MEASURE I

Graduate Student Health Insure Plan (GSHIP) Increase for Vision

- New graduate compulsory fee: not to exceed $25/qtr. in the initial year
- Fee begins: fall quarter 2000, permanent fee (no ending date) and would be used for the sole purpose of providing vision insurance for all graduate students.
- This question was approved for placement on the graduate ballot by the Dean of Graduate Studies and resolution of the Graduate Student Association (GSA).

MEASURE I BALLOT STATEMENT

This measure would authorize the campus GSHIP Committee in cooperation with the UCSC Office of Community Development and Health to solicit bids for vision insurance with coverage comparable to that outlined below and select the most advantageous policy available within the cost limitation ($25 per student per quarter) specified in the text of the meas-ure. Normal annual increases in premium expense would be reflected in the GSHIP Fee and would not require additional student approval.

The new vision coverage would take effect in fall quarter 2000. Any graduate student employed as a Graduate Student Researcher (GSR) at 25 percent or greater for the quarter would have the GSHIP Fee paid by the same fund source that pays the GSR's salary. Any student receiving a full Regents' Fellow-ship or other campus fellow-ship, or a major external award (e.g., NSF, GAANN, Mellon), would have the GSHIP Fee paid by the fellowship in addition to the normal fellowship stipend. Payment of the GSHIP Fee for Teach-ing Assistants, Teaching Fellows, and Associates-In would be subject to negotiation between the Universi-ty and the Association of Stu-dent Employees (ASE/UAW).

PRO/CON Statements for Measure I

Pro: None submitted.

Con: None submitted.

Sample Student Vision Insurance Plan

Following is an example of the coverage currently available in the student insurance market. Although any actual policy obtained by the campus may differ slightly in the benefits provided and in the premium cost, depending on the coverage recommended by the GSHIP Committee, the benefits described below generally represent the minimum level of coverage that would be accepted.

Health Plan Benefits and Coverage Matrix
Benefit Schedule--Plan II

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This document ("Benefit Schedule") describes the vision services that this vision plan covers, Copayment Requirements, and any benefits, exclusions, limitations of coverage and provisions which are different than those set forth in the Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage"). The Evidence of Coverage has been written in generic form to describe the provisions which are common to a number of different plan variations. If there are any inconsistencies in the provisions of the Evidence of Coverage and this Benefit Schedule, the provisions of the Benefit Schedule shall govern. Covered Services are also subject to the definitions, limitations, exclusions, terms and conditions stated in the Evidence of Coverage and the Group Agreement.

All of the following services must be provided by the Member's selected Participating Vision Provider in order to be covered under this vision plan.

Benefit Category: Copayment

DEDUCTIBLE: None

LIFETIME MAXIMUM: None

PROFESSIONAL SERVICES-

Examination (once every 12 months): $10.00

Materials: 25.00

Frames
(once every 24 months up to a maximum wholesale allowance of $35.00)

Spectable Lenses
(once every 12 months)

Medically Necessary Contact Lenses
(once every 12 months up to a maximum allowance of $250.00)

Non-Medically Necessary Contact Lenses (once every 12 months up to a maximum retail allowance of $120.00)

OUTPATIENT SERVICES: Not Covered

HOSPITALIZATION SERVICES: Not Covered

EMERGENCY COVERAGE - is provided at the same Service Interval and Copayment as indicated above under Professional Services. Examination and Materials will be covered up to the maximum benefit limit indicated in the Reimbursement for Emergency Services Section.

AMBULANCE SERVICES: Not Covered

PRESCRIPTION DRUG COVERAGE: Not Covered

DURABLE MEDICAL EQUIPMENT: Not Covered

MENTAL HEALTH SERVICES: Not Covered

CHEMICAL DEPENDENCY SERVICES: Not Covered

HOME HEALTH SERVICES: Not Covered

OTHER: Not Covered

COVERED SERVICES

Examination
In accordance with professionally recognized standards of practice, this examination will include an analysis of the eyes and related structures to determine the presence of vision problems or other

abnormalities.

Materials

Frames: If an examination indicates the necessity of spectacles, this vision plan will cover a frame at the service interval and up to the maximum wholesale frame allowance indicated above.

