New York State Vision Plan

For Employees of the State of New York in the Agency Police Services Unit (APSU)

Represented by the Police Benevolent Association of New York State (PBANYS)

and for their enrolled dependents
and for COBRA enrollees and their families with APSU vision care benefits

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Department of Civil Service
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NYSHIP
New York State
Health Insurance Program

DAVIS VISION
EYECARE REFRAMED℠

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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 Davis Vision, Inc., a national leader in the vision care industry.

With Davis Vision, quality care is easy to find. Enrollees have access to a nationwide network, including more than 2,304 providers across New York State. The network includes independent practice eye doctors as well as major optical retailers, including:

Davis Vision 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. Davis Vision also operates a Customer Relationship Center (Contact Center) to support the plan and manage the national 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 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. You are eligible for benefits 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 an Agency Police Service Unit Police Benevolent Association of New York State 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 did not 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. All vision benefits must occur within the 90-day Purchase/Services Period to be eligible for coverage. Before receiving services, you can confirm eligibility by visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website, or call Davis Vision's customer call center at 888-588-4823.

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 Davis Vision Network. These "in-network" or "participating" doctors have agreed to meet certain quality standards, and Davis Vision 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 visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan, then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website. Once on the Davis Vision website you select “Find a Provider” or you can call Davis Vision's Customer Contact Center at 888-588-4823.
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 Davis Vision 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 in the Davis Vision Network, you will be eligible for "out-of-network" or "non-participating" reimbursements as defined in the Benefit Overview on page 3 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*:** Print an out-of-network claim form by visiting the New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website, or call the Davis Vision Customer Contact Center at 888-588-4823.
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:*** Send the completed claim form and receipts to Davis Vision at the following address:

   ATTN: Vision Care Processing Unit
   Post Office Box 1525
   Latham, New York 12110
   Fax: 518-220-6012

4. ***Reimbursement:*** Davis Vision will process the claim and reimburse you directly up to the allowed amounts.

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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 age 19, once in any 12-month period. All vision benefits - eye exam, frames and lenses (or contacts) - must occur within the 90-day Purchase/Services Period to be eligible for coverage. 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	$16
Frames:		
Non-Collection Frame Allowance (Retail):	80% of balance over $100 Retail Allowance	
Davis Vision Collection[1]:		$14
Fashion level	$0	
Designer level	$0	
Premier level	$40 copayment	
Standard Plastic Lenses:		
Single Vision	$0	$14
Bifocal	$0	$23
Trifocal	$0	$32
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)	$0	N/A
Standard Scratch-Resistance	$0	N/A
Fashion Tints	$0	N/A
Polycarbonate	$0 or 30[1]	N/A
Progressive	$0	N/A
Intermediate lenses	$30	N/A
High Index	$0	N/A
Photosensitive – Plastic	$0	N/A
Photosensitive - Glass	$0	N/A
Standard Anti-Reflective Coating	$35	N/A
Premium Anti-Reflective Coating	$48	N/A
Ultra Anti-Reflective Coating	$60	N/A
Polaroid	$60	N/A

Contact Lenses: Prescription 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.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Non-Collection Contract Lenses:		
Conventional Contact Lenses Allowance	80% of balance over $105 Retail Allowance	$184[2]
Disposable Contact Lenses Allowance	80% of balance over $105 Retail Allowance	$184[2]
Collection Contact Lenses (in lieu of Allowance):		
Planned Replacement (2 boxes/multi-packs)	Included	N/A
Disposable includes specialty contact lenses examples: toric, multifocal, etc. (4 boxes/multi-packs)	Included	N/A
Evaluation, Fitting & Follow-Up Care – Standard Lens	Included	N/A
Evaluation, Fitting & Follow-Up Care – Specialty Lens	Included	
Eye Exam and Contact Lenses		$200

1/ Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
2/ Out-of-Network Contact Lens allowance of $184 applies to Contact Lens Fit and Follow-Up and Materials, and reimbursements must be claimed at the same time on one claim form.

Additional Plan Features

MEDICAL EXCEPTION VISION BENEFIT

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 may be eligible for an eye examination after 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 prescription

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.

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 prescription change is defined as a minimum change of .75D sphere and/or 1.00D cylinder or more since your last eye examination. You are only eligible for new frames if your current frames are broken or if you need new lenses that will not fit in your current frames.

> **Prior to receiving services,** ask your vision care provider to complete the Medical Exception Request Form. To request the form contact the Davis Vision Customer Contact Center at 1-888-588-4823. 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 documentation from your medical provider to Davis Vision's Medical Director for approval.

LASER VISION CORRECTION DISCOUNTS

Funded Benefit - Employees Only

Employees pay 10% of the price up to the maximum member cost of $200 per surgery once every five years. The covered benefit includes a pre-operative evaluation, the surgery, and necessary follow-up visits.

Discount Benefit - Covered Dependents Only

Covered Dependents get a discount of up to 25% off the providers' usual and customary fees, or a 5% discount from the laser center's advertised specials, whichever affords the member the greater benefit.

