GROUP VISION PLAN

EVIDENCE OF COVERAGE



3333 Quality Drive, Rancho Cordova, CA 95670

Customer Service: 800.400.4569
TTY: 711
Website: vsp.com or csuactives.vspforme.com

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

Group Plan Number: 30077022

CSU Actives Premier Plan

Effective January 1, 2025

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



PREMIER GROUP VISION PLAN
EVIDENCE OF COVERAGE BOOKLET
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DEFINITIONS:

ANISOMETROPIA	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual named as a Covered Person of and identifying those Plan Benefits to which a Covered Person is entitled.
COORDINATION OF COVERAGE	Coordination of coverage is a contract provision that provides dual coverage for the same allowable expense(s) if an Enrollee and/or any covered dependent(s) are enrolled in more than one non-CSU vision plan.
COPAY	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets CSU's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.
DOMESTIC PARTNER	An individual with whom the Enrollee has completed a declaration of domestic partnership with the Secretary of the State of California, filed for public record if required by law, and submitted to the Group. Domestic partnership is defined as specified partnerships between persons who are both at least 18 years of age and who are not legally married. A same-sex legal union other than marriage validly formed in another jurisdiction that is substantially equivalent to a registered domestic partner in California may also be recognized.
ELIGIBLE DEPENDENT	Any dependent of an Enrollee of Group who meets the criteria for eligibility specified herein under Eligibility for Coverage.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or person who meets the criteria for eligibility specified herein under Eligibility for Coverage or is eligible for and chooses to pay for optional Continuation of Coverage.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	The California State University ("CSU") which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
INTERIM BENEFITS	New prescription lenses will be approved and replaced every calendar year if certain criteria is met.
KERATOCONUS	A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

NON-MEMBER PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan, as defined on the enclosed insert.
PREMIUMS	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.
RENEWAL DATE	The date on which this plan shall renew or terminate if proper notice is given.
SCHEDULE OF BENEFITS	List of vision care services and vision care materials described herein which a Covered Person is entitled to receive by virtue of this plan.
VISUALLY NECESSARY APPROPRIATE	Services and materials medically or visually necessary to restore or maintain a patient's OR visual acuity and health and for which there is no less expensive professionally acceptable alternative.

ELIGIBILITY FOR COVERAGE

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

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

Coordination of Coverage Restrictions:
A married couple working for this company may not receive duplicate coverage as an employee and a dependent; therefore, coordination of benefits is not allowed.
An employee's dependent child who works for this company may not receive duplicate coverage as an employee and a dependent; therefore, coordination of benefits is not allowed.

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

1) the legal spouse, or
2) Domestic partner of any Enrollee, and
3) Dependent children are covered through the end of the month in which they turn 26. A child includes any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, Enrollee's stepchild, child living with the Enrollee in the Enrollee's household in a parent-child relationship and depends on the Enrollee for principal support, or other child for whom a court holds the Enrollee responsible.
4) A dependent child over the limiting age as shown above may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the Enrollee for support and maintenance.

Coordination of Coverage Restrictions:
Dependent children are covered under only one parent's plan when both parents work for this company.

EFFECTIVE DATE OF COVERAGE

New employees who are eligible must enroll themselves and eligible dependents within either sixty (60) days of employment or a qualifying event or during open enrollment. If you fail to add yourself or your eligible dependents within 60 days of the change in status event, there is a 90-day waiting period before benefits will be activated. If you do not enroll in Premier you will receive Basic coverage.

You and the CSU is responsible for a portion of the payment of the monthly premium. Your coverage will not be effective until your pay warrant shows your portion of the contribution.

TERMINATION OF COVERAGE:

Your coverage will terminate on the earliest of:

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

CONTINUATION OF INSURANCE DURING A LABOR DISPUTE

You may continue coverage for up to six months when:

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

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

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

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

PREMIUMS

The CSU pays a portion of the monthly premium for this plan. Your cost is based on a three-tier structure on the number of dependents covered. The monthly premium cost is as follows and is deducted from your pay warrant.

