# CERTIFICATE OF COVERAGE

# Optix Vision Plan

**Miami-Dade County Government**

Optix Vision Plan is offered by **Oral Health Services, Inc.** ("OHS"), a prepaid limited health service organization under Chapter 636, Florida Statutes.

## Choice of Vision Care Provider

The Optix Vision Plan Offers vision care through **Participating Providers** and **Non-participating Providers**. When a Member obtains care from a participating provider, care will be provided for a modest co-payment from the **Member** (as shown in the **Schedule of Benefits**). When the member obtains care from a non-participating provider, the plan will reimburse the member a fixed dollar amount (as shown in **the Schedule of Benefits**).

## Using Optix Vision Plan Participating Providers

Member chooses a provider from the list of Participating Providers. Member schedules an appointment after the effective date of coverage. Upon scheduling an appointment, the member must notify the office that they are a member of the Optix Vision Plan. There are no identification cards needed. The vision provider handles all claim forms.

## Using Optix Vision Plan Non-Participating Providers

After the effective date of coverage, Member can make an appointment with Non-Participating Provider. Member must obtain vision care claim forms at work site or by calling Fringe Benefits Management Co. 1-800-342-8017. Member must submit to the following address a fully completed claim form along with an itemized statement from the Non-Participating Provider within ninety (90) days of the date of service:

OHS/Vision Care, Inc.
Optix Vision Plan
P.O. Box 30349
Tampa, Fl 33630-3349

## Dependent Eligibility

**"Dependent "** means any of the following dependents of the Subscriber:

1) legal spouse;
2) unmarried child(ren);
   a) from birth to age nineteen (19) and dependent upon the Subscriber for support;
   b) nineteen (19) years of age through the end of the calendar year in which the child attains age twenty-five (25), if dependent upon the Subscriber for support and a full-time or part-time student or residing in the Subscriber's household; or
   c) at least nineteen (19) years of age and;
      i) primarily dependent upon the Subscriber for support due to mental or physical handicap;
      ii) as incapacitated and covered under the Certificate on his nineteenth (19th) birthday; and
      iii) continues to be incapacitated beyond his nineteenth (19th) birthday.

(The term "children" also includes adopted children, and stepchildren living with the Subscriber in a parent-child relationship, as well as children of a covered domestic partner.)

3) domestic partner who; i) has lived with Subscriber at the same regular residence and been each other's sole domestic partner continuously for a minimum of twelve (12) months and intends to continue such indefinitely; ii) is not legally married to anyone else; iii) is 18 years of age or older; iv) is not related to Subscriber, and v) is financially interdependent with Subscriber.

## Terms of Enrollment

Enrollment in the OHS vision plan is for a minimum of twelve (12) consecutive months while employed by employee's current employer. Enrollment in the plan or changes to the plan will be allowed during open enrollment periods as determined by the employer and OHS.

## Effective Dates of Coverage

The effective date of coverage is established between the employer and OHS. Upon enrollment the Member will be notified of the effective date of coverage.

## Emergency Care

In the event of an emergency, the Member may contact any Participating Provider. Emergency Vision Services, for the purposes hereof are limited to obtaining a vision service such as a vision examination, and lenses or frames, to which the Member is otherwise entitled under the Schedule of Benefits, on an expedited basis. If the member is unable to obtain the covered vision service on an expedited basis, when needed, Members should call:

**1-800-342-8017**

Members have the option to contact any Non-Participating Provider inside or outside of the Optix Vision Plan Service area to receive Emergency Care. Selection of a Non-Participating Provider for Emergency Services shall limit the Member to the services applicable to Non-Participating Providers as outlined in the Benefit Schedule. Emergency office visits may be subject to additional co-payments as stipulated in the Schedule of Benefits.