Davis Vision's laser providers are credentialed according to NCQA standards and represent ophthalmologists and surgeons who use the latest, most advanced instrumentation. The discount program is applicable to LASIK and PRK.

To locate a participating laser vision correction provider and learn how to schedule your pre-operative evaluation, call 1-888-588-4823 or Visit New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision website to locate a provider.

CATARACT CARE

If you or your covered dependents 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.

90-DAY PURCHASE/SERVICES PERIOD

You have 90 days to use your NYS Vision benefits (eye exam, frames and lenses (or contacts)) at a participating provider from the date of your first covered service under the Standard Plan, the Occupational Program and the Medical Exception Program. Otherwise, NYS Vision benefits will not be available until your next Eligibility Date.

PLAN LIMITATIONS/EXCLUSIONS

The following items are standard exclusions of Davis Vision's proposed primary vision care program:

- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in the benefit plan
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Prosthetic devices and services
- Materials and services not specified in the benefit design
- Services provided as a result of any Workers Compensation Law

Eligibility Guidelines

You, the Enrollee

All Agency Police Service Unit 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 and same-sex spouses, the fair market value of vision benefits for a domestic partner or same sex-spouse 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 or same-sex spouse 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), stepchildren and children of domestic partners. 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 PS-457 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, stepchildren or children of domestic partners, 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 Verification Form before an eligible student dependent can receive vision care benefits**. A Student Verification Form is included in this booklet or can be obtained online at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan, then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website or call Davis Vision's customer call center at 888-588-4823. 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 or changes from full-time to part-time status due to serious injury or illness, vision care coverage will continue for a maximum of one year from the month in which the student status changes plus any time before the start of the next regular semester. You must be able to provide written documentation from the school and/or 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 Davis Vision 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. The child may be granted a second semester of coverage during part-time attendance if there are unusual, extenuating circumstances, which through no fault of the student, prevent that student's timely graduation. Requests for this continued coverage must be submitted in writing to the Employee Benefits Division.

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 an application for your disabled dependent, 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 application for your disabled dependent, 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. 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 36 months. 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 Your 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. 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*
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, typically every 1 or 2 days.
Eligibility Date	The next date employees and covered dependents can use NYS Vision Plan benefits. Covered employees and dependents over age 19, may use their benefits 24 months from their first covered service. Covered dependents under age 19, may use their benefits 12 months from their first covered service.
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.
In-Network Benefits	Benefits obtained at a Davis Vision participating vision provider.
Intermediate Lenses	That area in a trifocal lens or lens blank that has been designed to correct vision at intermediate to distant ranges.
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.
Medical Exception Benefit	Special benefit program available for individuals with qualifying conditions such as diabetes, keratoconus, cataracts and other conditions that could cause a change in refractive status.
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.
Optometrist, or OD	An eye doctor who has completed four years of post-graduate optometry school. Optometrists examine eyes and can prescribe corrective eyewear.
Out-of-Network Benefits	Allowances reimbursed for services and materials obtained from vision providers who are not part of Davis Vision's Network.
Planned Replacement Contact Lenses	Soft lenses that are worn for a prescribed length of time, then are discarded.
Polaroid Lenses	Eyeglass lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.
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.
Photosensitive Lenses	Lenses that change from transparent to tinted when exposed to ultraviolet light.
Purchase/Services Period	The 90-day period of time starting from the date of your first covered service.
Standard Contact Lenses	Commonly used contact lens types defined as spherical clear contact lenses. These include disposable contact lenses, planned replacement lenses and others.
Specialty Contact Lenses	Contact lenses such as toric and multifocal lenses, which are not included in the standard contact lens selection.

Who To Contact

DAVIS VISION

Please contact Davis Vision 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 Davis Vision Network
- Obtain an identification card

General Address:	**Out-of-Network Claims Address:**
Davis Vision, Inc. 711 Troy Schenectady Road Latham, New York 12110	Davis Vision, Inc. Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110

Telephone: 888-588-4823 Fax: 518-220-6012
Website: Visit New York State Department of Civil Service website at https://www.cs.ny.gov. On the Civil Service home page, select Benefit Programs, then select NYSHIP Online and if prompted, choose your group and plan. Then select Other Benefits and then Vision Benefits and follow the links to the Davis Vision Website.

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
NYS Department of Civil Service
Alfred E. Smith Office 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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NEW YORK STATE VISION PLAN

STUDENT VERIFICATION FORM

DEPENDENT STUDENT: Is defined as an unmarried child, who is a full-time student, covered through age 24. *A dependent must be considered a full-time student by the school attended.*

Please return this form to Davis Vision, via email, Fax or US postal mail at least 10 days before your doctor appointment for a dependent student age 19 thru 24.

The member ID is necessary for us to process any requests.

I certify that my dependent, _____, _____ _____

Printed Last Name Printed First Name Date Of Birth

Is unmarried, and is enrolled full time in an accredited secondary or preparatory school or college. I agree to advise Davis Vision promptly of any changes in my child's dependent student status.

Name of School: _____ Location: _____

Semester Starts: _____ Semester Ends: _____

_____, _____ _____

Enrollee's Printed Last Name Enrollee's Printed First Name Enrollee's Member ID Number

_____ _____

Enrollee's Signature Date

The member ID is necessary for us to process any requests.

