SERVICES & MATERIALS

Vision Testing Services (one every 12 rolling months)

- Eye Examination (routine for eyeglasses)
  - Fully Covered
  - After $10 Co-pay
  - $30 Allowance

Eye Examination (for contact lenses & follow-up care)
- $35 Allowance
- $30 Allowance

Materials; Lenses and/or Frame (one pair of lenses every 12 rolling months)

- Single Vision Lenses
  - $75 Allowance
  - $50

- Bifocals Lenses
  - $75 Allowance
  - $50

- Trifocal Lenses
  - $75 Allowance
  - $50

- Lenticular Lenses
  - $75 Allowance
  - $50

- Frame
  - Included with Lenses

- Contact Lenses - (per pair during a 12-month period)
  - $75 Allowance
  - $50

COVERED EXPENSES

1. Eye examination limited to one examination per rolling 12-month period. The Plan shall include the following services when performed as part of such eye examination:

   - a case history;
   - an external examination of the eye and adnexa;
   - an ophthalmoscopic examination;
   - a determination of refractive status;
   - binocular balance testing;
   - tonometry (glaucoma check), as needed;
   - gross visual fields;
   - color vision testing;
   - summary findings; and
   - recommendations including prescribing Lenses.

2. Frames will be covered once every rolling 12-month period if the frame is to be used with lenses prescribed as a result of an eye examination which was made on or after the effective date of the Plan Member's coverage under this Plan. If the allowance for frames specified in the Schedule is to be applied to the cost of a frame; the date on which the frame is ordered shall be considered to be the date on which the expense is Incurred.
3. Lenses, including single vision, bifocal, trifocal, lenticular or contact lenses. Benefits will be paid as specified in the Schedule of Coverage, if the lenses are prescribed as a result of an eye examination made on or after the effective date of the Plan Member's coverage and such purchase is made within 12 months of the examination. The date on which the lenses are ordered shall be considered to be the date on which the expense is incurred.

**VISION EXCLUSIONS**

Benefits will not be provided:

1. Which are not received from a Provider acting within the scope of his or her license.
2. For diagnostic services and drugs or medications not part of a vision examination.
3. For Medical or surgical treatment.
4. Those that we determine are special or unusual, such as orthoptics, vision training, and low vision aids.
5. For the replacement of Lenses or Frames, except as shown in the Schedule of Coverage.
6. For any Lenses that are not prescribed or which can be purchased without a physician’s order.
7. For safety glasses and safety goggles.
8. For tint other than Number 1 or Number 2 or a tint with photosensitive or anti-reflective properties.
9. For eye examinations which occurred before your Effective Date of Coverage or for material ordered as a result of any eye examination which occurred before our Effective Date of Coverage.
10. Services Incurred or received after your cancellation date.
11. Services which are not specified in this Plan as Covered Services.
### UNION EYE CARE

**REIMBURSEMENT - VISION CLAIM FORM**

This form is required for reimbursement when you go out of the network. Attach originals of all your bills and make copies for your records. Be sure to enter the employer’s name, ID No. or SSN along with the PLAN NAME or No. in the Employer/Group box. Please submit to the location listed on the back of the form.

**THIS SECTION TO BE COMPLETED BY EMPLOYEE AND / OR PATIENT.... PLEASE PRINT.**

<table>
<thead>
<tr>
<th>Employee’s Name (Last, First, Middle)</th>
<th>Employee SSN or ID No.</th>
<th>Employer / Group</th>
<th>Employee’s Birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee’s Home Address</th>
<th>City,</th>
<th>State,</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Patient’s Name (Last, First, Middle)</th>
<th>Relationship to employee (spouse, child)</th>
<th>Sex</th>
<th>Patient Birthdate</th>
<th>If Patient is a Dependent Child Over Age 18: Full Time Student?</th>
<th>Disabled?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>/</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

**Is Patient Covered By Another Vision Plan?**

Yes ☐ No ☐

**Are Other Family Members Employed?**

Yes ☐ No ☐

Name: Social Security No. - -

**Spouse’s Birthday** / /

If yes furnish name and address of employer

---

I hereby authorize any insurance company, organization, employer, Ophthalmologist, Optometrist or Optician to release any information with respect to this claim. Furthermore, I agree to reimburse Union Eye Care Center, Inc. for any overpayment of benefits on this claim. In lieu of reimbursement, such overpayment may be deducted from future Vision Coverage benefits payable to me. I understand that any benefits payable for services will be paid to the Member.

Signature of Employee Also, Signature of Dependent (If patient and not a minor) Date

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE FACTS OUT YOU KNOW ARE IMPORTANT.

