Dental Plans • Optical Plans
Health Care Administration

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VISION PLAN

for

The District of Columbia Government

2017

This booklet provides you with a "Summary Plan Description" of your Optical Benefit Program.

You will notice that a brief description of your benefits is provided for your convenience. Should you have further or more detailed questions regarding the Plan, you are urged to refer to the Plan Document available for your review at the Department of Human Resources, Benefits and Retirement Administration.

While this booklet describes the principal provisions of your Plan in simplified terms, the administration of your Plan is subject to the actual terms and provisions of the Plan as set forth in the formal Plan Document. This description is intended only to help you understand the Plan and can in no way be considered to modify the actual terms and provisions as specified in the Plan Document.

Contents

I

Definitions

Claim Administrator

Quality Plan Administrators, Inc.

Plan Administrator

The Government of the District of Columbia (The "District")

Component Unit

An Employee or organizational unit within the Employer who participates in the plan if their agency signs a Joiner Agreement with the contracting officer.

Co-Payment

The figure shown as a percentage in the Schedule of Benefits used to compute the amount of benefits payable by the patient/employee when the Plan states that a percentage is payable.

Dependents

An employee's spouse, domestic partner, or dependent children up to the age of 26.

Excluded as Dependents under a., b., and c. are:

1. a spouse legally separated or divorced from the Employee;

2. any person(s) while on active duty in any military service of any country; and

3. an employee who is eligible for coverage under this Plan as an Employee in his/her own right.

Eligibility

The District provides vision care coverage for employees hired on or after October 1, 1987 to include all non-union employees and union employees covered by the Compensation Unit 1 and 2 Collective Bargaining Agreement, and Teamsters Local 639 and 730.

Employee

An individual, including a person elected, appointed, or salaried, who provides personal services to the Employer on a regular basis as an employee.

Employer

The Government of the District of Columbia (The "District")

Ophthalmologist

An individual acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) who specializes in the treatment of disorders of the eye.

Optician

An individual acting within the scope of his/her profession who see's or makes optical materials.

Optometrist

An individual acting within the scope of his/her license and holding the degree of Doctor of Optometry (O.D.) who specializes in the testing of visual acuity and prescribing corrective lenses.

Participant

A covered Employee or Eligible Dependent of a covered Employee.

Participating Health Care Provider

A provider of vision health care who has a contractual agreement with the Claim Administrator to provide covered vision services to Plan Participants at a pre-determined rate.

Plan

The District of Columbia Vision Health Care Plan as set forth herein and as it may be amended from time to time.

Plan Year

The Plan Year is 01/01/2017 - 12/31/2017

Separation from Service

Severance of the Employee's employment with the Employer. An Employee shall be deemed to have severed employment with the Employer for purposes of this Plan when, in accordance with the established practices of the Employer, the employment relationship is considered to have actually terminated.

Inactive Pay Status

A premium will be paid for each eligible employee who is on an active pay status i.e. has received a full 80-hour paycheck for a current pay period.

Employees on an Inactive/Non-Paid Pay Status (Leave without Pay (LWOP), Absent Without Leave (AWOL), Disability Compensation, Leave of Absence, etc.) are not eligible for benefits until such time as they return to work and receive a full, 80-hour pay check. Premiums are not paid by the District during an inactive pay session.

Waiting Period

No waiting period.

II

Eligibility

Who is Eligible? When?

You and your Dependents (see Definitions) are eligible for coverage on the first day of the pay period following your completion and submission of the enrollment form to the Plan Administrator.

If you acquire new Dependent(s) after your enrollment in the Plan you must submit documentation of life change event within 30 days after the date of the event to the Plan Administrator. Coverage for the new Dependent(s) will be effective the first day of the pay period following submission of the documentation and updated enrollment form.

Late Enrollees

If you or your qualified Dependent(s) do not enroll for coverage when first eligible, you will be required to submit supportive documentation.

When Does Coverage Terminate?

Coverage will terminate on the earliest of.

a. the date of termination of the Plan;

b. the day of the month that member becomes inactive (see below);

c. the date all coverage or certain benefits are terminated for the Covered Person's particular class by modification of the Plan; or

Non-pay status, such as leave without pay (LWOP), will cause coverage to be terminated until you return to full pay status.

III

Description of Vision Expense Benefits

All Vision Expense Benefits are subject to the maximum amounts indicated in the Schedule of Benefits.