Please return form to Davis Vision via one of the following methods:

1. **Email to: nysvision@davisvision.com**
2. **FAX to the attention of "NYS Student Proof" at 1-800-292-9687**
3. **Mail to: Davis Vision**
   Attn: NYS Student Proof
   PO Box 1501
   Latham, NY 12110

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

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NYSHIP
New York State Health Insurance Program

FOR INTERNAL USE ONLY
Auth #: _____
Paid ☐ Denied ☐ Pended ☐

Out of Network (Direct Reimbursement) Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **employee's** (or employee's authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110 or fax to 1-518-220-6012.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call 1-888-588-4823 or visit https://www.cs.ny.gov. The patient is responsible for the costs of all treatment and materials provided.

Employee Information

(PLEASE PRINT CLEARLY)

Employee Name: _____ Employee Identification No.: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Business Phone: _____ Home Phone: _____
Area Code Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: ☐ Employee ☐ Spouse/Domestic Partner ☐ Child DOB: _____ ☐ If student aged 19 or over, attach written proof of attendance at school

Provider Information

Examiner

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Dispenser

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

State License Number: _____

Phone Number: _____

Provider Signature: _____

Service	Date of Service	Expense(s) Incurred
1. Eye Examination	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses	(/ /)	$
4. Bifocal Lenses	(/ /)	$
5. Trifocal Lenses	(/ /)	$
6. Contact Lenses	(/ /)	$
7. Cataract S.V. Lenses	(/ /)	$
8. Cataract Bifocal Lenses	(/ /)	$
	Total	$

Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required

_____ _____
Employee or authorized person's signature **Date**

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **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.

In **Tennessee,** state law stipulates that 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.

For Washington, D.C. residents:

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.

DAVIS VISION
EYECARE REFRAMED℠

Authorization for Disclosure of Protected Health Information

This Authorization is Voluntary

Person Granting Authorization	Policy Holder Information
Date: _____	**ID Number:** _____
Name: _____	**Name:** _____
Address: _____	**Address:** _____
_____	_____
Date of Birth: _____	**Telephone:** _____

I authorize and direct Davis Vision, Inc. and its affiliates to furnish and release vision care insurance information regarding the person noted above.

Information to Be Disclosed:

____ Participating Vision Care Providers
____ Benefit, Policy and Procedure information
____ Vision Care Claims Information
____ Vision Care Claims Review Information
____ Eligibility Information
____ Other _____

Purpose of Disclosure:

____ To provide information to a family member or friend
____ As required for a legal matter
____ Other _____

Person(s) or Organization(s) To Receive the Identified Information:

Name: _____
Street Address: _____
City, State, Zip: _____
Name: _____
Street Address: _____
City, State, Zip: _____
Name: _____
Street Address: _____
City, State, Zip: _____

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present or future vision health care or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in the Davis Vision Care plan, my eligibility for benefits or payment of my claims.

Expiration: This authorization will expire on ____/____/____ or on occurrence of the following event _____

Right to Revoke: This authorization may be revoked at any time. Contact Davis Vision, Inc. Privacy Contact Office at 1-800-571-3366 for further instructions. Revocation of this authorization will not affect any action taken before Davis Vision, Inc. receives the notice of revocation.

Signature: _____ **Date:** _____
(Person Granting Authorization)

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

DAVIS VISION
EYECARE REFRAMED℠

PLEASE RETAIN A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

Please read the instructions below before completing the Authorization form. The information you provide will be used to fulfill your request to disclose your protected health information and identify the person(s) who will be receiving your information. All required sections of the form must be completed in order for us to process this request. If required information is not completed, we will not disclose your protected health information. In certain circumstances, a written authorization to disclose your protected health information to a third party specified by the individual is required by law.

Section 1 - Member Information (Required)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Section 2 - Granting Authorization/Specification of Information to be Disclosed (Required)

Select the type of Protected Health Information to be disclosed. If OTHER, specify what information you wish disclosed.

Section 3 – Purpose of Disclosure (Required)

Select the purpose of this authorization to disclose Protected Health Information. If OTHER, specify the reason for the authorization.

Section 4 – Designate the Recipient(s) (Required)

Identify to whom the requested information is to be provided.

Section 5 – Important Information (Required)

Please read this section carefully.

Section 6 - Expiration/Revocation of an Authorization (Required)

You must indicate a date or event that will trigger the expiration of this authorization. Once an authorization has expired, the person who has been receiving your information will no longer be able to receive your information. If an event will trigger the expiration of this authorization, please indicate that event in the space provided.

Section 7- Signatures and Personal Representatives (Required)

The individual whose information is being disclosed must sign and date in the space provided. If this form is completed by your personal representative, he or she must include his or her name and relationship to you. (e.g. attorney-in-fact, guardian, executor, parent of a minor, etc.)

Please Return the Completed Authorization Form to the Address Below:

Davis Vision - Privacy Office
PO Box 1416
Latham, NY 12110-1416
Telephone: 1-800-571-3366
Fax: 1-866-999-4640