New York State Vision Plan

For Employees of the State of New York

Represented by the Police Benevolent Association – Troopers (PBA-T)

and for their enrolled dependents
and for COBRA enrollees and their families with PBA-T vision care benefits

January 1, 2009

State of New York
Department of Civil Service
Employee Benefits Division
www.cs.state.ny.us

EyeMed VISION CARE®

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Introduction

The NYS Vision Plan provides you, your spouse or domestic partner and your covered dependents with eye care services and materials. The plan is administered by EyeMed Vision Care, a national leader in the vision care industry.

With EyeMed, quality care is easy to find. Enrollees have access to a nationwide network, including more than 1,800 providers across New York State. The network includes independent practice eye doctors as well as major optical retailers.

EyeMed verifies enrollee eligibility with the network provider, processes claims and reimburses the provider for in-network services or the enrollee for out-of-network services. EyeMed also operates a customer call center to support the plan and manages the nationwide network of vision providers.

The Importance of Vision Care

Vision care is an important benefit, as regular eye exams help ensure visual and overall health. Comprehensive eye exams not only detect the need for vision correction, but can also reveal medical conditions such as diabetes or high blood pressure.

How to Enroll

If you are newly eligible for the NYS Vision Plan as a PBA-T-represented employee and you decide to participate, you must sign up for coverage. **You will not be covered automatically.** To enroll for coverage, file Form PS-404 with your agency Health Benefits Administrator. If you are a new or newly eligible employee, your coverage will begin after you have completed 56 days of eligible employment. If you were previously assigned to another bargaining unit as a New York State employee, coverage as a PBA-T-represented employee will begin on the 1st day of the second payroll period following the one in which your bargaining unit changed.

Types of Coverage

You can choose one of two types of coverage:

- **Individual coverage** provides benefits for you only. It does not cover your dependents even if they are eligible for coverage.
- **Family coverage** provides benefits for you and your eligible enrolled dependents. To enroll yourself and your dependents in Family coverage, you must provide each person's date of birth, Social Security number (if one is assigned) and other information to the Vision Plan through your agency Health Benefits Administrator.

If you didn't enroll when you were first eligible, contact your agency Health Benefits Administrator to request an enrollment form (PS-404).

If you qualify for and want to make a change from Individual to Family coverage, contact your agency Health Benefits Administrator.

Using Your Benefits

The vision benefits described in this booklet are available to you, your spouse or domestic partner and covered dependents age 19 or over once every 24 months. Covered dependents under the age of 19 can receive benefits once every 12 months. Before receiving services, you can confirm eligibility by accessing your vision benefits on NYS online, www.cs.state.ny.us, choose Benefit Programs, choose NYSHIP Online, follow links and click on the link to EyeMed, or by calling EyeMed's customer call center at 877-226-1412.

The NYS Vision Plan is easy to use; simply follow the steps below to receive services.

Using a Participating Provider

To get the most out of your vision plan, consider receiving services at a provider who participates on the EyeMed panel. These "in-network" or "participating" doctors have agreed to meet certain quality standards, and EyeMed monitors their ongoing performance to help ensure quality member care.

In-network benefits are easy to use, as the provider will file the claim on your behalf. You will only need to do the following:

1. ***Locate a Provider:*** You can locate providers by accessing your vision benefits on NYS online, www.cs.state.ny.us, choose Benefit Programs, choose NYSHIP Online, follow links and click on the link to EyeMed, by referencing the provider listing included with your ID Card brochure or by calling EyeMed's customer call center at 877-226-1412.
2. ***Schedule an Appointment:*** Schedule an appointment with your selected provider and identify yourself as a member of the New York State Vision Plan.
3. ***Obtain Services:*** Present your EyeMed ID card at the time of service and the provider will take care of the rest. Your provider will verify eligibility, explain your benefit coverage and answer any questions you may have.