Vision Expense Benefits

The Plan will pay expenses incurred for the services of a licensed ophthalmologist, optometrist or optician, acting within the scope of his license, for those visual care services and supplies listed as Vision Expense Benefits in the Schedule of Benefits provided that:

1. Such services are rendered, and supplies furnished, while the individual is covered under the Plan;

2. Payment for any one service or supply will not exceed the lesser of the fee actually charged or the maximum amount payable for such services as indicated in the Schedule of Benefits.

Payment will not be made for more than:

1. one (1) complete eye examination in any consecutive twelve (12) month period;

2. one (1) pair of lenses (including contact lenses) in any consecutive twelve (12) month period

3. one (1) set of frames in any consecutive twelve (12) month period

The plan only covers one pair of glasses (lens and frame) **or** contacts in any consecutive twelve month period.

IV

DC Vision Plan
Administered by Quality Plan Administrators, Inc.

Employee Benefit Plan

CPT CODE	DESCRIPTION	PATIENT PAYS
92004	Case history and exam, including visual analysis (refraction), diagnosis, dispensing and eye glasses or contact fitting when done by plan Ophthalmologist (1 per year unless Medically necessary and authorized.)	$0.00
92006	Case history and exam, including visual analysis (refraction), diagnosis, dispensing, and fitting when done by Plan Optometrist (1 per year unless Medically necessary and authorized.)	$0.00
92481	Single Vision Lenses (standard)	$0.00
92482	Bifocal Lenses (standard)	$0.00
92483	Trifocal Lenses (standard)	$0.00
92484	Lenticular Lenses (standard)	$0.00
V2781	Progressive Lenses (standard)	$0.00
V2744	Photocromatic	$0.00
V2755	Photosensitive	$0.00
V2741	Gradient Tint	$0.00
92306	**Contact Lenses where medically indicated (corneal; Pre-Authorized and subject to COB provisions.)	$0.00
92301	Contact Lenses (standard hard or soft; cosmetically desired in lieu of glasses.) ** Disposable Lenses (2 boxes Maximum)	$0.00
92487	Contact Lenses (standard hard)	$ 0.00
92491	Contact Lenses (standard soft)	$ 0.00
92302	Contact Lenses (Gas Permeable)	$ 80.00

CPT CODE	DESCRIPTION	PATIENT PAYS
92303	Contact Lenses (Extended Wear)	$100.00
92304	Contact Lenses (Toric)	$100.00
92305	Contact Lenses (Opaque)	$150.00
	Rimless	$ 6.00
V2761	Younger or equivalent	$12.00
V2762	Younger 10/30 or equivalent	$35.00
V2763	Varilux or equivalent	$15.00
V2764	Varilux 11 or equivalent	$60.00
	Plastic cataract lenses	$75.00
V2765	Occupational bifocal lenses	$35.00
V2766	Safety Lenses	$35.00
92495	Frames (From plan selection; 1 yr)	$0.00
92497	Frames (outside of plan selection; 1 yr)	Retail Price - 40% discount

**Plan pays for the first 2 boxes of disposable lenses; thereafter the patient pays for any additional boxes.

V

Schedule of Benefits

Vision Expense Benefits

All Vision Expense Benefits are subject to the maximum scheduled payment amounts.* See the following chapters for a description of the specific covered expenses and limitations.

EXAMPLES:

The Plan pays the Provider for the following services:

Eye Examination (Includes Glaucoma Exam)	$55.00

Lenses

Single Vision	$ 26.00
Bifocal	$ 42.00
Trifocal	$ 50.00
Lenticular	$ 60.00
Contact Lenses	$ 70.00

Frames

1 frame per 12-month period	$ 20.00

*See addendum for a full listing of fees and benefits.

A co-payment of the plan benefit will be applicable when using a non-participating vision provider. We have no control over the amount that the non-plan provider charges. However, we encourage you to invite your non-plan provider to join our panel.

EXAMPLE:

At a participating provider the total charge is $120.00

1) Eye Exam Plan pays:	$ 55.00
2) Lenses Plan pays: (Single vision)	$ 26.00
3) Frames * Plan pays:	$ 20.00
Plan pays:	$101.00
Patient pays:	$ 0.00

At a non-participating provider the total charge is $120.00

1) Eye Exam Plan pays:	$ 55.00
2) Lenses Plan pays: (Single Vision)	$ 26.00
3) Frames* Plan pays:	$ 20.00
Plan pays:	$101.00
Patient pays:	$ 19.00

*Frames from pre-approved selection.

