \$10 Copay**

**EXAMINATION:** ONCE EVERY 12 MONTHS\*\*  
**LENSES:** ONCE EVERY 12 MONTHS\*\*  
**FRAMES:** ONCE EVERY 12 MONTHS\*\*

\*\*Beginning with the first date of service

**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 SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

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

## **SCHEDULE OF BENEFITS**

### **GENERAL**

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any 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 services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

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.

<b><u>PLAN BENEFITS</u></b>	<b><u>MEMBER DOCTOR BENEFIT</u></b>	<b><u>NON-MEMBER PROVIDER BENEFIT</u></b>
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### **VISION CARE SERVICES**

Vision Examination	Covered in Full*	Up to \$	50.00*
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### **VISION CARE MATERIALS**

Lenses			
Single Vision	Covered in Full*	Up to \$	50.00*
Bifocal	Covered in Full*	Up to \$	75.00*
Trifocal	Covered in Full*	Up to \$	100.00*
Lenticular	Covered in Full*	Up to \$	125.00*
Frames	Covered up to Plan Allowance*	Up to \$	70.00*

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

### **CONTACT LENSES**

Necessary			
Professional Fees and Materials	Covered in Full*	Up to \$	210.00*
Elective			
Professional Fees** and Materials	Up to \$ 200.00	Up to \$	105.00

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

**LENS OPTIONS**

Anti-reflective coating	Covered in full**	Not Covered
Polycarbonate Lenses	Covered in full	Not Covered

\*\*Less \$25.00 copayment

**\*Subject to Copayment, if any.**

**\*\*15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.**

**COPAYMENT**

A Copayment amount of \$10.00 shall be payable by the Covered Person to the Member Doctor or Non-Member Doctor at the time services are rendered.

**LOW VISION**

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

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Covered in Full	Up to \$125.00
Supplemental Aids	75% of cost	75% of cost

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

**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.**

**ADDENDUM**

**ADDITIONAL BENEFIT RIDER  
SECOND PAIR  
(DIVISIONS 0015, 0016, 0017, 0020, 0021)**

**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 or in the Schedule of Benefits with which it is associated. 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:

- Enrollee.
- The legal spouse of Enrollee.
- Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules.
- Any child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

**COPAYMENT**

A Copayment amount of \$10.00 shall be payable by the Covered Person at the time services are rendered.

**PLAN BENEFITS**

<b>MATERIAL</b>	<b>MEMBER DOCTOR BENEFIT</b>	<b>FREQUENCY</b>
<b>Lenses</b>	Covered in full*	Available once each 12 months**
*Less any applicable Copayment **Beginning with the first date of service Plan Benefits for lenses are per complete set, not per lens.		
<b>Frames</b>	Covered up to Plan allowance*	Available once each 12 months**

<b>MATERIAL</b>	<b>MEMBER DOCTOR BENEFIT</b>	<b>FREQUENCY</b>
<b>Lens Options</b>		Available once each 12 months**
Anti-reflective coating	Covered in full**	
**Less \$25.00 copayment		
Polycarbonate lenses	Covered in full	

<b>Contact Lenses</b>		
Necessary	Covered in full *	Available once every 12 months**
Elective	Up to \$ 200.00*	Available once every 12 months**
*Less any applicable Copayment **Beginning with the first date of service		
Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.		
<b>Contact lenses are provided in lieu of all other lens and frame benefits available herein.</b>		



When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

### SECOND PAIR BENEFIT ONLY

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

### NOT COVERED

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

- Eye examinations.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
- Plano contact lenses to change eye color cosmetically.
- 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.
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowance.
- Services and/or materials not included on this Rider as covered Plan Benefits.

**SERVICES FROM NON-MEMBER PROVIDERS**

LIABILITY OF COVERED PERSONS FOR PAYMENT  
REIMBURSEMENT PROVISIONS

When a Covered Person chooses to receive services from a Non-Member 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 Provider's fee in full. VSP will reimburse the Covered Person in accordance with the following schedule.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL BE SUFFICIENT TO PAY THE EXAMINATION OR THE MATERIALS IN FULL.