Employee Only (One Party)	$5.06
Employee + One Dependent (Two Party)	$17.08
Employee + Family (Three Party)	$31.73

PROCEDURES FOR USING THIS PLAN

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

1. To obtain Plan Benefits from a Member Doctor, you should contact a Member Doctor or VSP. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from CSU, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call (800) 400-4569 or write VSP to obtain one that does.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member, so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against this plan in-spite-of your termination of coverage or the termination of this plan. Should you receive services from a Member Doctor without such enefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment to the Member Doctor for the services covered by this plan. You are responsible for payment of any services not covered by VSP including, but not limited to, frames and lenses that exceed the covered limits established by this plan. VSP will pay the Member Doctor directly according to their agreement with the doctor. VSP reimburses its Member Doctors on a fee-for-service basis. There are no incentives or financial bonuses paid to Member Doctors for services covered under this plan.

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

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

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

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

BENEFIT AUTHORIZATION PROCESS

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

Prior Authorization

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

A. **Initial Determination:** VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. **Appeals:** If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requester with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Covered Person may designate any person, including the provider, as Covered Person's authorized representative.

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

BENEFITS AND COVERAGES

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

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

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Covered Person is entitled to an Eye Examination as indicated on the enclosed insert.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Covered Person is entitled to new lenses as indicated on the enclosed insert.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Covered Person is entitled to new frames as indicated on the enclosed insert.

4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein.

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

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

5. If you elect to receive vision care services from one of the Member Doctors, Plan Benefits are provided subject only to your payment of any applicable Copayment. If you choose to obtain Plan Benefits from a Non-Member Provider, you must pay the Non-Member Provider the full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAM OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

   Additional Discount: Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off Member Doctor professional fees for elective contact lens exam, evaluations and fittings. The Covered Person pays the Member Doctor the difference between the Plan Benefit Allowance and the Member Doctor's discounted usual and customary fees, plus any Copays and charges for services or materials not covered under this Plan. Contact lens materials are provided at the doctor's usual and customary charges. Discounts are applied to the Member Doctor's usual and customary fees for such services and are available within twelvemonths of the covered eye exam from the Member Doctor who provided the covered eye exam. Additional discounts noted on this schedule are subject to change as deemed appropriate by VSP with prior notification to the Group.

   DISCOUNTS DO NOT APPLY TO VISION CARE BENEFITS OBTAINED FROM NON-MEMBER PROVIDERS.

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

COPAY

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

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. Progressive multifocal lenses.
11. Certain limitations on low vision care.

NOT COVERED

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

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

LIABILITY IN EVENT OF NON-PAYMENT

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

COMPLAINTS AND GRIEVANCES

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

Claim Payments and Denials

A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741
(800) 400-4569

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

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

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

ARBITRATION

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

SECOND MEDICAL OPINIONS

- All requests for a second medical opinion shall be directed, in writing, to:

  VSP
  Clinical Consultant
  Provider Services
  3333 Quality Drive
  Rancho Cordova, CA 95670

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

TERMINATION OF BENEFITS

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

INDIVIDUAL CONTINUATION OF BENEFITS

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

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

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

VISION SERVICE PLAN
3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: *THE CALIFORNIA STATE UNIVERSITY-ACTIVE PREMIER*

Plan Number: *30077022*

Effective Date: *JANUARY 1, 2025*

Plan Term: *TWELVE (12) MONTHS*

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

HRM Benefits
(Name)
401 Golden Shore
(Address)
Long Beach, CA 90802-4210
(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. PLEASE REFER TO PAGE 5 FOR YOUR SHARE OF PREMIUMS.

ELIGIBILITY:

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

PLAN AND SCHEDULE:

VSP CHOICE PLAN

EXAMINATION:	*ONCE EVERY PLAN YEAR**
LENSES:	*ONCE EVERY PLAN YEAR**
FRAMES:	*ONCE EVERY PLAN YEAR**

*PLAN YEAR BEGINS JANUARY 1ST.

TERM, TERMINATION AND RENEWAL:

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

TYPE OF ADMINISTRATION:

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

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

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.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

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

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***	
VISION CARE SERVICES			
Vision Examination	*Covered in Full**	*Up to $*	*50.00**
Comprehensive examination of visual functions and prescription of corrective eyewear.			
VISION CARE MATERIALS			
Lenses			
Single Vision	*Covered in Full**	*Up to $*	*45.00**
Bifocal	*Covered in Full**	*Up to $*	*65.00**
Trifocal	*Covered in Full**	*Up to $*	*85.00**
Lenticular	*Covered in Full**	*Up to $*	*125.00**
Lens Enhancements			
Polycarbonate Lenses (for children only)	*Covered in Full**	*Up to $*	*20.00**
Standard Progressives	*Covered in Full**	*Up to $*	*85.00**
Tints	*Covered in Full**	*Up to $*	*5.00**
UV Protection	*Covered in Full**	*Up to $*	*0.00**
Frames	*Covered up to $210 Retail Frame Allowance**	*Up to $*	*60.00**

Frame Allowance may be applied towards non-prescription sunglasses or blue light filtering glasses, exhausting both frame and lens eligibility.

