Vision Care Plan Disclosure Statement and Evidence of Coverage

Effective January 1, 2025

Basic Plan, 30052011
Premier Plan, 30034581

PLAN ADMINISTRATOR:

California Department of
Human Resources Benefits Division
1515 "S" Street, North Bldg., Suite 400
Sacramento, California 95811

CAL HR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES
Benefits Division

PROVIDED BY:

vsp vision care

3333 Quality Drive, Rancho Cordova, CA 95670
(800) 400-4569
vsp.com or stateofcaemployee.vspforme.com

T.T.Y. for the hearing impaired: 711

VSP is an Equal Opportunity and Affirmative Action employer.

FOREWORD

The state-sponsored vision benefit provides vision care coverage for eligible employees and their eligible dependents. Your vision benefit is being provided by VSP® Vision Care.

The information contained in this booklet constitutes only a summary of your vision benefit and should not be construed as a substitute for the terms and conditions contained in the contract between the State of California, CalHR, and VSP.

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ELIGIBILITY

Employees: Eligible employees are defined as: state employees that are (1) permanent employees appointed/working half-time or more who are designated represented rank and file, managerial, supervisory, confidential, and all other eligible employees excluded from collective bargaining, constitutional officers, employees of the judicial counsel, and supreme, appellate, and superior court judges; (2) limited-term employees or TAU appointees; (3) permanent-intermittent employees who work a minimum of 480 hours in each six-month control period ending June 30 or December 31; and (4) seasonal employees in Bargaining Units 7 and 8, as defined by their MOUs respectively; an employee appointed half-time or more to a temporary appointment in lieu of a permanent appointment, and a limited term employee who is half-time or more with an appointment of six months or more.

Represented employees in Bargaining Unit 6 have vision coverage through their union trust fund and are not eligible to enroll in the state's vision program unless otherwise designated by the state as eligible for this program.

Contact your personnel office for additional information regarding eligibility. Conditions of eligibility are subject to collective bargaining.

Dependents: Eligible dependents include the employee's spouse, registered domestic partner and dependent child under 26 years of age. Dependent children include: (1) natural child; (2) stepchild (3) legally adopted child or (4), a child living with the employee in a parent/child relationship.

A child may continue to be eligible as a dependent, beyond age 26, if he/she is incapable of self-sustaining employment due to mental incapacity or physical disability. Medical proof of such incapacity and dependency must be provided to VSP within 31 days of continued coverage and may be requested annually thereafter.

BASIC ENROLLMENT/EFFECTIVE DATE

Enrollment into the state's Basic Vision Plan for most eligible employees and their eligible dependents are automatic. Permanent-intermittent employees who meet the eligibility requirements must complete a Vision Plan Enrollment Authorization (STD 700).

Your Basic Vision coverage will be effective the first of the month following the pay period in which your earning statement shows an employer contribution. Contact your departmental personnel office for additional information regarding your enrollment and/or effective date of coverage.

PREMIER ENROLLMENT/EFFECTIVE DATE

If you elect to enroll in the state's Premier Vision Plan, you must do so within 60 days as a new hire or newly eligible status. Permanent-intermittent employees who meet the eligibility requirements must have their state agency complete a Vision Plan Enrollment Authorization (STD 700). The employee must complete a Premier Vision enrollment form (CALHR 774) which also has to be signed by the state agency representative.

Your Premier Vision coverage will be effective the first of the month following the pay period in which your earning statement shows an employer contribution. Contact your personnel office for additional information regarding your enrollment and/or effective date of coverage.

MONTHLY PREMIUM AND COPAYS

The state is responsible for payment of the monthly premium to VSP for the Basic Plan. The state pays a portion (equal to the Basic Plan) of the Premier Plan. See enrollment materials or VSP Member Benefit Summary for employee cost.

