



# VisionCare Plan Member Handbook

## The CompBenefits Family of Companies

This notice is provided to you by the CompBenefits family of companies:

CompBenefits Insurance Company, American Dental Providers of Arkansas, Inc., CompDent of Alabama, Inc., OHS of Alabama, Inc., American Dental Plan, Inc., Oral Health Services, Inc., Vision Care, Inc., CompDent of Illinois, Inc., CompDent Corp., American Dental Plan of North Carolina, Inc., DentiCare, Inc (d/b/a CompDent). The CompBenefits family of companies are affiliated companies and may share health information with each other as necessary to carry out treatment, payment, or health care operations.



## VisionCare Plan

### Member Handbook

**Welcome to CompBenefits!** We are pleased that you have selected our plan for your vision needs. If you have any questions about your vision plan, please contact your group's benefits administrator or call Member Services at (800) 865-3676.

#### CHOICE OF EYE CARE PROVIDERS

You may choose the eye care professional of your choice. To receive the highest level of benefits, you and your dependents must select an eye care provider from CompBenefits' list of participating eye care providers. When you select a participating eye care provider, your out-of-pocket costs for covered eye care services are limited to the copayment amounts shown on your Schedule of Benefits.

#### USING YOUR PLAN

**VisionPass:** You may obtain a VisionPass form before scheduling an appointment. VisionPass forms are available at our web-site [www.CompBenefits.com](http://www.CompBenefits.com) or by calling Member Services at (800) 865-3676 or faxing us at (800) 421-0100 or mailing us at P.O. Box 30349, Tampa, FL 33630-3349. Upon determination that you are eligible, a VisionPass form will be sent to you together with a list of participating providers in your area. The VisionPass is valid for sixty days. You only pay your copayments, if any, and the costs and fees associated with services or materials NOT covered under your plan at the time services are rendered. If you do not obtain the VisionPass and visit a participating provider as a private patient, the provider is not obligated to accept our fees as full payment for services and may elect to charge you his usual and customary fees.

**ID Card:** Call to schedule an appointment with a CompBenefits participating provider and give your name, the patient's name, ID number, group number and the name of the group. After scheduling the appointment, the provider's office verifies your eligibility and benefits before performing the exam. There are no forms for you to complete. You simply pay the participating provider for any applicable copayments and any extra costs for services and materials not covered by you plan at the time services are rendered.

If you choose to receive covered services from a provider other than a CompBenefits participating provider, your benefits are based upon allowance shown on your Schedule of Benefits. You must pay the provider in full at the time the services are rendered and then submit to us an itemized statement of charges. You are responsible for the costs and fees in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered under your plan.

#### TERMS OF ENROLLMENT

Enrollment in CompBenefits vision plan is for a minimum of twelve (12) consecutive months while you are covered under your group plan. Enrollment in the plan will be allowed during open enrollment periods as determined by your group and CompBenefits.

#### EFFECTIVE DATE OF COVERAGE

The effective date of coverage is established between the group and CompBenefits. Upon enrollment you will be notified of your effective date of coverage.

#### DEPENDENT ELIGIBILITY

Eligible dependents include your spouse and your children, including newborn and adopted children. Your newborn child is covered for 30 days from birth. You must enroll your newborn child within 60 days from the date of birth or coverage for that child will terminate at the end of the 30 day period.

Your adopted child will be covered from the earlier of the date of birth if a petition for adoption is filed within 30 days of birth; the date you gain custody of the child under a temporary court order that grants you conservatorship of the child; or the date the child is placed with you for adoption.

## **RENEWALS**

Your coverage will automatically be renewed each year unless you notify your group's benefits administrator to terminate your coverage.

## **COORDINATION OF BENEFITS**

If you have vision care coverage under more than one plan, the benefits under this plan may be reduced if it is determined that the benefits under the other plan must be applied first.

## **EXTENSION OF BENEFITS**

In the event coverage is cancelled by CompBenefits, participating providers will complete all procedures started prior to cancellation until the procedure is completed or for 90 days, whichever occurs first.

## **CONVERSION**

You may have the right to receive a converted contract if you were continuously covered under this plan for at least 3 consecutive months prior to termination.

## **CONTINUATION OF COVERAGE**

When your coverage terminates, you may have the right to continue coverage under the group plan for a certain period of time. Please consult your group's benefits administrator to see if this applies to you.

## **COMPLAINTS AND GRIEVANCES**

We are committed to offering outstanding service to our members. If you have a concern or complaint about your vision plan, we want to know. If you have a complaint or grievance you must follow our grievance procedures, and all grievances must be filed within one year of the occurrence. Complaints and grievances can be handled informally by calling Member Services at (800) 865-3676. You may submit a formal grievance in writing to CompBenefits Company, Attn: Grievance Coordinator, P.O. Box 30349, Tampa, FL 33630-3349. Please remember to include your name, address phone number, ID number, signature, date, and action requested with your correspondence. Assistance with the grievance procedures may be obtained by calling Member Services at the number shown above. Your formal grievance will be investigated and responded to within 60 days, however if the grievance involves collection of information from outside the plan's service area, an additional 30 days will be allowed for processing. If you are not satisfied with the formal grievance decision, you may request a reconsideration within 60 days of receipt of the decision.

Please note that at any time you have the right to grieve directly to the Florida Department of Insurance Consumer Assistance at 200 East Gaines Street, Tallahassee, FL 32399, or call the toll free consumer hotline at (800) 342-2762.