Lab-fabricated plano lenses are not covered.

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

CONTACT LENSES

Necessary			
Professional Fees and Materials	*Covered in Full**	*Up to $*	*250.00**
Elective			
*Professional Fees** and Materials*	*Up to $ 200.00*	*Up to $*	*110.00*

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 $10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.

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.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

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

BENEFIT PERIOD

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

COPAYMENT

A Copayment amount of $10.00 shall be payable by the Covered Person at the time of the examination.

COVERED SERVICES AND MATERIALS

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

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, or Lined Trifocal)

LENS ENHANCEMENTS-

Polycarbonate Lenses for Dependent Children
Standard Progressives
Tints

FRAMES - Covered up to the Plan allowance* once every 12 months**
CONTACT LENSES
ELECTIVE
Elective Contact Lenses are covered up to $200.00 once every 12 months**

The Elective Contact Lens allowance applies to materials only.

NECESSARY
Necessary Contact Lenses are covered up to $250.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

Exhibit C

VISION SERVICE PLAN
ADDITIONAL BENEFIT RIDER - COMPUTER VISIONCARE PLAN
(ENROLLEES ONLY)

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.

BENEFIT PERIOD

A twelve-month period beginning on JANUARY 1ST and ending on DECEMBER 31ST.

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 24 months**
A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs of computer use. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.		

SERVICE OR MATERIAL		
Lenses	**Available only when the Covered Person has been diagnosed by an eye care professional as having a vision condition affecting computer use**.	
	MEMBER DOCTOR BENEFIT	**FREQUENCY**
Single Vision	Covered in full *	Available once each 24 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 day of the Benefit Period.		

INTERIM BENEFITS

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

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

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Frames	$95* Retail Frame 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 day of the Benefit Period.		

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

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) 400.4569.

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.

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

NOT COVERED

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

1. There are no benefits for professional services or materials connected with Subnormal vision aids.
2. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer.
3. Corneal Refractive Therapy (CRT).
4. Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
5. Refitting of contact lenses after the initial (90-day) fitting period.
6. Plano contact lenses (lenses with refractive correction of less than ±.50 diopter).
7. Two pair of glasses in lieu of bifocals.
8. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
9. Medical or surgical treatment of the eyes.
10. Corrective vision treatment of an Experimental Nature.
11. Plano contact lenses to change eye color cosmetically.
12. Plano lenses.
13. Costs for services and/or materials exceeding Plan Benefit allowances.
14. Artistically painted contact lenses.
15. Contact lens modification, polishing or cleaning.
16. Additional office visits associated with contact lens pathology.
17. Contact lens insurance policies or service agreements.
18. Photochromic or tints greater than 20%.
19. Laminated lenses.
20. Services or materials of a cosmetic nature.
21. Services and/or materials not indicated on this Schedule 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

SERVICE OR MATERIAL	NON-MEMBER PROVIDER BENEFIT	FREQUENCY
Eye Examination	Up to $ 50.00*	Available once each 24 months**
Lenses		Available once each 24 months**
Single Vision	Up to $ 45.00*	
Bifocal	Up to $ 65.00*	
Trifocal	Up to $ 85.00*	
Lenticular	Up to $ 125.00*	
Frame	Up to $ 60.00*	Available once each 24 months**
Plan Benefits for lenses are per complete set, not per lens *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.		

ADDENDUM

ADDITIONAL BENEFIT RIDER SUPPLEMENTAL
ESSENTIAL MEDICAL EYE CARE

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

ELIGIBILITY

- Enrollee.
- Legal spouse of Enrollee.
- Registered Domestic Partner
- Any child of an Enrollee, including a natural child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they attain the age of 26 years.

A dependent, unmarried child over the limiting age 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 Enrollee for support and maintenance.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

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

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: THE CALIFORNIA STATE UNIVERSITY-ACTIVE PREMIER
Group ID: 30077022
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 Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $0.00 Copay (lenses and/ or frames only)	Frames reimbursed up to $ 60.00 SV Lenses reimbursed up to $ 45.00 Bi-Focal Lenses reimbursed up to $ 65.00 Tri-Focal Lenses reimbursed up to $ 85.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $110.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees			

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

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