Using a Non-Participating Provider

Should you decide to obtain vision services from a doctor who does not participate on EyeMed's panel, you will be eligible for "out-of-network" or "non-participating" reimbursements as defined in the Benefit Summary on page 4 of this booklet. Be sure to confirm eligibility before receiving services. The out-of-network process is as follows:

1. ***Obtain an Out-of-Network Claim Form:*** Use the claim form found in this booklet or print an out-of-network claim form from EyeMed's website for the New York State Vision Plan, which you can link to from www.cs.state.ny.us, choose Benefit Programs, choose NYSHIP Online, follow links and click on the link to EyeMed or call the EyeMed Customer Care Center at 877-226-1412.
2. ***Pay for Services:*** At the time of your appointment, pay for all services and materials in full and obtain an itemized receipt.
3. ***Mail Claim Form and Receipts:*** All receipts for out-of-network claims for the eligible member must be submitted on the same claim form. Receipts not submitted with the original claim form will not be reimbursed. Send the completed claim form and receipts to EyeMed at the following address:

   ATTN: Out-of-Network Claims
   PO Box 8504
   Mason, Ohio 45040-7111
   Fax: 866-293-7373
4. ***Reimbursement:*** EyeMed will process the claim and reimburse you directly up to the allowed amounts.

EyeMed VISION CARE®

Benefit Summary – Standard Plan

Benefits under the plan are available to employees and covered dependents age 19 and over once in any 24-month period. Benefits are available to covered dependents up to, but not including 19 once in any 12-month period. This benefit covers an eye exam, frames and lenses (or contacts). The benefit does not cover both lenses and contacts.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary:	$0	$20
Frames: Any available frame at provider location	$130 retail allowance, 80% of balance over $130	$22
Standard Plastic Lenses:		
Single Vision	$0	$22
Bifocal	$0	$30
Trifocal	$0	$40
Cataract (Lenticular and Aphakic)	$0	$35
Lens Options:		
Glass	$0	N/A
Blended Segment	$0	N/A
UV Coating	$0	N/A
Tint (Solid and Gradient)[1]	$0	N/A
Standard Scratch-Resistance	$0	N/A
Standard Polycarbonate	$0	N/A
Standard Progressive (Add-on to Bifocal)	$0	N/A
High Index	$0	N/A
Photocromatic SV Glass	$0	N/A
Photocromatic MF Glass	$0	N/A
Photocromatic SV Plastic	$54	N/A
Photocromatic MF Plastic	$62	N/A
Standard Anti-Reflective Coating	$45	N/A
Other Add-Ons and Services	80% of retail price	N/A

Contact Lenses: Prescriptions for contact lenses are valid for one year only. NYS State law requires that the contact lens wearer get a new eye exam before a new prescription is issued. The NYS Vision Plan covers an eye exam once every 24 months for employees and covered dependents age 19 and older. The cost of an eye exam more frequently than 24 months is the responsibility of the member.

Contact Lens Fit and Follow-Up: (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit and Follow-Up: (Spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc.)	Paid-in-full fit and two follow-up visits	N/A[2]
Premium Contact Lens Fit and Follow-Up: (All lens designs, materials and specialty fittings other than Standard Contact Lenses. Examples include toric, mulitfocal, etc.)	Paid-in-full fit and two follow-up visits	N/A[2]
Contact Lenses *(Contact lens allowance covers materials only)*		
Conventional	$105 allowance, 85% of balance over $105	$184[2]
Disposable	$105 allowance, plus balance over $105	$184[2]

[1] Light transmission created by tint at 30% or less combined with UV protection would be considered a sunglass lens and is not covered.
[2] Out-of-Network Contact Lens allowance of $184 applies to Contact Lens Fit & Follow-up, and Materials, and reimbursement must be claimed at the same time on one claim form.

Additional Plan Features

Occupational Program

Benefits under the Occupational Program are available to employees once in any 24-month period. The occupational vision benefit provides you with Plan coverage for an additional pair of job-related eyeglasses if determined necessary by a participating provider based on your job duties and through special testing done in conjunction with your regular vision examination. Occupational eyeglasses are available to employees only; dependents are not eligible for this benefit. Sun sensitive and polarized lens options are not available for occupational eyeglasses. **This benefit is not available to COBRA enrollees.**

Contact lenses: are not available under the Occupational Program.

In-Network Services: All services must be obtained from a participating provider. There is no out-of-network reimbursement.

Medical Exception Program

Under the Medical Exception Program, enrollees and covered dependents with a medical condition that may impact vision refraction, when referred by the physician caring for that medical condition, are eligible for an eye examination once every twelve months.