# CERTIFICATE OF COVERAGE

## Member Support and Grievance Procedure

If you have an inquiry or grievance, OHS encourages you to submit it in writing to:

OHS/Vision Care, Inc.
Optix Vision Plan
P.O. Box 30349
Tampa, Fl 33630-3349

Or call Compbenefits Corp., Monday through Friday, 8:00 AM to 5:00 PM at:

**1-800-393-2873**

## Grievances must be filed no later than one year from the date of the occurrence.

Support Associates are trained to address and satisfactorily resolve grievances. In the event a resolution cannot be achieved by the Member Support Department; the grievance is referred to the Case Support Department. A Case Support Associate will research the issues and attempt to resolve the grievance in a manner satisfactory to all affected parties. Members wishing to appeal decisions rendered by the Case Support Department must do so in writing to the Manger of Quality Assurance within sixty (60) days following the date of decision. Grievance appeals will be reviewed by the Quality Assurance Committee. The member will receive a final written determination within thirty (30) days after OHS receives the completed grievance appeals form. The final determination of the Committee will be binding on the member and the provider. A copy of the OHS conflict resolution program policies and procedures is available to each member upon request. Members also have the right to submit grievances directly to the Florida Department of Insurance at:

Florida Department of Insurance
Consumer Assistance
200 East Gaines Street
Tallahassee, Florida 32399-0322
Or the Member may call the Florida Department of Insurance at 1-800-342-2762.

## Coordination of Benefits

The benefits of this plan may be coordinated with an indemnity vision insurance plan. For information on coordination of benefits you should contact your primary indemnity vision insurance carrier.

## Grace Period

Premiums are collected from Member through payroll deduction and will vary depending on the payroll deduction schedule, and are remitted to OHS on a monthly basis. Although payment to OHS is due no later than the last day of each month, Premiums must be paid no later than the expiration of the grace period, which is twenty (20) days after the first day of the month immediately following the month for which payment was due. In the event a monthly Premium payment is not received by OHS prior to the expiration of the grace period, OHS, at its sole option, may terminate all coverage to the Group effective as of the first day of the month following the month for which the Premium was due.

## Termination of Membership

Coverage for Member and each Dependent will cease the first day of the month following the day in which the Member's affiliation with Group is terminated, for any reason, and OHS receives written notice of the termination; and for non-payment of Premium pursuant to the section titled "Grace Period," above.

OHS may disenroll a Member for any of the following reasons after forty-five (45) days notice and reasonable efforts are made to resolve any conflict through the use of the grievance procedure. OHS will make a reasonable effort to resolve the problem, including consideration of extenuating circumstances.

**a.** A Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation would impair OHS' or a Provider's ability to provide covered vision services to the Member, or to other Members;
**b.** A Member commits fraud or makes a material misrepresentation in seeking vision services.
**c.** A Member willfully misuses any documents provided as evidence of benefits available under this Agreement; or
**d.** A Member furnishes to OHS, to any Participating Provider, or to any insurance agent, broker, or agency, incorrect or incomplete information for the purpose of fraudulently obtaining covered Dental Services. Coverage for Dependents shall automatically terminate in the event the Member is disenrolled.

## Continuation of Benefits

A Member and any Dependent of said Member whose coverage is terminated for any reason other than as set forth in Termination of Membership, may elect no later than sixty (60) days form the effective date of termination to continue coverage with OHS directly if he/she was enrolled in a OHS plan for at least three (3) Successive months immediately preceding termination. Plan benefits available for continuation shall be similar to those then being offered by OHS to the group.

## Extension of Benefits

If vision services to Member is actively being rendered as of the termination date of this coverage, continuing services will be authorized for the Member until the earliest of the following dates:
**1.** the expiration of ninety (90) days;
**2.** the maximum benefits have been paid for the Member;
**3.** Vision services have been completed for the Member.

## Definitions

**Co-payments:** Co-payments are reduced fees charged by the Participating Provider for some covered vision procedures as specified in the Schedule of Benefits. The reduced fees are less than the usual, customary and reasonable fees charged in a Participating Provider's office. Members are financially responsible for co-payment fees which are payable to the Participating Provider.
**Covered Services:** Are those vision care services that are covered under this plan as described in the Schedule of Benefits.
**Employee:** An employee of the employer,
**Dependent:** The employee's spouse (includes domestic partners) and/or unmarried eligible children.
**Member:** An employee or dependent covered under this plan.
Participating Provider: A vision care professional who has contracted with the plan to offer services at reduced negotiated fees.
**Non-Participating Provider:** A vision care professional who has not contracted with the plan.

### Additional Information Available

OHS shall make available to Members, upon request, a description of the process used to analyze the qualifications and credentials of the Participating Providers.