AVP does not cover costs above the maximum wholesale frame allowance; however, if a Member selects frames that are more expensive than this allowance, the Member will be charged the difference between the allowance and the wholesale cost of the more expensive frame, plus an additional service fee. The total cost represents a saving to the Member off retail prices.

Spectacle Lenses: If an examination results in corrective lenses being prescribed for the first time, or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of standard single vision, bifocal, trifocal or lenticular clear glass or plastic lenses that are Medically Necessary to correct vision at the service interval indicated above. Polycarbonate lenses are covered for children 12 years of age and under at no additional charge.

If the Member selects lenses with non-Basic features, the Member will be responsible for the provider's charges for the extra features. Note: Although this vision plan does not cover non-Basic features, AVP's Participating Vision Providers have agreed to a reduced fee schedule for these non-Basic features, therefore, Members are able to receive such items from Participating Vision Providers at favorable prices.

Medically Necessary Contact Lenses: Coverage for prescriptions for contact lenses is subject to Medical Necessity, Prior Authorization from AVP, and all applicable exclusions and limitations. Medically Necessary contact lenses are furnished at the service interval and up to the maximum allowance indicated above.

Non-Medically Necessary (Cosmetic) Contact Lenses: Prescriptions for contact lenses which are not Medically Necessary are covered at the service interval and up to the maximum contact lens materials and dispensing retail allowance indicated above.

Note: A $20.00 fee may be charged for a broken or missed appointment when the appointment is not canceled with a minimum of 24 hours notice, and when the Participating Vision Provider determines that the Member did not have good cause for not canceling the appointment. **Reimbursement for Emergency Services:** If the Member obtains services from a provider other than a Participating Vision Provider, the provider may require immediate payment for his or her services. The vision plan will cover up to the following maximum benefit limits, subject to the Service Intervals and Copayment shown in the Benefit Schedule:

Professional Services: Maximum Benefit

Vision Examination: $40

Materials (Spectacles):

Single Vision Lenses: $30

Bifocal Lenses: $50

Trifocal Lenses: $65

Lenticular Lenses, up to: $125

Frame, up to: $32

The above lens allowance is for two lenses. If only one lens is needed, the allowance will be one-half of the pair allowance.

Medically Necessary Contact Lenses: AVP will reimburse 80% of the provider. s usual charges for Materials, up to $175.

Non-Medically Necessary (Cosmetic) Contact Lenses: AVP will reimburse up to $130 for all Materials and services including the vision examination.

Second Pair: Participating Vision Providers will provide a 20% discount from usual and customary fees for a second pair of frames and spectacle lenses (this can include a pair of prescription "sunglasses") to Members covered under a plan with a Materials benefit at the same interval as the first pair of frames and spectacle lenses.

The following services and supplies are excluded from, or limited in, coverage under this Vision Plan, as specified. (Note: All charges related to, or as a follow-up to services and supplies that are specified as excluded or limited below are likewise excluded):

Coverage limited to care rendered by selected Participating Vision Provider. All Covered Services must be provided by a Participating Vision Provider in order to be covered under this vision plan. This vision plan will not cover services and supplies provided by a provider who is not a Participating Vision Provider, except as specifically described in the section entitled "Emergency Vision Care" in the Evidence of Coverage.

Extras and Non-Medically Necessary services and Materials. This vision plan is designed to cover Medically Necessary visual needs rather than cosmetic desires. Charges for services and Materials that AVP determines to be (1) not Medically Necessary, (2) beyond the maximum Material allowance for frames and contact lenses indicated in the Benefit Schedule, or (3) non-Basic, are excluded. Non-Basic lens features include, special lens fabrication, Coated Lenses, tinted lenses, dyed lenses, laminated lenses, progressive lenses, Blended Lenses, oversize lenses, occupational lenses, and any other types of lenses or features that AVP determines to be non-Basic or not Medically Necessary.