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District of Columbia's Vision Plan Benefits
AT A GLANCE
Effective January 1, 2017

- One examination per 12 consecutive months
- Lenses or Contact Lenses (2 boxes) once per 12 consecutive months
- One frame per 12 consecutive months. If contacts are purchased, frames are not covered for payment.
- May use any provider in the network
- Use of non-plan provider, employee is subject to additional co-payments
- Plan covers eligible dependents; please refer to your schedule of benefits to examine the factors concerning eligible dependent coverage.

VII

Miscellaneous Provisions

Coordination of Benefits Provision

There are many families today where two or more people work. As a result, members of such families are often covered under more than one health plan.

Nearly all medical benefit plans, including yours, have adopted a Coordination of Benefits provision. This provision is designed to take the unfair profiteering out of multiple coverage, yet enable the individual to be reimbursed for as much of the vision expenses as possible, but only up to 100% of allowable expenses.

All health plans covering individuals as groups are considered in applying the Coordination of Benefits provision.

How Coordination of Benefits Works

When you are covered by more than one health care plan to which the Coordination of Benefits provision applies, these rules are followed to determine which plan will be first to determine its benefits:

1. When only one of the plans has a Coordination of Benefits provision, then the plan without such provision will determine its benefits first.

2. When both plans have a Coordination of Benefits provision, then:

    a. the plan under which the patient is covered as an employee will determine its benefits first;

    b. the plan covering the patient as a dependent child whose custody is shared will determine its benefits based on who has the custody at time of service.

    c. if neither "a." nor "b." above establish an order of benefit determination, then the plan which has covered the patient for the longer period of time will be the first to determine its benefits.

Note: If the patient is a dependent child of divorced parent’s special provisions may apply.

How Your Benefits Are Paid

The plan which is the first to determine its benefits (primary) will pay its benefits without regard to any other coverage. When a plan is not the first to determine its benefits, and there are allowable expenses that have not been covered by the other plan(s) (secondary), it will then pay its regular benefits up to the amount of the remaining allowable expenses.

Any benefit savings resulting from the application of the Coordination of Benefits provision will be available for future claims. These savings may be applied toward additional allowable expenses, not otherwise payable under another plan, which the Covered Person incurs later in the same Claim Determination Period.

(The Claim Determination Period is from January 1 to December 31, except the first Claim Determination Period that starts the day you first become covered under the Coordination of Benefits provision.)

Here Is An Example Of How The Coordination Of Benefits Provision Works

Mary Williams is covered under our Plan as a Dependent and under the plan of another employer as an Employee. Both plans include a Coordination of Benefits provision.

Mary receives extensive vision services and two claims are filed-one under our Plan and one under the other plan. Assume that the Allowable Expense for all types of vision expenses totals $125.00 and that the full benefit allowance, in the absence of other coverage, would be $91.00 under our Plan and $70.00 under the other plan. Since the other plan covers Mary as an Employee, it will determine its benefits first and will pay its full $70.00 allowance.

Our Plan will pay $55.00, the remaining Allowable Expense actually incurred. If our Plan had paid its $91.00 benefit allowance, the total benefit paid would have exceeded the cost of Mary's bills by $36.00.

Summary

Our Plan

Full Benefit Allowance	$ 91.00
Benefits Actually Paid	$ 55.00
Remainder Available for Future Allowable Expenses	$ 36.00

Third-Party Recovery

If any services or treatment are related to an injury or illness due to another person's negligence for which you may seek recovery from a third party, your Plan will pay its normal benefits provided you agree, in writing, to reimburse the Plan when you receive payment from the third party. This provision also applies to any payments made under an automobile insurance policy because of "no-fault" automobile legislation.

Assignment of Benefits/Out-of-Network Service

Any benefits payable under the Plan for services rendered by a Nonparticipating Health Care Provider are paid to you unless you specifically request in writing, when the claim is submitted, that payment be made directly to the provider of service.

Benefits for services rendered by a Participating Vision Care Provider are automatically paid to the Provider.

In the event that payment is made directly to the Provider of service, you will receive written notification of the payment and how it was computed.

Termination or Amendment of the Plan

The Plan may be amended, canceled or discontinued at any time by the Employer without the consent of any covered individual. In the event of termination of the Plan, the Employer shall provide written notice of such termination and the rights of all Plan Participants to all covered Employees in a timely manner. In the event of an amendment that affects any rights described in the Summary Plan Description issued under the Plan, new booklets or notices showing the change will be distributed.