If at least one year has elapsed since the Plan last provided benefits, you have one of the following medical conditions and you are under the care of a medical practitioner for that condition, you are eligible for an examination with dilation:

1. diabetes;
2. cataracts;
3. keratoconus;
4. cataract surgery within two years of last Rx
5. you are taking a prescription drug which could cause vision changes; or
6. any other condition which could reasonably be expected to result in a change in refractive status as determined by the Provider Manual.

You are eligible for new lenses or contacts under the Standard Plan if you experience a significant vision loss due to a medical condition. Significant Rx change is defined as a minimum change of .75D sphere and/or 1.00D cylinder or more since your last examination. You are only eligible for new frames if your current frames are broken or if your new lenses will not fit in your current frames. Employees may also be eligible for new lenses under the Occupational Program if they meet additional criteria under that Program.

Prior to receiving services, ask your vision care provider to complete the Medical Exception Request Form included in this booklet or contact the EyeMed Customer Care Center at 877-226-1412 to request a Medical Exception Request Form. You must also provide your vision care provider with documentation from a medical practitioner that states you are receiving care for one of the qualifying medical conditions under the Medical Exception Program. Have your vision care provider fax the completed Medical Exception Request Form and the documentation from your medical provider to EyeMed's medical director for approval at 1-866-552-9115.

Refer to the Standard Plan and Occupational Program Benefits Summary for additional information on plan allowances.

Additional Savings

After your initial benefit has been used, you can still save money on additional purchases at in-network providers. You will receive 40% off the retail price for additional complete pairs of glasses, 15% off additional conventional contact lenses and 20% off non-covered items such as lens solutions and accessories (cannot be applied to doctor's services or contact lenses).

Laser Vision Correction Discounts

Enrollees and covered dependents can save 15% off the retail price or 5% off the promotional price (whichever is the lower cost) of laser vision correction procedures through the U.S. Laser Network, owned and operated by LCA Vision. This could result in a discount up to 25%. To locate a participating laser vision correction provider and learn how to schedule your pre-operative evaluation, call 1-877-572-7822.

Cataract Care

If you or your covered dependent have cataract surgery and are enrolled in the New York State Health Insurance Program, additional benefits may be available under the Empire Plan or your HMO.

Eyewear Purchase Period

You have 90 days to purchase eyewear at a participating provider from the date of the exam under the Standard Plan, the Occupational Program and the Medical Exception Program. Otherwise, the eyewear benefit will not be available until you are eligible for your next exam.

Plan Limitations / Exclusions

The following are excluded from coverage under this plan:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Services provided as a result of any Worker's Compensation law
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Service or materials provided by any other group benefit providing for vision care
- Two pairs of glasses in lieu of bifocals
- Aniseikonic lenses
- Prism lenses

Eligibility Guidelines

You, the Enrollee

All PBA-T employees who are eligible to enroll for coverage in the New York State Health Insurance Program (NYSHIP) and for whom coverage under the NYS Vision Plan has been negotiated or administratively extended are eligible. You may enroll in the NYS Vision Plan even if you do not enroll in NYSHIP.

To be eligible for coverage, you must be expected to:

1. work at least six biweekly payroll periods; **and**
2. work at least half time on a regular schedule; **and**
3. You must be on the payroll at the time you enroll. If you begin work, then take an unpaid leave of absence, you are not eligible until you return to the payroll and complete a total of 56 days on the payroll, including days worked before your leave began.

Dependents

Dependents are also eligible, as follows:

1. Spouses or Domestic Partners

Spouses, including those legally separated, are eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.

You may also enroll a same or opposite sex domestic partner as a dependent. A domestic partnership, for eligibility under the Vision Plan, is one in which you and your partner are 18 years of age or older, and unmarried at the time of application; not related in a way that would bar marriage; living together and financially interdependent for at least six months, and involved in a lifetime relationship. To enroll a domestic partner, you must provide proof that you have lived together and been financially interdependent for at least six months and that you presently satisfy the other eligibility criteria. Your agency Health Benefits Administrator (HBA) has complete information on eligibility, enrollment procedures, proof requirements and coverage dates.