Medically Necessary contact lenses. Coverage for prescriptions for contact lenses is subject to Medical Necessity, Prior Authorization by AVP, and all applicable exclusions and limitations. Generally, coverage (exclusive of the indicated Copayment) for contact lenses will only be authorized (1) for contact lenses to correct extreme visual acuity problems that cannot be corrected (to 20/70 in the better eye) with spectacle lenses, (2) following cataract surgery resulting in aphakia, (3) for Anisometropia of 4.0 diopters or greater, or (4) for Keratoconus, or other corneal irregularities. When covered, contact lenses are furnished at the same coverage interval as spectacle lenses under this vision plan and are in lieu of all other Material benefits. For Medically Necessary contact lenses, Participating Vision Providers have agreed to limit their charges to a reduced amount that is 80% of their usual retail fees. AVP will pay an allowance up to $250 of that reduced amount minus any applicable Copayments. The $250 allowance applies to all costs associated with obtaining contact lenses, including the examination, fitting fees and Materials. Members are responsible for any reduced amount charged by Participating Vision Providers in excess of the $250 allowance plus any applicable Copayments.

Non-Medically Necessary contact lenses. Prescriptions for contact lenses which are not Medically Necessary are covered up to the maximum contact lens and dispensing allowance indicated in the Benefit Schedule. Non-Medically Necessary contact lenses, when covered, will be provided in lieu of all other Materials benefits at the same interval as spectacle lenses. The allowance applies to all costs associated with obtaining contact lenses including fitting fees and Materials. If the Member selects contact lenses that are more expensive than this allowance, the Member will be responsible for the provider's charges in excess of the allowance.

Medical or hospital. Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of the eyes, are excluded.

Prescriptions from non-Participating Vision Providers. Participating Vision Providers are not required to fill prescriptions from non-Participating Vision Providers and such prescriptions will not be covered under this vision plan.

Loss or theft. Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this vision plan.

Orthoptics, vision training, etc. Orthoptics and vision training, and any associated testing, subnormal vision aids, plano (non-prescription) lenses, lenses are excluded unless specifically identified as a Covered Service on the Benefit Schedule.

Second Pair. A second pair of glasses in lieu of bifocals is excluded.

Health, emotional or mental limitations. Services that cannot be performed because of the general health, physical, emotional, mental or behavioral limitations of the patient, are excluded.

Experimental. Experimental services and supplies are excluded. Experimental services and supplies generally include any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which has not been demonstrated to be safe, effective and efficacious for use in the treatment of the illness, injury or condition at issue as compared with the conventional means of treatment or diagnosis. AVP, in its sole discretion, shall determine whether such service or supply is safe, effective and efficacious for the injury or condition at issue according to the criteria set forth in the definition of "Experimental".

No credits. This vision plan does not apply the allowable cost of Covered Services toward similar services and supplies that are not Covered Services.

Medical transportation. Medical transportation is excluded.

Care by relatives, etc. Services and supplies rendered by a person who resides in the Member. s home, or by an immediate relative of the Member, are excluded.

Governmental programs. Charges for services or supplies for treatment of conditions where the Member is entitled to care or reimbursement through a government agency or program and for which such care is available are excluded, unless otherwise provided by law.

No legal obligation to Pay. Services or supplies for which the Member has no legal obligation to pay, or for which no charge would be made if the Member was not eligible under this vision plan, are excluded.

Fraud. If a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, AVP shall have no liability for the provision of coverage under this vision plan. In addition, any intentional or unintentional non-disclosure or misstatement of fact in application materials is cause for disenrollment and AVP may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatements of facts.

Workers' Compensation, insurance and third party liability recoveries. Services and supplies that are otherwise covered under this vision plan are excluded to the extent that a Member realizes a recovery from any source, including settlements and recoveries derived from Workers' Compensation, a liable third party, or from other insurance coverage (e.g., homeowners' insurance, underinsured and uninsured motorists insurance). Coverage for any condition caused by another person's negligence or intentional act or omission is excluded. This vision plan will, however, advance the benefits of this vision plan, subject to an automatic lien against the recovery.

Employment Related. Any services or Materials as a condition of employment (e.g., safety glasses).

Medical records. Charges associated with copying or transferring vision records are excluded.

Mid-year vision plan changes. Benefits under this vision plan that are subject to annual limitations, will not be increased, even when a Member becomes covered under two separate AVP plan contracts during the same annual period.

Medications. Prescription and non-prescription drugs and medications are excluded.