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

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

**SCHEDULE OF ALLOWANCES**

MATERIAL	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
<b>Lenses</b>		
Single Vision	Up to \$ 50.00*	Available once each 12 months**
Bifocal	Up to \$ 75.00*	Available once each 12 months**
Trifocal	Up to \$ 100.00*	Available once each 12 months**
Lenticular	Up to \$ 125.00*	Available once each 12 months**
<b>Frame</b>		
Up to \$ 70.00*		Available once each 12 months**
<p>*Less any applicable Copayment  **Beginning with the first date of service.   Plan Benefits for lenses are per complete set, not per lens.</p>		
<b>Contact Lenses</b>		
Necessary	Up to \$ 210.00*	Available once each 12 months**
Elective	Up to \$ 105.00*	Available once each 12 months**

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

**ADDENDUM**

**ADDITIONAL BENEFIT RIDER  
COMPUTER VISIONCARE PLAN  
(DIVISIONS 0014 & 0019)**

**GENERAL**

This Rider lists the 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. This Rider forms a part of the Plan or Evidence of Coverage to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED BELOW AND WHO UTILIZE A COMPUTER MONITOR SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.

**ELIGIBILITY**

The following are Covered Persons under this Plan.

- Enrollee.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

**COPAYMENT**

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from Member Doctors and Non-Member Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be no Copayment payable by the Covered Person to the Member Doctor or the Non-Member Provider at the time services are rendered.

**PLAN BENEFITS**

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Available once each 12 months**
<b>A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use.</b>		
*Less any applicable Copayment **Beginning with the first date of service		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use.	
Single Vision	Covered in full *	Available once each 12 months**
Bifocal	Covered in full *	
Trifocal	Covered in full *	
Near Variable Focus	Covered in full *	
Occupational Progressive	Covered in full *	
Plan Benefits for lenses are per complete set, not per lens.		
*Less any applicable Copayment **Beginning with the first date of service		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Available once each 24 months**
VSP reserves the right to limit the cost of the frames provided by Member Doctors under this Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.		
*Less any applicable Copayment **Beginning with the first date of service.		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Associated Vision Therapy (specific to computer use)	Up to \$200.00 per year (includes any supplemental testing)	Available once each 12 months**
**Beginning with the first date of service.		
This benefit is limited to Covered Persons who are eligible for CVC Coverage and who are diagnosed as having one of the following conditions:		
<p><b>Accommodative Infacility</b> – 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.)</p> <p><b>Convergence Insufficiency</b> – The occasional problem with the eye muscles' ability to point the eyes straight when working up close.</p>		

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

### CVC VISIONCARE PLAN

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

### 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.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

### 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.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- 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.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

**ADDENDUM**

**ADDITIONAL BENEFIT RIDER  
COMPUTER VISIONCARE PLAN  
(DIVISIONS 0020 & 0021)**

**GENERAL**

This Rider lists the 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. This Rider forms a part of the Plan or Evidence of Coverage to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED BELOW AND WHO UTILIZE A COMPUTER MONITOR SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.

**ELIGIBILITY**

The following are Covered Persons under this Plan.

- Enrollee.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

**COPAYMENT**

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from Member Doctors and Non-Member Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

A Copayment amount of \$10.00 shall be payable by the Covered Person at the time services are rendered.

**PLAN BENEFITS**

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Available once each 12 months**
<b>A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use.</b>		
*Less any applicable Copayment **Beginning with the first date of service		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use.	
Single Vision	Covered in full *	Available once each 12 months**
Bifocal	Covered in full *	
Trifocal	Covered in full *	
Near Variable Focus	Covered in full *	
Occupational Progressive	Covered in full *	
Plan Benefits for lenses are per complete set, not per lens.		
*Less any applicable Copayment **Beginning with the first date of service		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Available once each 12 months**
VSP reserves the right to limit the cost of the frames provided by Member Doctors under this Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.		
*Less any applicable Copayment **Beginning with the first date of service		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Associated Vision Therapy (specific to computer use)	Up to \$200.00 per year (includes any supplemental testing)	Available once each 12 months**
**Beginning with the first date of service		
This benefit is limited to Covered Persons who are eligible for CVC Coverage and who are diagnosed as having one of the following conditions:		
<p><b>Accommodative Infacility</b> – 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.)</p> <p><b>Convergence Insufficiency</b> – The occasional problem with the eye muscles' ability to point the eyes straight when working up close.</p>		



## EXCLUSIONS AND LIMITATIONS OF BENEFITS

### CVC VISIONCARE PLAN

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

### 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.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

### 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.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%.
- Laminated lenses.
- 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.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

**ADDENDUM**

**ADDITIONAL BENEFIT RIDER  
SAFETY EYECARE PLAN  
(DIVISIONS 0010, 0019 AND 0016, 0021)**

**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. This Rider forms a part of the Plan or Evidence of Coverage to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED UNDER ARTICLE VI. OF THE GROUP VISION CARE Plan AND WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE SAFETY EYECARE PLAN.

**ELIGIBILITY**

The following are Covered Persons under this Plan.