Note on tax implications: Under the Internal Revenue Service (IRS) rules for domestic partners, the fair market value of vision benefits for a domestic partner who is not the enrollee's qualified dependent for Federal income tax purposes is treated as income for tax purposes. Ask your tax consultant how enrolling your domestic partner will affect your taxes.

2. Children Under Age 19

Unmarried children under age 19 are eligible, including natural children, legally adopted children (including children in a waiting period prior to finalization of adoption) and dependent stepchildren. Other children who reside permanently in your household and who are chiefly dependent on you (more than 50%), and for whom you have assumed legal responsibility in place of the parent, are also eligible. Qualifying support and residence must have started prior to the age of 19. You must file a Statement of Dependence form with your HBA and be able to provide documentation.

3. Children Age 19 or Over

Unmarried dependent children age 19 or over, but under age 25, are eligible if they are **full-time** students at an accredited secondary or preparatory school, college, or other educational institution and are otherwise not eligible for NYSHIP coverage as an employee. They continue to be eligible until the first of the following dates:

- The end of the third month following the month in which they complete each semester as a full-time student. For dependent students who withdraw from school after classes began for the semester and provide documentation of the date of withdrawal, coverage will end on the last day of the month in which the dependent attended classes as a full-time student or the last day of the third month following the completion of the preceding completed semester, whichever is later. If the dependent student withdraws from school and does not provide documentation of attendance during the semester, coverage ends as of the first day of the current semester or the end of the month following the completion of the

preceding completed semester, whichever is later; or
- The end of the month in which they reach age 25; or
- The date on which they marry. Children other than your natural children, legally adopted children or dependent stepchildren must live with you and be chiefly dependent on you after age 19 to be eligible, and support and residence must have started prior to age 19. **You must complete a Student Status Form before an eligible student dependent can receive vision care benefits**. A Student Status Form is included in this booklet or can be obtained online at http://www.cs.state.ny.us. It is the enrollee's responsibility to submit the form to ensure dependent eligibility at the time of service.

If a child turns 19 during a school vacation period, coverage will continue provided the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period. If your child is granted a medical leave by the school, vision care coverage will continue for a maximum of one year from the day the student withdraws from classes plus any time before the start of the next regular semester. You must be able to provide written documentation from the school, or if the school does not grant medical leaves, from the student's doctor.

Military Service Extends Eligibility

For purposes of eligibility as a full-time student, up to four years may be deducted from a dependent's age for service in a branch of the U.S. Military. You must be able to provide written documentation from the U.S. Military.

4. Certain Students Completing Graduation Requirements

Unmarried dependent children age 19 or over, but under age 25, who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

a. otherwise qualify; **and**
b. have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed.

You may be required to provide EyeMed with a statement from your child's school or college administrator that verifies student status. The child will continue to be eligible for up to three months after the end of the month in which he or she completes course requirements for graduation. Coverage will not be extended beyond this semester or trimester unless full-time student status is resumed.

5. Disabled Dependents

Unmarried dependent children age 19 or over who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for vision care coverage are eligible. For example, if your child becomes disabled after reaching age 19 while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

If you have a child who qualifies for coverage as a disabled dependent, you must provide medical documentation. If you anticipate eligibility on this basis, you must file a Disability Form PS-451. Contact your agency Health Benefits Administrator as soon as possible after enrollment, even if your child is under the age when eligibility would normally terminate through age disqualification. The deadline for filing Disability Form PS-451 is 60 days after the child's 19th birthday. Coverage for disabled children may continue beyond age 25.

Ending Coverage and COBRA Continuation

When Coverage Ends

Vision Care benefits cease while you are on leave without pay, unless you arrange for an extension of benefits with your agency Health Benefits Administrator. If you resign, retire, transfer to an ineligible negotiating unit or are terminated, your Vision Care coverage will end **28 days after the last day of the last payroll period worked**. You may have certain rights to continue coverage as explained below.

COBRA: Continuation of Coverage

This section explains your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you, your spouse or domestic partner and your covered dependents. The law requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage called "continuation coverage" at group rates in certain instances where coverage under the program would otherwise end.

The Vision Care benefits you may continue are the same benefits you receive as an active employee, with the exception of the Occupational Program, which is not available to COBRA enrollees. This section summarizes your rights and obligations under the continuation coverage provisions of the law. If your spouse or domestic partner is also covered under the Plan, they should take the time to read this carefully.