You and your eligible dependents will be required to pay a $10 copay to the VSP network doctor at the time of your eye exam or a $0 copay at a Premier Edge™ location. If eyewear (frames and/or lenses) or medically necessary contact lenses are provided, you will also be required to pay a $25 copay if you are enrolled in the Basic Plan or a $10 copay if you are enrolled in the Premier Plan, at the time the eyewear or medically necessary contact lenses are ordered. CCPOA Supervisors enrolled in the Premier plan will be required to pay a $35 copay for the second pair benefit if eyewear (frames and/or lenses) or medically necessary contact lenses are provided.

Any additional care, service, and/or eyewear not covered by this plan may be arranged between you and the provider.

PROCEDURE FOR USING THE PLAN

1. **Select a VSP network doctor.** If you need help locating one, call VSP at (800) 400-4569 or access the VSP website at vsp.com.
2. **Call your VSP network doctor for an appointment and identify yourself as a VSP member.** Simply provide your name and date of birth, as well as the last four digits of covered member's Social Security number and the organization that provides the coverage (the State of California).
3. **Your doctor and VSP handle the rest.** Your doctor will contact VSP to verify your eligibility and plan coverage. If you are not eligible at the time, the doctor will communicate this to you. If you are eligible, you'll need to pay any applicable copays at the time of your visit.

   Selecting a VSP network doctor assures direct payment to the doctor and guarantees quality services and eyewear.

PLAN AND SERVICE FREQUENCIES - Basic Plan

Exam	Once every calendar year
Lenses	Once every calendar year
Frames	Once every calendar year
Lens Options	Tints/Photochromics; polycarbonate lenses copay $35 for adults; polycarbonate lenses fully covered for children; progressive lenses copays between $55 and $175, depending on lens type.
Frames	up to $150
Contact Lenses	up to $110

PLAN AND SERVICE FREQUENCIES - Premier Plan

Exam	Once every calendar year
Lenses	Once every calendar year
Frames	Once every calendar year
Lens Options	Tints/Photochromics; polycarbonate lenses copay $15 for adults; polycarbonate lenses fully covered for children; progressive lenses copays between $0 and $120, depending on lens type.
Frames	up to $250
Costco Frames	up to $135
Walmart/Sam's Club Frames	up to $135
Contact Lenses	up to $200

PLAN AND SERVICE FREQUENCIES - Second Pair:
CCPOA Supervisors enrolled in the Premier Plan option offered through the State of California are entitled to a second pair benefit covered by the CCPOA Benefit Trust Fund. Second pair benefit includes:

Lenses	Once every calendar year
Frames	Once every calendar year
Lens Options	Tints/Photochromics and polycarbonate lenses are covered in full; progressive lenses copays between $55 and $175, depending on lens type.
Frames	up to $120
Contact Lenses	up to $110

SUMMARY OF BENEFITS

1. Vision Exam: You are entitled to a comprehensive exam, including a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.
2. Lenses: The VSP network doctor will order the proper lenses necessary for your visual welfare. The provider shall verify the accuracy of the finished lenses.
3. Frames: The VSP plan provides a frame allowance. The frame benefit provides you a choice to select a frame that fits your lifestyle. Therefore, if you choose a frame that exceeds the plan allowance, you will pay the difference.

   The VSP network doctor will assist in the selection of frames, properly fit and adjust the frames and provide subsequent adjustments to maintain comfort and efficiency. VSP network doctors are required to offer a selection of frames that are fully covered under your VSP plan.
4. Contact Lenses:
   Elective Contact Lenses – The VSP plan provides an allowance toward the cost of the contact materials and lens exam (fitting and evaluation). The contacts will be in lieu of glasses. You are responsible for any costs exceeding this allowance.

   Medically Necessary Contact Lenses – A VSP network doctor may prescribe medically necessary contact lenses for certain conditions.

A VSP network doctor may need prior approval from VSP for medically necessary contact lenses. Such cases, are fully covered by VSP, less any applicable copays and are in lieu of all benefits for that eligibility period.

