GROUP VISION CARE PLAN

Program Document and Summary Program Description

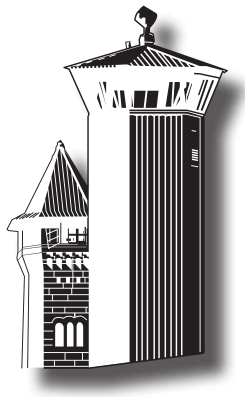
vsp® Vision care for life

CCPOA
Benefit Trust Fund

Vision Care for
Rank and File Members

Effective January 2014

This page left blank.



GROUP VISION CARE PLAN
RANK AND FILE MEMBERS

California Correctional
Peace Officers Association
Benefit Trust Fund

SUMMARY PROGRAM DESCRIPTION AND PROGRAM DOCUMENT

Updated:
JANUARY 1, 2014

VISION SERVICE PLAN
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.

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.

TABLE OF CONTENTS

DEFINITIONS: 7
ANNUAL ENROLLMENT/DISENROLLMENT 9
PREMIUMS 10
PROCEDURES FOR USING THIS PLAN 10
BENEFIT AUTHORIZATION PROCESS 11
BENEFITS AND COVERAGES 12
COPAYMENT 14
EXCLUSIONS AND LIMITATIONS OF BENEFITS 14
COMPLAINTS AND GRIEVANCES 16
TERMINATION OF BENEFITS 18
INDIVIDUAL CONTINUATION OF BENEFITS 18
THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) 19
SCHEDULE OF BENEFITS 20
COPAYMENT 21
EXHIBIT C 22
ADDITIONAL BENEFIT RIDER SECOND PAIR 22
GENERAL 22
EXCLUSIONS AND LIMITATIONS OF BENEFITS 23
SERVICES FROM NON-MEMBER PROVIDERS 24
ADDITIONAL BENEFIT RIDER PRIMARY EYECARE PLAN 26
PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES 27
REFERRALS BY THE MEMBER DOCTOR 28
EXCLUSIONS AND LIMITATIONS OF BENEFITS 29

This page left blank.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER: 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.

ANISOMETROPIA: A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

BENEFIT AUTHORIZATION: Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

COPAYMENTS: 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 VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.

ELIGIBLE DEPENDENT: 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.

EMERGENCY CONDITION: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

ENROLLEE: An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator.

EXPERIMENTAL NATURE: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

GROUP: 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.

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 or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

PREMIUMS: 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.

RENEWAL DATE: The date on which this plan shall renew or terminate if proper notice is given.

SCHEDULE OF BENEFITS: 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.

SCHEDULE OF PREMIUMS: 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 Cov-

ered 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 ±.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 your health plan, you should first telephone your health plan at (800) 877-7195 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available

to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

The Department also has a toll-free telephone number (1-888-HMO-2219), a TDD line (1-877-688-9891) for the hearing impaired and its Internet Web site (http://www.hmohelp.ca.gov) has complaint forms online. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to Covered Persons, and the failure to use these procedures does not preclude Covered Person's use of any other remedy provided by law.

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.

VISION SERVICE PLAN **3333 Quality Drive** **Rancho Cordova, CA 95670**	
GROUP NAME:	CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION BENEFIT TRUST FUND
PLAN NUMBER:	30043896
EFFECTIVE DATE:	JANUARY 1, 2014
PLAN TERM:	TWELVE (12) MONTHS
VISION CARE PLAN **DISCLOSURE FORM AND EVIDENCE OF COVERAGE**	
PLAN ADMINISTRATOR	Michael Smalley 755 Riverpoint Dr Ste 100 West Sacramento, CA 95605-1673
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 THE END OF THE MONTH IN WHICH THEY TURN AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:	VSP ADVANTAGE PLAN
EXAMINATION:	ONCE EVERY 12 MONTHS
LENSES:	ONCE EVERY 12 MONTHS
FRAMES:	ONCE EVERY 12 MONTHS
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 lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Plan or Evidence of Coverage to which it is attached.

Member Doctors are those doctors that have agreed to participate in VSP's Advantage Network.

PLAN BENEFITS	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Vision Examination	Covered in Full*	Up to $47.00*
Comprehensive examination of visual functions and prescription of corrective eyewear.		

VISION CARE MATERIALS		
Lenses		
Single Vision	Covered in Full*	Up to $30.00*
Bifocal	Covered in Full*	Up to $50.00*
Trifocal	Covered in Full*	Up to $60.00*
Lenticular	Covered in Full*	Up to $75.00*
Frames	Covered up to Plan Allowance*	Up to $45.00*
The Member Doctor 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 $210.00*
Elective		
Professional Fees and Materials	Up to $110.00	Up to $100.00
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.		