60-Day Deadline

In order for dependents to continue coverage under COBRA, the employee or a family member is responsible for notifying the Employee Benefits Division of the New York State Department of Civil Service in writing of a divorce or termination of domestic partnership, a legal separation or of a child's losing eligible dependent status under the NYS Vision Plan within 60 days from the date coverage ends due to one of those events. Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA qualifying event. **If notice is not received in writing within that 60-day period, regardless of the reason, the dependent will not be entitled to choose continuation coverage.**

When you notify the Employee Benefits Division of one of these events, the Division will advise you of your right to choose continuation of coverage. You must inform the Employee Benefits Division of your desire to continue coverage within 60 days of the date you would lose coverage because of the events described previously, or 60 days from the date you are notified of your eligibility for continuation coverage, whichever is later.

A dependent who wishes to continue coverage as a COBRA enrollee must send a written request to the Employee Benefits Division within 60 days from the date coverage would otherwise end. If you, your eligible dependent or someone acting on your behalf does not choose continuation coverage, Vision Care coverage will end.

How Long You May Keep COBRA Coverage

You, the employee, will have the opportunity to maintain continuation coverage for 18 months. However, the continuation coverage period will be extended to 29 months for you and your enrolled dependents if you or your enrolled dependent is disabled (under Social Security Act provisions defining disabilities). If you are disabled under Social Security at the time of COBRA election, you must notify the Employee Benefits Division within the first 60 days of COBRA coverage in order to qualify for the 11 month extension for the disabled. If you become disabled under Social Security during COBRA continuation, you must notify the Employee Benefits Division within 60 days of the notice of disability and prior to the end of the 18 month COBRA continuation period. If, during the continuation coverage period, another event takes place that would entitle a dependent spouse/domestic partner or child to his or her own continuation coverage, the continuation coverage may be extended.

However, in no case will any period of continuation coverage be more than 36 months from the original COBRA qualifying event.

Dependents who were covered at the time of your initial qualifying event, and newborns or newly adopted children added to your COBRA continuation coverage within 30 days of birth or final adoption during your period of COBRA coverage, are considered qualified beneficiaries with their own rights to continue COBRA coverage for up to 36 months in the event of a second qualifying event. Other dependents added to your COBRA coverage, such as a newly acquired spouse or child who returns to school full-time, do not have continuation rights apart from yours.

Enrolled spouses/domestic partners and dependent children who lose eligibility due to a COBRA qualifying event have the opportunity to elect COBRA continuation coverage for up to 36 months.

Who Is Eligible For COBRA: You

If you are an active employee enrolled in the NYS Vision Plan, you have the right to continue coverage if you lose your coverage because of a reduction in your hours of employment or the termination of employment.

Spouses or Domestic Partners

The spouse or domestic partner of an employee covered as the employee's dependent by this Plan has the right to continue coverage if coverage under this Plan is lost for any of the following reasons:

1. Your death;
2. Termination of your employment;
3. Reduction in your hours of employment with New York State;
4. Divorce or termination of domestic partnership;
5. Legal separation (spouses only) -- Your spouse does not automatically lose Vision Care coverage if you are legally separated. However, if your spouse loses coverage under this Plan, he or she may continue coverage under COBRA.

Dependent Children

A dependent child of a covered employee has the right to continue coverage if coverage under this Plan is lost for any of the following reasons:

1. The dependent ceases to be an eligible "dependent child" under this Plan;
2. The termination of your employment;
3. A reduction in your hours of employment with New York State;
4. Your divorce or termination of domestic partnership;
5. Your legal separation (NOTE: A dependent child does not automatically lose coverage because of parents' legal separation).
6. Your death.

When You or Dependents No Longer Qualify for COBRA

New York State law provides that your COBRA coverage may be cancelled for any of the following reasons:

1. If New York State no longer provides Vision Care coverage to State employees;
2. If the premium for your COBRA coverage is not paid on time;
3. If you become entitled to Medicare benefits during the COBRA continuation period.

Costs Under COBRA

You will have to pay the entire premium for your continuation coverage plus a two (2) percent administration fee. (If your coverage continues beyond 18 months due to a determination of disability under the Social Security Act, you will pay 150% of the premium cost for the 19th through the 29th month.) You will have 45 days starting with the date you choose continuation coverage to pay any premium. After this 45-day period, you will have a grace period of 30 days to pay any subsequent premiums.