## LIMITATIONS AND EXCLUSIONS

The plan is designed to cover visual needs rather than cosmetic choices. Covered materials that are lost or broken will only be replaced at normal intervals as provided in the Schedule of Benefits. You are responsible extra items, including but not limited to:

- Coated or laminated lenses
- Blended or progressive multifocal lenses
- Tinted or photochromic lenses, sunglasses, prescription and plano
- A frame that costs more than the plan allowance
- Groove, drill or notch, and roll and polish

The following items and services are excluded from coverage:

- Orthoptics or vision training and any associated supplemental testing;
- Subnormal vision aids, non-prescription or aniseikonic lenses;
- Contact lenses, except as covered in the Schedule of Benefits;
- Hi-index, aspheric and non-aspheric styles;
- Oversized 61 and above lens or lenses;
- Experimental or non-conventional treatment or device;
- Medical or surgical treatment of the eyes;
- Charges incurred after coverage ends;
- Cosmetic items, unless specifically covered in the Schedule of Benefits;
- Any injury or illness paid by any Workers Compensation or similar law;
- Two pairs of glasses in lieu of bifocals, trifocals or progressives;
- Any services or materials required by an employer as a condition of employment.

## DEFINITIONS

“CompBenefits” means CompBenefits Company, a Pre-paid Limited Health Service Organization licensed under Chapter 636, Florida Statutes.

“Copayment” means the amount paid by you for services rendered or materials purchased.

“Dependent” means any of the following persons: your spouse; your children; from birth to age 19 and dependent upon you for support; or 19 years of age through the end of the calendar year in which the child reaches the age of 25, if the child meets all of the following: the child is dependent upon you for support; and the child is living in your household, or the child is a full-time or part-time student. A child also includes adopted children, as well as stepchildren or foster children living with you in a parent-child relationship.

***Please refer to the Group Contract for the controlling terms and conditions of the vision benefit plan.***

*Out-of-network benefits are underwritten by CompBenefits Insurance Company, a licensed life and health insurer in the state of Florida.*

# LAKE COUNTY BOARD OF COUNTY COMMISSIONERS

## SCHEDULE OF BENEFITS

*The following vision services and materials are covered up to the Allowance shown below after deduction of the applicable copayment, if any.*

**Vision Examinations** - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities; 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once in any **12 month** period.

**Materials** - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

**Lenses** - One pair of prescription lenses once in any **12 month** period.

**Frames** - One new frame once in any **24 month** period.

**Contact lenses when necessary** – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 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) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month** period and only if prior authorization is obtained from the Plan. The Copayment is waived.

**Contact lenses when elective** - We will cover the combined cost of an annual vision exam, contact lens evaluation exam, fitting cost and contact lenses up to a maximum of **\$105.00**. Payment will be IN LIEU OF ALL OTHER BENEFITS. Replacement will not be more often than once in any **12 month** period. The Copayment is waived.

**Co-Payment** - An Insured's Co-payment is:

1. Vision Examination **\$10**
2. Materials **\$15**

**Allowance** – Vision Benefits will be reimbursed according to the following schedule after deduction of the applicable Co-payment.

|                               |       |
|-------------------------------|-------|
| Vision Examination            | \$35  |
| Single Vision Lens            | \$20  |
| Bifocal Lens                  | \$40  |
| Trifocal Lens                 | \$60  |
| Lenticular Lens               | \$100 |
| Contact Lenses when elective  | \$105 |
| Contact Lenses when necessary | \$150 |
| Frame                         | \$40  |



## NOTICE OF PRIVACY PRACTICES

*Effective April 14, 2003*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

### **PLEASE REVIEW IT CAREFULLY.**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60-days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (770) 998-8936 or toll free at (800) 342-5209.

### ***How We May Use or Disclose Your Health Information***

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

**Treatment:** We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

**Payment:** We may use or disclose your health information in order to process claims or make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim to us for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**Health Care Operations:** We may use or disclose your health information for health care operations. Health care operations include, but not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

**Business Associates:** There may be instances where services are provided to our organization through contracts with third-party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

**Required by Law:** We will disclose medical information about you when required to do so by federal, state or local law.

**Communication with Family or Friends:** Our service professionals, using their best judgement, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Marketing:** We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Coroners, Medical Examiners and Funeral Directors:**

We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties. Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Fund Raising:** We may contact you as part of a fund-raising effort.

**Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers' Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**To Avert a Serious Threat to Health or Safety:** Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Military and Veterans:** If you are a member of the armed forces, we may disclose health information about you as required by military command.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

**Protective Services for the President, National Security and Intelligence Activities:** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

**Law Enforcement:** We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

**Inmates:** We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

**Lawsuits and Disputes:** We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

**Plan Sponsors:** We may disclose health information about you to your plan sponsor to carry out plan administration functions that the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended as set forth under HIPAA regulations.

**Your Rights Regarding Your Health Information**

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at 100 Mansell Court E., Suite 400, Roswell, GA 30076.

**Right to Request Restrictions.** You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.

***Right to Receive Confidential Communications.*** You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

***Right to Inspect and Copy.*** You have the right to inspect and copy health information that we maintain about you in a designated record set. A “designated record set” is a group of records that we maintain such as enrollment, payment, and claims adjudication record systems. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

***Right to Amend.*** You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.

***Right to Receive an Accounting of Disclosures.*** You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.

***Right to Obtain a Paper Copy.*** You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

**How to File a Complaint if You Believe Your Privacy Rights Have Been Violated**

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

**CompBenefits  
Attn: Privacy Officer  
100 Mansell Court East, Suite 400  
Roswell, GA 30076**

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

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