MEDICAL MUTUAL OF OHIO
Your healthcare partner since 1934

Vision Expense Benefits

Eye Examinations

One regular eye examination in each 12 consecutive month period by an ophthalmologist, optician or optometrist is provided for each person covered under the program. The maximum payment is $40.00 per exam.

Lenses

One pair in each 12 consecutive month period is covered. Payment is made for the actual charge for one or two lenses or contact lenses, but not more than:

	Per Lens	Per Pair
Single Vision	$ 20.00	$ 40.00
Bifocals	$ 30.00	$ 60.00
Trifocals	$ 40.00	$ 80.00
Lenticular	$100.00	$200.00
Contact Lenses (Cosmetic)	$ 35.00	$ 70.00
Contact Lenses (Medically Necessary)	$200.00	$400.00

*NOTE: the amount for a single lens is fifty percent (50%) of the amount for a pair of lenses.

The allowance for medically necessary contact lenses will be paid only if: (a) the lenses are necessary following cataract surgery; (b) visual acuity cannot be correct to 20/70 in either eye with other lenses, but can be correct to at least 20/70 in either eye with contact lenses; or (c) the lenses are necessary for the treatment of anisometropia for keratoconus.

Should an individual select contact lenses instead of conventional lenses, when the latter is all that is needed, the program will pay the amount equal to the single lenses plus the frames toward the cost of the contact lenses.

Maximum

The plan will pay the actual charge for the services and supplies up to the maximum, the difference will be added to the maximum amount applicable to any other service or supply for which a charge is incurred within sixty days.

Frames

One set of frames is covered every 24 consecutive month period provided the frames are used with lenses prescribed after an eye examination. Frame allowance: $30.00. When new frames are not required, the payment allowed for frame may be applied toward the cost of lenses.

Limitations and Exclusions

Services for which vision care coverage does not provide benefits include:

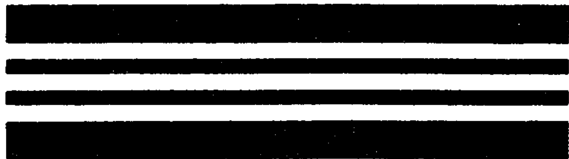
- Sunglasses, whether or not a prescription is required.
- Drug or Medications
- Employer furnished services or supplies or those covered under Worker's Compensation laws, occupational disease laws or similar legislation
- Services and supplies rendered of furnished as a result of loss, theft, or breakage of lenses, contact lenses or frames for which benefits were paid under the Group Contract and Certificate
- Orthoptics or vision training
- Aniseikonic lenses
- Coated lenses

Vision Care does not provide full benefits for cosmetic vision needs. This distinction applies particularly to frames and contact lenses.

Mail Claim Form To:

MEDICAL MUTUAL™
Your healthcare partner since 1934

Medical Mutual
P.O. Box 6018
Cleveland, Ohio 44101-1018



VISION CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION *(please print or type)*

1. Certificate Holder's name ______
   Address ______
   City ______
   State ______ Zip ______
   Phone (____) ______
2. Patient (first name, middle initial, last name)
3. Certificate Holder's ID number: ______
   Medical Mutual Plan code: ______
   (Numbers can be found on Certificate Holder's ID card.)
4. Group name: ______
5. Group number: ______

6. Patient's date of birth / / Age

7. Patient's relation to Certificate Holder
   - self (male) 1 ☐
   - self (female) 2 ☐
   - husband 3 ☐
   - wife 4 ☐
   - son 5 ☐
   - daughter 6 ☐
   - other male dependent 7 ☐
   - other female dependent 8 ☐

8. Is patient full-time student 19 years of age or older? ☐ yes ☐ no
   Name of school:

9. Was condition related to:
   A. Employment ☐ yes ☐ no
   B. Accident ☐ yes ☐ no
   Date of Onset: ______

10. ****IMPORTANT****

If the patient is covered by any other group or non-group health insurance, including Medical Mutual, please complete this section.

Name of other employer ______
Address of other employer ______
Name of other person employed ______
Birthdate of other person employed ______
Relationship to patient ______
Other health care plan ______

If the patient is a child and parent's are divorced, please answer the following:

a. Which parent has custody of the patient? ______
b. Is there a court decree that states which parent is responsible for medical bills? ____ yes ____ no. If yes, please attach a copy of the court decree.

11. Is the patient eligible for Medicare? ☐ yes ☐ no

12. Describe the illness, injury or symptom: ______

Date symptom first appeared: ______

5a. I authorize release of any information relative to this claim to be used by Medical Mutual or a review agency with which it has contracted solely for the purposes of determining reimbursement.

______ DATE: ______
(Signature of Certificate Holder or Spouse)

PART II PHYSICIAN OR PROVIDER INFORMATION *(to be completed by physician or provider only)*

OFFICE SERVICES

Date of examination ____ / ____ / ____

Service Description	FEES
TOTAL OFFICE FEES	

Refraction ☐ yes ☐ no

OPTICAL STYLE

☐ Glass ☐ Plastic ☐ Other
☐ One eye ☐ Both eyes

CONTACT LENSES

☐ Due to cataract surgery ☐ Other
☐ To obtain 20/70 vision

OPTICAL CHARGES

(Date of service ____ / ____ / ____)

Lens	Acquisition fee (L)	Acquisition fee (R)	Dispensing fee (L)	Dispensing fee (R)
Single vision				
Bifocal				
Trifocal				
Lenticular				
Tint				
Type ______				
Photochromatic				
Contact lenses				
Frames				
Options				

SUBTOTAL: ______
TAX: ______
OPTICAL CHARGES TOTAL: ______

I certify that the services were performed by me or in my presence under my supervision.

Physician/provider name ______
Address ______
City ______ State ______ Zip ______
Provider Tax ID ______
▶ Signature ______

MED/SURG 006 R5/88

Z5004 R6/01

Medical Mutual of Ohio®

Medical Mutual Services, L.L.C.

FOR THE CERTIFICATE HOLDER

1. Use this form for all your vision claims. Use a separate form for each patient and each physician.
2. Complete all items on Part I of the form for both the patient and the Certificate Holder. If any information is missing a delay in processing will result. Make sure you sign the form in Block #5A to authorize release of information.
3. After còmpletion of Part I give the form to your physician or provider.

FOR THE PHYSICIAN OR PROVIDER

1. Use a separate claim form for each patient and each provider rendering service.
2. Review the top of the form to make sure the employee has provided all information, especially Coordination of Benefits (Block 10) and a signature (Block 5A). Missing information will cause a delay in processing.
3. Complete Part II with all information pertinent to the patient's treatment.
4. Be sure to use your taxpayer ID number.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)