Who to Contact

If you have any questions about COBRA, please contact your agency Health Benefits Administrator.

Glossary of Terms

Term	*Definition*
In-Network Benefits	Benefits obtained at an EyeMed participating vision provider.
Out-of-Network Benefits	Allowances reimbursed for services and materials obtained from vision providers who are not part of EyeMed's panel.
Optometrist, or OD	An eye doctor who has completed four years of post-graduate optometry school. Optometrists examine eyes and can prescribe corrective eyewear.
Ophthalmologist, or MD	A medical doctor who specializes in the eye. In addition to preventive eye care, ophthalmologists can prescribe medication for eye conditions and perform eye surgery.
Optician	Opticians sell and fit eyeglasses, sunglasses, and specialty eyewear. Opticians are not doctors but in most states must be licensed following specialized training.
Polycarbonate Lenses	Lenses made from a lightweight material 10 times more impact-resistant than other plastics. Recommended for children's eyewear and required in children's glasses in some states.
Progressive Lenses	Sometimes referred to as no-line bifocals, provide visual correction for distances and for up-close work.
High Index Lenses	Lenses made from newer plastic materials that bend light more than the traditional plastic lenses. This results in lighter, thinner lenses, especially for those with strong prescriptions.
Photocromatic Lenses	Lenses that change from transparent to tinted when exposed to ultraviolet light.
Lenticular Lenses	Lenses that are designed to reduce the weight and thickness and are used primarily for post-cataract lenses. The power is in the center of the lens but the edge is a portion of plain glass, so it is easily mounted in a frame.
Conventional Contact Lenses	Traditional contact lenses worn for six months or longer.
Disposable Contact Lenses	Contact lenses that must be replaced within a certain period of time. Frequencies range from daily to monthly to quarterly.
Standard Contact Lens Fit and Follow-Up	Commonly used contact lens types defined as spherical clear contact lenses. These include disposable contact lenses, planned replacement lenses and others.
Premium Contact Lens Fit and Follow-Up	Contact lenses such as toric and multifocal lenses, which are not included in the standard contact lens selection.
Occupational Exam/Testing	The occupational benefit covers the cost of job-related eyeglasses. Dependents are not eligible for occupational benefits. Occupational eyeglasses are only available through a network provider.
Medical Exception Program	Special benefit program available for individuals with qualifying conditions such as diabetes, keratoconus, cataracts and other conditions that after review could cause a change in refractive status.

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Who To Contact

EyeMed Vision Care

Please contact EyeMed Vision Care with any questions or if you wish to:

- Verify eligibility
- Obtain a list of participating providers
- Obtain an out-of-network claim form
- Obtain a Student Status Verification Form
- Check the status of an out-of-network claim
- Recommend a provider for participation on the EyeMed panel
- Obtain a Medical Exception Request Form

General Address: EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040-7111	**Out-of-Network Claims Address:** EyeMed Vision Care Attn: Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111
Telephone: 877-226-1412 **Fax:** 866-293-7373 **Website**: http://www.cs.state.ny.us	

Health Benefits Administrator

Contact your agency Health Benefits Administrator if you wish to:

- Enroll in the Plan
- Notify the Plan of a change of address
- Add or remove a dependent
- If you, your spouse, domestic partner or a dependent loses eligibility for Vision Care coverage and would like to continue coverage under COBRA, or if you or your enrolled dependents have any questions regarding continuing coverage under COBRA

Agency Health Benefits Administrator:

_____

(Fill in phone number)

or **Employee Benefits Division**

Address: NYS Department of Civil Service Alfred E. Smith Building Albany, NY 12239	**Telephone:** In the Capital District Area: 518-457-5754 Outside the Capital District Area: 800-833-4344

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STATE OF NEW YORK
STUDENT STATUS VERIFICATION FORM

Complete this form for unmarried dependent students ages 19 through 24 prior to using services under the NYS Vision Plan. The dependent must be considered a full-time student by the school attended. Please return this form to EyeMed Vision Care via U.S. postal mail, e-mail, or fax at least 10 days before services will be requested.