- Enrollee.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

**COPAYMENT**

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered person. Plan Benefits received from Member Doctors and Non-Member Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be no Copayment payable by the Covered Person to the Member Doctor or the Non-Member Provider at the time services are rendered.

**PLAN BENEFITS**

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Covered in full*	Available once each 12 months**
<b>Member Doctors shall ensure that lenses provided under the Safety EyeCare Plan meet the following minimum standards:</b> <ul style="list-style-type: none"><li>• Be no less than 3mm at the thinnest point.</li><li>• Be impact-tested with a one-inch steel ball dropped from a height of 50 inches.</li><li>• Be engraved by the manufacturer that it is a safety lens.</li></ul> <p>*Less any applicable Copayment **Beginning with the first date of service</p>		

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Available once each 24 months**
<p><b>Member Doctors shall ensure that frames provided under the Safety EyeCare Plan meet the following minimum standards:</b></p> <ul style="list-style-type: none"> <li>• Have a “Z-87” stamp on the front and temples.</li> <li>• Be fabricated of a slow-burning material.</li> <li>• Have the manufacturer’s logo imprint.</li> <li>• Be constructed so that, if impacted from the front, the lens will not come out through the back of the frame.</li> </ul> <p>Materials will be certified as safe for a work environment by meeting the required test standards as set forth by the American National Standards Institute (ANSI).</p> <p>VSP reserves the right to limit the cost of the frames provided by Member Doctors under this Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.</p> <p>*Less any applicable Copayment  **Beginning with the first date of service</p>		

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

### SAFETY EYECARE PLAN

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

### 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.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

### 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 VDT eye care.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Photochromic or tints greater than 20%
- Laminated lenses
- 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.
- Examinations above a Limited Level unless the Covered Person: (i) is not eligible for an eye examination under the Plan to which this Rider is attached; (ii) received an eye examination from another Member Doctor during the same eligibility period; or (iii) received an eye examination during the preceding 6 months from a practitioner in the same Member Doctor's office that will be providing the VDT eye care examination.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.

## **ADDENDUM**

### **ADDITIONAL BENEFIT RIDER REPAIR/REPLACE BENEFITS (DIVISIONS 0010, 0019 and 0016, 0021)**

#### **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 or in the Schedule of Benefits with which it is associated. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

Repair/Replace Benefits provide coverage for materials obtained when the Covered Person is not eligible for materials under the Schedule of Benefits to which this Rider is attached. Covered Persons are eligible if their spectacle lenses or frame are broken or damaged and in need of repair or replacement.

Persons covered under this additional benefit may be entitled to eyeglass frame repairs, which shall include but not be limited to temples only, front only, hinge and miscellaneous repairs; or replacement of complete frame and single vision and multifocal lens repair or replacement.

#### **ELIGIBILITY**

The following are Covered Persons under this Plan:

- Enrollee

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

#### **COPAYMENT**

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

**PLAN BENEFITS**

VSP may authorize payment under this Rider for materials for Covered Persons more frequently than 12 months if

1. Eyeglass frames are broken or damaged, which shall include but are not limited to temples only, front only, hinge and miscellaneous repairs. Replacement of complete frame may be covered if frame is damaged beyond repair.
2. Single vision and multifocal lens require repair or replacement.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
<b>Lenses</b>	Refer to Schedule of Benefits	Available once each 12 months**
<b>Frames</b>	Refer to Schedule of Benefits	Available once each 12 months**
<p>VSP reserves the right to limit the cost of the frames provided by its Member Doctors under the Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.</p> <p>If the Covered Person wishes to select a more expensive frame than that allowed under this Rider, the cost difference shall be by agreement between the Covered Person and Member Doctor.</p> <p>Plan Benefits for lenses are per complete set, not per lens.</p>		

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**  
REPAIR/REPLACE BENEFIT ONLY

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

**NOT COVERED**

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

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
3. Two pair of glasses in lieu of bifocals.
4. Medical or surgical treatment of the eyes.
5. Corrective vision treatment of an Experimental Nature.
6. Services or materials of a cosmetic nature.
7. Costs for services and/or materials exceeding Plan Benefit allowances.
8. Services and/or materials not indicated on this Rider as covered Plan Benefits.



Vision Care for Life

## CONTINUATION COVERAGE UNDER CAL-COBRA

If you are covered under a group policy providing coverage to 2 to 19 eligible employees, you may be eligible to purchase continued coverage under this group vision plan under California Health and Safety Code Section 1366.20 et seq. (Cal-COBRA).