5. Low Vision - Limitations: The Low Vision benefit provides special aid for people who have severe visual problems that are not correctable with regular lenses. The treatment plan and charges must be approved by VSP prior to services being rendered. VSP network doctors have the forms to submit for approval. The covered person is required to pay 25% of the cost of any approved Low Vision services. This benefit has a maximum of $1,000 (excluding copayments) every two years. Maximum includes supplementary testing. Low Vision benefits obtained from a non-VSP provider will be subject to the same limitations described above. The covered person will be required to pay the non-VSP provider in full and will be reimbursed in accordance with what VSP would pay a VSP network doctor for this benefit. VSP cannot guarantee the reimbursed amount will be within the 25% copayment required when services are obtained from a non-VSP provider.
6. Essential Medical Eye Care (EMEC): The EMEC benefit provides medical and urgent eyecare needs to treat conditions like pink eye and other eye related illnesses. The program also provides additional testing and exams for sudden vision changes. There is a $5 copay. Coordination with your medical coverage may apply. Ask your VSP network doctor for details.
7. Retinal Screening: Coverage for retinal imaging as an enhancement to eye examination is covered once every calendar year; up to a $39 copay at a VSP network doctor or $0 copay at Premier Edge location.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP plan may also be able to take advantage of COB.

DUAL COVERAGE

A married enrollee whose spouse is also an enrollee under his/her own VSP Plan may coordinate benefits between their respective VSP Plans. Such "dual coverage" will be subject to the same procedures and limitations applicable to coordination of benefits with non-VSP plans.

Eligible married state employees or those state employees with eligible domestic partners may co-cover each other under the state's Vision Program. This option also applies to their dependent children, including dependents of domestic partners. The procedure for coordination of Dual coverage benefits will be available as follows:

a) Eligible married state employees or those state employees with eligible domestic partners can receive benefits under each other's plan and receive two pairs of eyeglasses subject to the independent deductibles and all other plan limitations. Dependent children can receive one pair of eyeglasses under either their father's or mother's plan, or both, subject to the deductible and plan limitations. In both instances, this provision applies to the active basic and retiree plans, as well as the Premier Vision Plan.

b) Eligible married state employees or those state employees with eligible domestic partners cannot use their secondary coverage to cover the cost of extras.

c) If an Eligible Employee receives only one pair of eyeglasses, the deductible may be paid by the secondary coverage.

In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

PROVISIONS FOR VSP NETWORK DOCTORS

If you elect to receive vision care services from one of the VSP network doctors, covered services as described herein are provided with no additional out-of-pocket cost after any applicable copays. Additional services selected for cosmetic purposes will be the responsibility of the patient. Selecting a VSP network doctor assures direct payment to the doctor and a guarantee of quality services.

PROVISIONS FOR NON-VSP PROVIDERS

If you elect to receive vision care services from a non-VSP provider, you will be reimbursed according to a reimbursement schedule. You must pay the non-VSP provider for all services and eyewear received at the time of your appointment.

FILING A CLAIM FOR NON-VSP PROVIDER SERVICES

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

VSP
P.O. Box 495918
Cincinnati, OH 45249-5918

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

NON-VSP PROVIDER REIMBURSEMENT SCHEDULE

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

PROFESSIONAL SERVICES - Basic Plan
- Vision Exam, up to $35

EYEWEAR
- Single Vision Lenses, up to $25
- Lined Bifocal Lenses, up to $50
- Lined Trifocal Lenses, up to $50
- Lenticular Lenses, up to. $100
- Frame, up to $40
- Tints, up to $5

CONTACT LENSES*
- Necessary, up to $250
- Elective, up to $110

PROFESSIONAL SERVICES - Premier Plan
- Vision Exam, up to $45

EYEWEAR
- Single Vision Lenses, up to $30
- Lined Bifocal Lenses, up to $50
- Lined Trifocal Lenses, up to $65
- Lenticular Lenses, up to $100
- Frame, up to $70
- Tints, up to $5

CONTACT LENSES*

Necessary, up to $250
Elective, up to $105

CCPOA SECOND PAIR:
EYEWEAR

Single Vision Lenses, up to $30
Lined Bifocal Lenses, up to $50
Lined Trifocal Lenses, up to $60
Lenticular Lenses, up to. $75
Frame, up to $45
Tints. up to $5

CONTACT LENSES*

Necessary, up to $210
Elective, up to $100

* Determination of "necessary" versus "elective" contact lenses under the non-VSP reimbursement schedule will be consistent with VSP network doctor services.