**THIS SECTION TO BE COMPLETED BY PROVIDER OF PROFESSIONAL SERVICES .... PLEASE PRINT.**

**Date of Exam:** / / **Diagnosis:**

Initial prescription Yes ☐ No ☐ Refraction Yes ☐ No ☐ Contact Lens Yes ☐ No ☐

If contact lenses were prescribed: Tonometry Yes ☐ No ☐ Cataract Surgery Yes ☐ No ☐

Please indicate if: Cosmetic ☐ Medically Necessary ☐

Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? Yes ☐ No ☐

**TO OPHTHALMOLOGIST ONLY:** Was the patient referred to you for an examination of an unresolved Medical or Pathological problem by an Optometrist who performed a vision examination within the last 60 days? Yes ☐ No ☐

**AMOUNT PAID BY EMPLOYEE $**

**EXAMINATION CHARGE $**

<table>
<thead>
<tr>
<th>Type of Provider:</th>
<th>Participating ☐ Non-Participating ☐</th>
</tr>
</thead>
</table>

Name of provider who performed the service: Phone No. ( ) -

<table>
<thead>
<tr>
<th>Address</th>
<th>City, State, Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Signature Degree/Title Date

SSN - -

Employer I.D. No. -

**THIS SECTION TO BE COMPLETED BY PROVIDER OF MATERIALS.... PLEASE PRINT.**

**Date Lenses Ordered:** / /

<table>
<thead>
<tr>
<th>Single Vision</th>
<th>Bifocat</th>
<th>Trifocat</th>
<th>Lenticular</th>
<th>Progressive</th>
<th>Round</th>
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</thead>
</table>

| Medically Necessary ☐ |

SPECTACLE CHARGES

<table>
<thead>
<tr>
<th>SPECTACLE</th>
<th>CHARGES</th>
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<tbody>
<tr>
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</tbody>
</table>

LENSES

<table>
<thead>
<tr>
<th>LENSES</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Sphere</th>
<th>Cylinder</th>
<th>Axis</th>
<th>Prism</th>
<th>Add</th>
<th>Miscellaneous</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oversized</td>
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</table>

OD

<table>
<thead>
<tr>
<th>CONTACT LENSES</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

OS

<table>
<thead>
<tr>
<th>CONTACT LENSES</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hard</th>
<th>Date Frames Ordered</th>
<th>Frame Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>POLYCARB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gas Permeable</th>
<th>Frame Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>POLYCARB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disposable - No of Pairs</th>
<th>Frame Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other (Specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (please specify)</th>
<th>Frame Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxes</th>
<th>Type-Zyl</th>
<th>Metal</th>
<th>Rimless</th>
<th>Combination</th>
<th>Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBTOTAL $</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL $</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**TOTAL AMOUNT PAID BY EMPLOYEE $**

**TOTAL CHARGE FOR LENSES AND FRAME (Including taxes) $**

<table>
<thead>
<tr>
<th>Type of Provider:</th>
<th>Participating ☐ Non-participating ☐</th>
</tr>
</thead>
</table>

Name of provider who performed the service: Phone No. ( ) -

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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature Degree/Title Date

SSN - -

Employer I.D. No. -

**Must be furnished under authority of law.**
It is not necessary to complete this form unless you intend to go out-of-network.

Please be sure to enter the PLAN NAME / NO., in the space provided in the Employee's Section. Enter all patient information.

For reimbursement you must attach and submit originals of all bills.

Please make copies for your records.

Mail this form and all attachments to:

VISION CARE ADMINISTRATOR
UNION EYE CARE CENTER, INC.
4750 BEIDLER ROAD
WILLOUGHBY, OHIO 44094

PHONE: 1 (800) 443-9699 1 (216) 986-9700
FAX: 1 (216) 986-1996
VISION CARE BENEFITS

Who is Covered?
Participating members of the Greater Cleveland Automobile Dealers Association Group Health Plan (GCADA) are eligible for benefits up to the maximums as indicated below. GCADA will determine participant eligibility in accordance with the Plan Description. Eligible dependents will include the spouse and dependent children up to the age of 26 or up to the age of 28 if the member elects the optional dependent child coverage.

What is covered?
Eye Examination • Prescription Lenses • Frame

<table>
<thead>
<tr>
<th>FREQUENCY OF SERVICE:</th>
<th>Union Eye Care Network Benefit</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Fully Covered after $10 Co-pay</td>
<td>$30.00 Allowance</td>
</tr>
<tr>
<td></td>
<td>$30.00 Allowance</td>
<td>$50.00 Allowance</td>
</tr>
<tr>
<td>Lenses &amp; Frame or Contacts</td>
<td>$75.00 Allowance</td>
<td></td>
</tr>
</tbody>
</table>

Where do I get services?
Your plan allows for a choice of Network (Union Eye Care) or Out-of-Network services. If you elect to go to Union Eye Care Network locations, you are eligible for improved benefits as described below.