You may qualify for Cal-COBRA continuation coverage if you lose coverage for one of the following reasons:

- a. The death of the covered employee.
- b. The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.
- c. The divorce or legal separation of the covered employee from the covered employee's spouse.
- d. The loss of dependent status by a dependent enrolled in the group benefit plan.
- e. With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

As a condition of receiving benefits, you must notify VSP within 60 days of the loss of coverage for one of the foregoing reasons. **FAILURE TO NOTIFY VSP WITHIN THE REQUIRED 60 DAY PERIOD WILL DISQUALIFY YOU FROM RECEIVING CONTINUATION COVERAGE.**

You must request the continuation in writing and deliver the written request to VSP by first class mail or other reliable means of delivery within the 60 day period following the later of (1) the date your coverage under the group benefit plan terminated or will terminate by reason of a qualifying reason, or (2) the date you were sent notice from the group benefit plan or VSP of eligibility to continue coverage under Cal-COBRA.

In order to continue receiving coverage under this plan, you are responsible for making all of the required premium payments in accordance with the terms and conditions of the plan contract. The first premium payment must be made to VSP by first-class mail, certified mail or other reliable means of delivery including personal delivery, express mail, or private courier within 45 days of the date you provided written notice to VSP of your election of continuation of benefits. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify you from receiving continuation coverage.

Notice: If the contract between VSP and the employer is terminated prior to the date your continuation coverage would terminate pursuant to the Cal-COBRA statute, you may elect continuation coverage under the employer's subsequent group benefit plan, if any, for the balance of the period you would have remained covered under this plan. However, continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in and payment of premiums to the new benefit plan within 30 days of receiving notice of termination of the prior group benefit plan.

All notices to VSP must be sent to:

VISION SERVICE PLAN  
Attn: COBRA Administration  
3333 Quality Drive  
Rancho Cordova, CA 95670



## ADDENDUM

### EVIDENCE OF COVERAGE & DISCLOSURE FORM

Please note the following revisions to your Evidence of Coverage and Disclosure Form. Keep this document with your Evidence of Coverage and Disclosure Form for a complete and accurate description of your benefits.

1. The following provision is added to the section titled **DEPENDENT ELIGIBILITY**:

Domestic Partners: Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits.



Contact Lenses (Elective)	Includes such professional services as are necessary, which shall include: contact lens evaluation, fitting, and verifying the accuracy of the finished lenses.	Copay for exam (if applicable) would apply here. Normally ranges from \$0 - \$50 (Can be group specific)	Any amount exceeding VSP's contact lens allowance (as determined by the group).	Maximum determined by lens eligibility. Can be once every 12, 24 or 36 months (as determined by the group)	Yes	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
Contact Lenses (Necessary)	Prior Authorization required. Includes such professional services as are necessary, which shall include: contact lens evaluation, fitting, and verifying the accuracy of the finished lenses.	Copay for exam and materials (lenses and frame - if applicable) would apply here. Normally ranges from \$0 - \$50 (Can be group specific)	None. Covered in full for most lens types.	Maximum determined by lens eligibility. Can be once every 12, 24 or 36 months (as determined by group)	Yes	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
Low Vision	If included in the plan: Prior authorization required. Includes such professional services as are necessary, which shall include: Supplemental testing Low Vision RX Evaluations Optical & non-optical aids Training Plan pays 50-75% of the approved allowable amount (maximum allowable is \$500 to \$1,000. Benefit is plan specific and can be group specific.)	25-50% of the approved allowable amount (Maximum allowable is \$500 to \$1,000. Benefit is plan specific and can be group specific.)	Any amount exceeding the maximum allowable amount.	Every 2 years	No	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE

**Summary of Benefits and Coverage**  
**SIGNATURE PLAN (\$20 Copay)**

**Prepared for:** CITY OF PALO ALTO  
**Group ID:** 00102584  
**Effective Date:** JANUARY 1, 2015

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	*	Reimbursed up to \$50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	*	Frames reimbursed up to \$ 70.00 SV Lenses reimbursed up to \$ 50.00 Bi-Focal Lenses reimbursed up to \$ 75.00 Tri-Focal Lenses reimbursed up to \$100.00 Lenticular Lenses reimbursed up to \$125.00 ECL reimbursed up to \$105.00	Frames covered every 24 months** Lenses covered every 24 months**
	Fees	\$20.00 Copay		

\* Fees copay applies to first service used

\*\* Beginning with the first date of service

**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: 800-877-7195.

**Summary of Benefits and Coverage**  
**SIGNATURE PLAN (\$10 Copay)**

**Prepared for:** CITY OF PALO ALTO  
**Group ID:** 00102584  
**Effective Date:** JANUARY 1, 2015

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