INDIANA TEAMSTERS HEALTH BENEFITS FUND

6007 S. Harding St.
Indianapolis, Indiana 46217
Phone: (317) 639-3573
Fax: (317) 639-3548

VISION BENEFITS

Eligible Optical Expenses: Charges Incurred by a Covered Person (while covered under the Plan) for specified vision care procedures performed by a licensed Vision Care Professional, subject to the Maximum Annual Eligible Expenses specified for the procedure in the Schedule of Vision Care Procedures below for an **Adult Covered Person.**

Schedule of Vision Care Procedures

Procedure	Maximum Annual Eligible
COMPLETE EXAMINATION	
Ophthalmologist (M.D.)	$50
Optometrist	$50
LENS PAIR	
Single Vision Rx	$50
Bi-Focal Rx	$60
Tri-Focal Rx	$70
Contacts	$80
FRAMES	$80

The Plan will cover the maximum annual eligible expense for Bi-Focal Rx or Tri-Focal Rx or Progressives but does not provide coverage for all three expenses. The Plan will cover Frames and Lenses or Contacts, but not both

Under the Patient Protection and Affordable Care Act (**PPACA**), pediatric vision care is classified as an Essential Health Benefit **up to the age of 19 years old.**

Covered benefits up to the age of 19 years old:

- **One Routine Eye Exam per year:** Comprehensive annual exams to check overall eye health and development, $0 out of pocket cost.
- **One Pair of Glasses or Contacts per year:** Coverage for standard lenses and frames or standard Contacts.
- **Not covered items**: Designer frames, nonstandard contacts, or convenience items.

Vision Exclusions

Benefits will not be payable for the following non-Covered Expenses:

a) more than one complete examination in any calendar year;
b) more than one pair of lenses in any calendar year;
c) more than one set of frames in any calendar year (contacts are considered to be lenses and frames);
d) expenses Incurred for children who do not satisfy the definition of "Dependent" under Section 2(p) of Article IV; or
e) any loss or expense caused by, incurred for, or resulting from:
    1) procedures or supplies furnished on account of a visual defect which arises out of, or in the course of, any occupation for wage or profit;
    2) declared or undeclared war, or any act thereof, or military or naval service of any country;
    3) vision care services or supplies furnished by or at the direction of the United States Government or any agency thereof;
    4) vision care services or supplies received from a medical department maintained by a mutual benefit association, labor union, trustee or other similar group;
    5) any medical or surgical treatment of the eye;
    6) sunglasses, plain or prescription, or safety lenses or goggles; or
    7) orthoptics, vision training or aniseikonia.

If you have any questions on your vision coverage, please call our Customer Service Department at 1-800-859-6862. Please have your Member Identification Number ready.

Vision Plan
Claim Reimbursement Form

Insured Name: _____ Date: _____

Insured DOB: _____

Insured Address: _____

Insured ID #: _____

Patient Name: _____

Patient DOB: _____

_____

Date of Eye Exam: _____

92004 Comprehensive Eye Exam/New Patient: _____

92014 Comprehensive Eye Exam/Established: _____

92310 Contact Lens Fitting: $ _____

Charges Exam: $ _____

Charges Fitting: _____

_____

H52.13 Myopia: _____

H52.03 Hyperopia: _____

H52.4 Presbyopia: _____

_____

V2020 Frame: _____

_____

V2100 Single Vision $ _____

V2200 FT _____

V2300 FT _____

V2781 Progressive _____

V2500 – V2599 _____

V2784 Poly/Trivex _____

V2783 Hi Index _____

V2750 Anti Reflective V2744 Transition _____

_____

V2745 Tint _____

V2715 Prism _____

Doctor/Optician Signature: _____ Date: _____

RETURN THIS FORM WITH A COPY OF YOUR PROVIDER'S BILL AND ITEMIZED PAID RECEIPT OR PROOF OF PAYMENT TO THE BELOW ADDRESS.

AETNA
PO Box 981106
El Paso, TX 79998-1106