OBTAINING YOUR BENEFITS through Union Eye Care
If you need an eye examination and wish to use a Network location, simply call any Union Eye Care office listed on the back of this brochure or on your member identification card. Inform the receptionist that you are eligible for the GCADA vision benefit. Please have the following information available.

✔ EMPLOYEE’S NAME
✔ EMPLOYEE’S ID NUMBER or SSN
✔ DEPENDENT’S NAME
✔ DEPENDENT’S DATE OF BIRTH

If you currently have a valid eyewear or contact lens prescription and wish to duplicate it, you will not need an appointment. Just bring your prescription to any network location and have it filled.

Union Eye Care
NETWORK COVERAGE
(see back panel for locations)

Union Eye Care Accepts Assignment ...
Union Eye Care Centers and their affiliated Network locations are on the network, and agree to accept assignment of your vision care benefits, i.e. if you use a Union Eye Care Network location, you will not be required to pay the covered portion of your benefit to your NETWORK PROVIDER and wait for reimbursement from the GCADA Group Health Plan.

Your Union Eye Care Network Advantage ...

✔ Eye examination (routine) for eyeglasses... fully covered after a $10 co-payment
✔ Eye examination for contacts... $35 allowance
✔ $25 or more in additional member eyewear benefits
✔ Union Eye Care accepts assignment of your benefits
✔ Discounts are applied before your benefit
✔ No need to wait for your reimbursement check
✔ No lengthy paper claims to complete
✔ Quality Service
✔ Guaranteed value
✔ Satisfaction guaranteed!

Network Benefit -
Remember, your Network benefit is greater than your out-of-network benefit.

Eye Examination - routine for eyeglasses by independent doctors
Fully Covered... after a $10 copay

Lenses Frames or Contact Lenses
$75.00 Allowance...
that's a 50% increase in benefits per participant

What does the Union Eye Care Network provide?
Eye Examinations
Eye doctors are available at each location to serve a wide range of your needs, from standard eyeglass lens exams and glaucoma checks, to specialized contact lens eye exams and fittings. Eye examinations include tonometry (pressure check) and dilation when indicated. Be sure to call for an appointment.

Eyeglasses and / or Contact Lenses
Licensed opticians fill all of your eyewear prescription needs. They are trained for expert fitting of eyeglasses and contact lenses.

Out-of-Network Coverage
You may elect to go to your current doctor or optician, then submit for reimbursement directly to Union Eye Care. However, be aware that you will receive reduced benefits.

Out-of-Network - Out-of-Network benefits are as follows ...

<table>
<thead>
<tr>
<th>MAXIMUM BENEFIT TYPE</th>
<th>REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>$30.00</td>
</tr>
<tr>
<td>Lenses, frames or contacts</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

You may elect to receive your examination Out-of-Network, and choose to have your prescription filled by a NETWORK PROVIDER to maximize your benefits.

Conversely, you may choose to be examined by a NETWORK PROVIDER and purchase your eyewear elsewhere.

A. How To Obtain Your Reimbursement Claim Form
Reimbursement forms are available from the GCADA Insurance office, or you may call or write Union Eye Care to obtain claim forms. You must attach originals of your bills to the claim form.

B. Submit Your Reimbursement Claim Form(s) to:
Vision Care Administrator
Union Eye Care
4750 Beidler Road
Willoughby, Ohio 44094
(216) 986-9700 or (800) 443-9699 ext. 17 or 19
Fax: (216) 986-1996

Visit us on the web at http://www.unioneyecare.com

PROGRAM EXCLUSIONS
A. Lenses not requiring prescription
B. Medical surgical treatment of eyes
C. Drugs or medication not administered for the purpose of a vision testing examination
D. Special or unusual procedures, such as orthoptics perimetry, tonography, vision training, sub-normal vision aids, aniseikonic disease or injury
E. Expenses resulting from an occupational injury or disease covered under any workers’ compensation law or similar legislation
Visit Us On The Web At ...
http://www.unioneyecare.com

NOTICE

Call the nearest Union Eye Care or affiliated location for an appointment today.

APPOINTMENTS

The Greater Cleveland Automobile Dealers Association Group Health Plan has authorized Union Eye Care Center to maintain eligibility, dependent and utilization data on file as may be necessary to administer vision examination and optometric services to eligible members in accordance with the plan description.

QUALITY • VISION • VALUE

through

Union Eye Care

GROUP HEALTH

VISION PLAN

CONVENIENT NETWORK LOCATIONS