VIII

How to Use Your Benefits

When to File a Claim

If you use a participating provider, there is no need to submit a claim form.
The participating provider will file the claim on your behalf.

If you use a non-participating provider, a claim should be filed as soon as you receive charges for covered services. Claim forms can be obtained from the Claim Administrators website www.qualityplanadmin.com or by calling 202-722-2744.

How to File A Claim (non-participating provider)

Make sure that your bill from the provider of service contains all of the following information:

1. Patient's name;
2. Description of each service rendered;
3. Date of each service rendered;
4. Charge for each service rendered;
5. Name, address and tax identification number of the provider of service, and
6. Information related to Coordination of Benefits.

Mail the completed claim form with the itemized receipt to the Claims Administrator:

Quality Plan Administrators, Inc.
7824 Eastern Avenue N.W., Suite 100
Washington, DC 20012
(202) 722-2744

A **separate** claim form must be submitted for each family member for whom a claim is being made. The Plan maintains separate payment and deductible records on you and each of your Dependents. It is not necessary to submit another form with billings for subsequent service. If you have made payment to the provider, be sure the bill is marked paid or is accompanied by a paid receipt.

Please review the claim form carefully and follow the instructions it contains.
It is not always necessary to complete every section. You need only complete those sections applicable to the claim being filed. For example, if no accident is involved, you need not complete the Accident section; if the claim is for you, it is not necessary to complete the Dependent section, etc.

Other Group Coverage

Since this Plan contains a Coordination of Benefits provision, it is important that you advise the Claims Administrator of any other group health plan covering you or your Dependents. You should complete the appropriate section of your claim form in full.

Note: When another plan covers the claimant, send exact duplicates of all bills being submitted with a claim to each carrier or administrator involved to assist them in coordinating benefits. If this Plan is paying as the secondary plan, we must be notified of the amount(s) paid by the primary plan before our payment can be made. To help you understand what Coordination of Benefits is and how it affects you, refer to, "The Coordination of Benefits Provision."

Incomplete Claim Forms

Your Claims Administrator has simplified procedures for handling your Plan benefits by providing you with a claim form which contains the information necessary to process your claim. When a claim form is submitted without completion of all appropriate items, it can cause unnecessary delays in providing you with your eligible benefits.

LATE SUBMISSION OF CLAIM

Claims received more than one hundred eighty (180) days after the date of service may be denied. To make sure payment is received make sure to follow the claim filing instructions.

Important Notice

SIGNIFICANT REMINDER: If you use a Participating Health Care Provider for your vision care, there can be a co-payment; however the vision care provider will bill the Plan for you.

IX

Exclusions and Limitations

In order to avoid confusion or misunderstanding, the limitations, exclusions and conditions listed below have been taken verbatim from the official Plan Document.

If there is anything in this chapter that you don't fully understand you are encouraged to contact the Plan or Claims Administrator.

General Limitations

No benefits shall be payable under the Plan with respect to:

1. Services or expenses incurred prior to the effective date or after the termination date of coverage under the Plan;

2. Any services, supplies, charges or expenses, which are not specifically included in the coverage of the Plan;

3. Charges for experimental, or investigative therapy or treatment;

4. Any services or supplies for which benefits may be claimed under Disability Compensation (D.C. Code 1-624) or which are due to the treatment of an illness or injury arising out of or in the course of any occupation or employment for wage or profit;

5. Any condition, disability or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act, duty as a member of the armed forces of any state or country or war or act of war declared or undeclared;

6. Any condition, disability or expense resulting from an injury caused by participating in civil insurrection or a riot;

7. Any services for care or treatment provided or furnished by the United States Government or the government of any country;

8. Any services for which a charge would not have been made in the absence of coverage.

LIMITATIONS APPLICABLE TO VISION EXPENSE BENEFITS

In addition to the General Limitations, no benefits shall be payable for:

1. Sunglasses
2. Vision training
3. Aniseikonia
4. Two pairs of frames and lenses in lieu of bifocals
5. Lens styles and/or materials not listed as a covered benefit
6. Orthoptics, vision training, low vision aids, or any supplemental training
7. Non-prescription (plano) eyewear or eyewear with a total refractive value of less than + 0.50 diopter in at least one eye
8. Medical eye care services and diagnostic procedures
9. Conditions covered by Worker's Compensation
10. Any services or materials provided by another vision plan.

Our hours of operation are as follows:

We are available 24 hours a day and our live answering service is Monday-Saturday 8am-9pm and Sunday 8am-7pm.

Administered by:

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