TO BE COMPLETED BY THE ENROLLEE:

Name of Dependent	**Dependent Date of Birth**
Name and Address of School	
Date Semester Starts	**Date Semester Ends**
Enrollee Name	**EyeMed MVC Number (located on your ID card) or Enrollee SSN**

I certify that my dependent, is unmarried, and is enrolled as a full-time student in an accredited secondary or preparatory school or college. I agree to advise EyeMed Vision Care promptly of any changes in my child's dependent student status.

Enrollee's Signature	**Date**

Please return completed form to EyeMed Vision Care via one of the following methods:

1. **Mail to:** EyeMed Vision Care
   Attn: Membership
   4000 Luxottica Place
   Mason, OH 45040

2. **Fax** to the attention of **EyeMed Vision Care – Membership** at 513-492-3605.

3. **E-mail** Address: Enroll@eyemedvisioncare.com

Any person who knowingly and with the intent to defraud, files an application for insurance or statement of claim containing any materially false information, or conceals for purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act. A fraudulent insurance act is a crime and shall be subject to a civil penalty for each violation not to exceed five thousand dollars and the stated value of the claims.

Tear Here

EyeMed VISION CARE®

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION NYS VISION PLAN

I hereby authorize the use or disclosure of my individually identifiable health information as described below. By signing this document I understand that I authorize a person or entity to receive information and it may be re-disclosed and no longer protected by federal privacy regulations.

Persons/organizations authorized to use or disclose the information: EyeMed Vision Care

Complete the following information:

The persons/organizations you are authorizing to receive the information:
Specific description of information that may be used/disclosed:
This authorization expires on [insert applicable date or event]:

I understand that I may inspect or copy the information used or disclosed. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:

- action has been taken in reliance on this authorization; or
- if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

A copy of this signed form will be provided to the member.

Complete the following information only if EyeMed Vision Care is requesting the information for its own uses and disclosures:

The information will be used/disclosed for the following purposes [Check One]: ☐ At the Request of the Individual ☐ Other-Please Describe:
The organization authorized to use/disclose the information will receive compensation for doing so. Yes☐ No☐
This authorization expires on [insert applicable date or event]:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

Complete and sign this section:

Signature of Patient:	Date
Printed Name of Patient:	Patient Date of Birth:
EyeMed MVC Number (located on your ID card) or Enrollee SSN:	

EyeMed VISION CARE®

Medical Exception Request Form
Submit Completed Form and proof of care for qualifying medical condition to: **Fax** 1-866-552-9115 **Email:** medexceptions@eyemedvisioncare.com **Mail to:** P.O. Box 8504 Mason, OH 45040 **Provider Form Questions:** Phone: 1-888-581-3648 www.eyemedvisioncare.com

- This is for the **New York State Vision Plan**
- To qualify for medical exception:
  1. At least one year must have elapsed since the last date of service; **AND**
  2. Patient must be under the care of a physician for the qualifying medical condition and provide proof of care for the qualifying medical condition at the eye examination; **AND**
  3. Patient must experience significant vision loss due to a qualifying medical condition.
     Definition of significant prescription change and qualifying medical conditions are listed below.
- All information must be complete in order for the request to be considered for approval

Provider Information	
Provider ID	Date
Federal Tax ID	Provider Location ID
First Name	Last Name
Phone (xxx-xxx-xxxx)	Fax (xxx-xxx-xxxx)
Patient Information	
Enrollee / Subscriber ID or SSN	Plan ID
Enrollee/ Subscriber Name	
Patient Name	Patient Birth Date (mm/dd/yyyy)
***Enrollee Union or Group:** ☐ BL2 (PEF) ☐ BL3 (M/C) ☐ BL4 (PIA) ☐ BL5 (PBA-T) ☐ BL6 (PBA-S) ☐ BL15 (Retiree) * The *annual examination* will be covered for eligible employees and dependents with a medical condition that may impact their vision refraction and who are referred by a qualified medical provider caring for that condition, regardless of whether the medical condition has caused a vision loss that requires a new prescription.	****Enrollee Union or Group:** ☐ BL8 (ALESU – arbitration eligible) ☐ BL9 (ALESU – contract affected) ☐ BL10 (NYSCOPBA – arbitration eligible) ☐ BL12 (NYSCOPBA– contract affected) ☐ BL 13 (Council 82 – arbitration eligible) ☐ BL 14 (Council 82– contract affected) ** If the medical exception is denied, patient is responsible for cost associated with exam and materials
Requested Services/Materials *All information must be completed for the request to be considered for approval*	
ICD-9 Diagnosis Code(s):	
(Definition of significant prescription change requirement: .75D sphere and/or 1.00D cylinder)	
Current Prescription	
OD	BVA 20/
OS	BVA 20/
New Prescription	
OD	BVA 20/
OS	BVA 20/
Qualifying Conditions (Check all that apply):	
☐ Diabetes ☐ Keratoconus ☐ Cataracts ☐ Cataract surgery within two years of last prescription ☐ Prescription Medication (type:) ☐ Other as determined by the Provider Manual	