EXCLUSIONS AND LIMITATIONS - Basic Plan
Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Coverage with a retail chain may be different or not apply. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 400-4569.

Your vision plan is designed cover to visual needs rather than cosmetic eyewear. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you will be required to pay any additional costs associated with these extras:

1. Optional cosmetic processes.
2. Anti-reflective coating.
3. Color coating.
4. Mirror coating.
5. Scratch coating.
6. Blended lenses.
7. Cosmetic lenses.
8. Laminated lenses.
9. Oversize lenses.
10. Polycarbonate lenses for adults.
11. Progressive multifocal lenses.
12. UV (ultraviolet) protected lenses.
13. Certain limitations on low vision care.
14. A frame that costs more than the Plan allowance
15. Contact lenses (except as noted elsewhere herein).

The following services or eyewear are excluded under your plan:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (less than ± .50 diopter power).
3. Two pairs of glasses in lieu of bifocals.
4. Replacement or repair of lost or broken lenses or frames prior to service eligibility.
5. Medical or surgical treatment of the eyes
6. Services or eyewear covered under Worker's Compensation.
7. Eye exams required as a condition of employment.
8. Services or eyewear provided by any other group benefit vision care program.
9. Corrective vision treatment of an Experimental Nature.
10. Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
11. Services/materials not indicated as covered Plan Benefits on the enclosed insert.

EXCLUSIONS AND LIMITATIONS - Premier Plan

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5. Scratch coating.
6. Blended lenses.
7. Cosmetic lenses.
8. Laminated lenses.
9. Oversize lenses.
10. Polycarbonate lenses.
11. Progressive multifocal lenses (except as noted elsewhere herein).
12. UV (ultraviolet) protected lenses.
13. Certain limitations on low vision care.
14. A frame that costs more than the Plan allowance

15. Contact lenses (except as noted elsewhere herein).

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EXCLUSIONS AND LIMITATIONS – CCPOA
Second Pair

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Coverage with a retail chain may be different or not apply. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 400-4569.

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8. Laminated lenses.
9. Oversize lenses.
10. Progressive multifocal lenses
11. UV (ultraviolet) protected lenses.
12. Certain limitations on low vision care.

13. A frame that costs more than the Plan allowance
14. Contact lenses (except as noted elsewhere herein).

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8. Services or eyewear provided by any other group benefit vision care program.
9. Corrective vision treatment of an Experimental Nature.
10. Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
11. Services/materials not indicated as covered Plan Benefits on the enclosed insert.

CONTINUATION OF BENEFITS

The VSP coverage is not available on an individual basis, unless you are eligible for continuation of group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Individuals who lose coverage due to certain "qualifying events" are entitled to elect continued coverage. Payment for continuation of vision coverage through COBRA will be paid by the enrollee and mailed directly to VSP. Contact your personnel office for specific qualifying events and the premium you will be required to pay for continuation of your vision coverage with VSP through COBRA.

CLAIMS APPEAL PROCEDURE

VSP shall notify you in writing if a claim is denied in whole or part, of the reason or reasons for the denial. Within one hundred eighty days after receipt of such notice, you may make a written or verbal request for review of such denial, by addressing such request to VSP, whose address and phone number is shown on the front of this booklet. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to

present materials or arguments. The determination of VSP, including specific reasons for the decision, shall be provided, and communicated to you in writing within thirty days after receipt of a request for review.

COMPLAINTS AND GRIEVANCES

If you have a complaint or grievance regarding VSP service or claim payment, you may communicate your complaint or grievance to VSP by using a complaint form which may be obtained by calling the VSP Member Services Department (800) 400-4569, Monday through Saturday, 6:00 a.m. - 5:00 p.m. (PST). The completed form should be sent to the address shown on the front of this booklet.