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered.

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.

EXHIBIT C

ADDITIONAL BENEFIT RIDER SECOND PAIR 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.
- 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 the end of the month in which they attain the age of 26 years.

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

COPAYMENT

A Copayment amount of $35.00 shall be payable by the Covered Person to the Member Doctor or Non-Member Doctor at the time services are rendered.

PLAN BENEFITS		
MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Covered in full*	Available once each 12 months
*Less any applicable Copayment. Plan Benefits for lenses are per complete set, not per lens		

PLAN BENEFITS		
Frames	Covered up to Plan allowance*	Available once each 12 months
Contact Lenses		
Necessary	Covered in full *	Available once every 12 months
Elective	Up to $ 110.00*	Available once every 12 months

*Less any applicable Copayment.

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.

Contact lenses are provided in lieu of all other lens and frame benefits available herein.

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 ± .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**
Lenses		
Single Vision	Up to $ 30.00*	Available once each 12 months
Bifocal	Up to $ 50.00*	Available once each 12 months
Trifocal	Up to $ 60.00*	Available once each 12 months
Lenticular	Up to $ 75.00*	Available once each 12 months
Frame	Up to $ 45.00*	Available once each 12 months
*Less any applicable Copayment Plan Benefits for lenses are per complete set, not per lens.		
Contact Lenses		
Necessary	Up to $ 210.00*	Available once each 12 months
Elective	Up to $ 100.00*	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.

EXHIBIT C

ADDITIONAL BENEFIT RIDER PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. This Rider forms a part of the Policy and Evidence of coverage to which it is attached.

The Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the Plan, Member Doctors provide treatment and management of urgent and follow-up services. Primary EyeCare also involves management of conditions that require monitoring to prevent future vision loss.

The Member Doctor is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Member Doctor as a Primary EyeCare professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS, below) will be covered for certain Primary EyeCare services in accordance with the optometric scope of licensure in the Member Doctor's state. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

SYMPTOMS

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

- ocular discomfort or pain
- recent onset of eye muscle dysfunction
- transient loss of vision
- ocular foreign body sensation

- flashes or floaters
- pain in or around the eyes
- ocular trauma
- swollen lids
- diplopia
- red eyes

CONDITIONS

Examples of conditions which may require management under the Primary EyeCare Plan include, but are not limited to:

- ocular hypertension
- macular degeneration
- retinal nevus
- corneal dystrophy
- glaucoma
- corneal abrasion
- cataract
- blepharitis
- pink-eye
- sty

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

PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES

To obtain Primary EyeCare Services, the Covered Person contacts a Member Doctor's office and makes an appointment. If necessary, the Covered Person may first call VSP's Customer Service Department to determine the location of the nearest Member Doctor's office.

If urgent care is necessary, the Covered Person may be seen by a Member Doctor immediately.

The Covered Person pays the applicable Copayment to the Member Doctor at the time of each Primary EyeCare office visit, and for any additional services not covered by the Plan.

Upon completion of the services, the Member Doctor will submit the required claim information to VSP. VSP will pay the Member Doctor directly in accor-

dance with VSP's agreement with the doctor.

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

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time of each Primary EyeCare office visit.

REFERRALS BY THE MEMBER DOCTOR

The Member Doctor will refer the Covered Person to another doctor under the following circumstances:

If the Covered Person requires additional services which are covered by the Primary EyeCare Plan but can not be provided in the Member Doctor's office, the doctor will refer the Covered Person to another Member Doctor or to the Group's major medical physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the Primary EyeCare Plan, the Member Doctor will refer the Covered Person to the Group's major medical physician.

If the Covered Person requires emergency services beyond the scope of the Primary EyeCare Plan, the Member Doctor will make an urgent referral by calling either another Member Doctor or the Group's major medical physician.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary EyeCare Plan is designed to cover Primary EyeCare services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing materials such as lenses and frames.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical or pathological treatment.
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- Medication.
- Pre- and post-operative services.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.

DEFINITIONS	
Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.

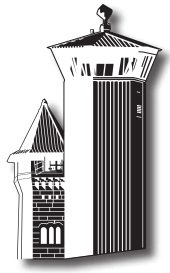
DEFINITIONS	
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem, or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink eye	An acute, highly contagious inflammation of the conjunctiva.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens.
Systemic Condition	Any condition or problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

This page left blank.

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486



CCPOA
Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

www.ccpoabtf.org

2-04-4001-00
2014_VSP-SPD.v1
Q214R08