Services And Materials Requested
☐ Contact Lens ☐ Exam ☐ Fit and Follow up ☐ Frame ☐ Lens ☐ Occupational Vision Glasses (Must meet criteria. Covered benefit for some groups) ☐ Standard Polycarbonate Lenses are covered benefit for some groups or in full for monocular adults or adults requiring correction + or –6.00D (If lens, type:_____) **** Please note member must purchase materials within 90 days of exam. ****

Provider Signature: _____ Date:_____

*****Provider must notify member of approval or denial by close of business following day***

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Effective 1/1/09

EyeMed VISION CARE®

Out of Network Vision Services Claim Form

NEW YORK STATE VISION PLAN

Claim Form Instructions

Most EyeMed Vision Care plans allow members the choice to visit an in-network or out-of-network vision care provider. You only need to complete this form if you are visiting a provider that is not a participating provider in the EyeMed network. Not all plans have out-of-network benefits, so please consult your vision benefit booklet information to ensure coverage of services and/or materials from non-participating providers.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to EyeMed. Any missing or incomplete information may result in delay of payment or the form being returned. **Please complete and send this form to EyeMed by March 31st following the year the claim was incurred.**

Reimbursement for the eye exam, lenses and frame must be claimed at the same time on one claim form. Partial usage of plan benefits is considered full usage.

1. When visiting an out-of-network provider, you are responsible for payment of services and/or materials at the time of service. EyeMed will reimburse you for services according to your plan design.
2. Please complete all sections of this form to ensure proper benefit allocation. Plan information may be found on your benefit ID Card or by calling EyeMed at (877) 226-1412.
3. EyeMed will only accept **itemized paid receipts** that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the provider's letterhead. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in US dollars, please identify the currency in which the receipt was paid.
4. Please include a copy of your Explanation of Benefits if submitting for a Secondary Insurance Benefit.
5. Sign the claim form below.

Return the completed form and your itemized paid receipts to:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Please allow at least 14 calendar days to process your claims once received by EyeMed. Your claim will be processed in the order it is received. A check and/or explanation of benefits will be mailed within seven (7) calendar days of the date your claim is processed.

Inquiries regarding your submitted claim should be made to the Customer Service number printed on the back of your benefit identification card.

EyeMed VISION CARE®

Out of Network Vision Services Claim Form

NEW YORK STATE VISION PLAN

Patient Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Enrollee MVC Number (located on ID card) or SSN	Relationship to Enrollee Self ☐ Spouse ☐ Child ☐ Other ☐		

Enrollee Information (**Required**)			
Last Name			
First Name			Middle Initial
Street Address	City	State	Zip Code
Birth Date (*MM/DD/YYYY*)	Telephone Number		
Vision Plan Name New York State Vision Plan	Vision Plan ID # 9682005		

Date of Service (**Required**) (*MM/DD/YYYY*)
☐☐ - ☐☐ - ☐☐☐☐

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:

Exam	Frame	Lenses	Contact Lenses
$_____	$_____	$_____	$_____

If lenses were purchased, please check type: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive

I hereby understand that I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Member/Guardian/Patient Signature (not a minor) _____ Date: _____

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EyeMed VISION CARE®

Out of Network Vision Services Claim Form

NEW YORK STATE VISION PLAN

FRAUD WARNING STATEMENTS

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties**.**

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kansas: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application or claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person, who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in § 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or files a false claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.