**Oral Health Services, Inc. is licensed and approved by the State of Florida Department of Insurance as a prepaid limited health service organization under chapter 636 of the Florida Statutes.**

# CERTIFICATE OF COVERAGE

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## SCHEDULE OF BENEFITS

| | | Participating Provider | Non-Participating Provider Reimbursement[1] |
|---|---|---|---|
| **Plan Frequencies** | **Exam Every** | **12** | **12** |
| | **Lenses Every** | **12** | **12** |
| | **Frames Every** | **12** | **24** |
| **Co-payments** | **Exam** | **$0** | **NA** |
| | **Lenses and/ or Frames** | **$10** | **NA** |
| **Covered Lens Options** | **Transition[6]** | **Paid in full** | **$75** |
| | **Child Polycarbonate[5]** | **Paid in full** | **$0** |
| | **Progressive Levels 1-3** | **Paid in full** | **$0** |
| **Maximum Allowances** | | **(after co-payments up to plan limits)** | |
| **Eye Exam** | | Paid in full | $40 |
| **Lenses (per pair)** | Single | Paid in full | $40 |
| | Bifocal | Paid in full | $50 |
| | Trifocal | Paid in full | $60 |
| | Lenticular | Paid in full | $100 |
| **Contact Lenses[2]** | Medically necessary[3] | *** Paid in full or up to $175 Allowance | up to $175 |
| | Elective | *** Paid in full or up to $120 Allowance | up to $120 |
| | Contact Lens Fitting Fee | *** Paid in full | NA |
| | Mail Order Contact Repacement | 20% provider discount | NA |
| | LASIK Surgery Co-payment | $3,600 both eyes | NA |
| **Frame** | Select Frame or $45 wholesale | $117 retail equivalent[4] | $50 retail |

| | |
|---|---|
| **Calendar Year Deductible** | None, after plan Co-payments |
| **Calendar Year Maximum Benefit** | Up to plan limits |
| **Lifetime Maximum Benefit** | Unlimited |
| **Waiting Periods** | None |

[1] The amounts shown are maximum benefits. The actual benefit amount the plan will reimburse to a plan member for non-network doctors will be the least of the maximum shown in the schedule, the amount actually charged, or the amount a doctor usually charges a private patient.

The availability of services under the non-network reimbursement schedule is subject to the same time limits and copayments as those for network services. The plan pays non-network benefits in place of services from a network doctor.

[2] This allowance is paid with the same frequency as lenses, in place of the lens and frame benefit. Contact Exam is covered by Exam Co-payment.

[3] Medically necessary (prior authorization required) is defined as 1) following cataract surgery without intraocular lens, 2) correction of extreme visual acuity problems not correctable with glasses, 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles, 4) Keratoconus, or 5) moncular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life

[4] The retail value is approximately 2.6 times the wholesale allowance.

[5] Polycarbonate lens option covered in full for dependents under 19 years of age.

[6] Transition lens options covered: Glass PGX and PBX, Glass Thin & Dark / PhotoSun 2 / Photo Gray 2 and other transition materials.

*** Limited to a select group of daily wear contacts (CIBA Soft, Wesley Jessen D2T4, and Optima 35) and does not include the fitting fee. The allowance applies to non-select contact lenses.

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Benefits included for each covered person:

**1.** A vision care examination (every year).

Each Covered Person shall be entitled to a vision examination once every twelve (12) months as follows:

Vision Analysis- A comprehensive examination of the visual functions, including the prescription of corrective eye wear where indicated.

**A.** An examination for vision analysis shall include the following procedures which shall be recorded on the Member's record.

**1.** Member's history (personal and family medical history, personal and family ocular history, and chief complaint);
**2.** Visual acuity (unaided or acuity with present correction);
**3.** External Examination;
**4.** Pupillary Examination;
**5.** Visual Field Testing (Confrontation);
**6.** Internal Examination (Direct or indirect ophthalmoscopy
recording cup disc ration, blood vessel status and any abnormalities);
**7.** Biomicroscopy (Binocular or monocular);
**8.** Tonometry;
**9.** Refraction (with recorded visual acuity);
**10.** Extra ocular muscle balance assessment;
**11.** Diagnosis and treatment plan.

**B.** If, because of the Member's age or physical limitations, one or more of the procedures specified herein or any part thereof, cannot be performed, the reason for same shall be noted on the Member's case record.

## EXCLUSIONS AND LIMITATIONS (NOT COVERED):

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

**1.** Orthoptics or vision training, subnormal vision aids, aniseikonic lenses, plan (non-prescription) lenses or glasses secured when there is no prescription change.
**2.** Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
**3.** Medical or surgical treatment of the eyes.
**4.** Low vision services.