VSP shall acknowledge receipt of your grievance within five calendar days of receipt by VSP. VSP shall also provide a written response to your grievances as required by VSP's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. There shall be no discrimination against a member on the basis of filing a complaint or grievance.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 400-4569** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty 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 urgent medical services. The department also has a toll-free telephone number **(888) 466-2219** and a T.D.D. line **(877) 688-9891** for the hearing and speech impaired. The department's Internet Web site **hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

LIABILITY IN EVENT OF NON-PAYMENT

In the event VSP fails to pay the VSP network doctor, you shall not be liable to the provider for any sums owed by VSP other than those not covered by your vision benefit.

TERMS AND CANCELLATION

If service is being rendered to you as of the termination date of this coverage, such service shall be continued to completion, but in no event beyond six months after the termination date of the contract.

VSP reserves the right to reject any and all claims for services or benefits which are filed with it more than one hundred eighty days after completion of services.

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.

DEFINITIONS

BLENDED LENSES - Bifocals which do not have a visible dividing line.

CLAIM - A benefit form submitted to VSP by a VSP network doctor for payment of services or submission of paid receipts by a covered employee/ dependent who has received services from a non-VSP provider.

COATED LENSES - A lens with substance added to one or both surfaces.

DIOPTER - A unit of measurement used to designate the refractive power of a lens or optical system.

ELIGIBLE DEPENDENT - A dependent of an eligible employee who is eligible to be enrolled in accordance with the conditions of eligibility as generally outlined in this booklet.

ELIGIBLE EMPLOYEE - An employee who is eligible to enroll in accordance with the conditions of eligibility as generally outlined in this booklet.

COVERED PERSON - An Enrollee or Eligible dependent who is covered under this plan.

EYEWEAR - Lenses, frame, low vision aides, contact lenses.

GROUP - "Group" refers to the State of California which contracts with VSP on behalf of its employees.

ORTHOPTICS - The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

OVERSIZE LENSES - Larger than standard lens blank to accommodate prescriptions.

PHOTOCHROMIC LENSES - Lenses which change color with intensity of sunlight.

PLANO LENSES - Lenses which have no refractive power.

PROFESSIONAL SERVICE - Exam, eyewear selection, fitting of glasses, and related adjustments.

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

USUAL AND CUSTOMARY FEES - Fees for services and eyewear that are charged by VSP network doctors to their private (non-VSP) patients.

VSP NETWORK DOCTOR - An optometrist or ophthalmologist who has signed an agreement with VSP to provide services to VSP patients.

VSP PREMIER EDGE LOCATION - A custom network of optometrist or ophthalmologist who has signed an agreement with VSP to provide services to VSP patients.

RETINAL SCREENING - Retinal screening uses high-resolution imaging systems to take digital pictures of the inside of the eye.

RETINAL IMAGING - Digital picture of the inside of the eye.

Prepared for: STATE OF CALIFORNIA
Group ID: 30052011
Effective Date: JANUARY 1, 2025

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 Doctor	Out-of-Network Provider	
If you or your dependents need eyecare (if applicable)	Eye Exam	$10.00 Copay	Reimbursed Up to $35.00	Exam covered in full every calendar year; in-net-work. Out of network exam allowed once every calendar year.
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and frames)	Frames reimbursed up to $40.00 SV Lenses reimbursed up to $25.00 Bi-Focal Lenses reimbursed up to $50.00 Tri-Focal Lenses reimbursed up to $50.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $110.00	Frames and Lens covered every calendar year.
	Fees			

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: (800) 400-4569.

Employee Premier Plan

Prepared for: STATE OF CALIFORNIA
Group ID: 30034581
Effective Date: JANUARY 1, 2025

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Doctor	Out-of-Network Provider	
If you or your dependents need eyecare (if applicable)	Eye Exam	$10.00 Copay	Reimbursed Up to $45.00	Exam covered in full every calendar year; in-network. Out of network exam allowed once every calendar year.
	Frames, Lenses or Contacts	Glasses: $10.00 Copay (lenses and frames)	Frames reimbursed up to $70.00 SV Lenses reimbursed up to $35.00 Bi-Focal Lenses reimbursed up to $50.00 Tri-Focal Lenses reimbursed up to $65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames and Lens covered every calendar year.
	Fees			

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