The City of New York
Office of Labor Relations
Employee Benefits Program
Citywide Programs

The VDT Program is an Occupational Vision Care Benefit that allows eligible employees to obtain eyeglasses for video display terminals in conjunction with their existing Welfare Fund/Union vision care benefits. Employees who meet VDT Program eligibility requirements are entitled to vision examinations, lenses and frames, where necessary, for VDT operation, biennially.

For VDT eligibility information, please contact your Welfare Fund/Union or your Welfare Fund's/Union's Vision Administrator directly. Please see reverse side for your Welfare Fund/Union contact information. To obtain a VDT Benefit Authorization Form, please contact your Welfare Fund/Union directly when obtaining your regular vision benefits.

What is a VDT?

VDT stands for Video Display Terminal.

What are some of the effects caused by VDTs?

Some employees may experience visual symptoms, such as eyestrain, when working with VDTs. Often, eyestrain can be reduced by simple changes to the work area. For example, screens and copy should be placed side-by-side, slightly below eye level, and screen brightness and contrast should be properly adjusted. In some cases, eyeglasses prescribed specifically for use at a VDT may also be helpful.

What are the eligibility requirements?

The VDT Program is a biennial (two year) benefit for employees who regularly and for continuous periods of time operate VDT terminals twenty (20) hours or more per week.

Who is eligible for the program?

Employees who are entitled to Welfare Fund/Union benefits and are covered by the Citywide contract, which includes Mayoralty, NYC Health + Hospitals Corporation (H+H), Housing Authority or employees covered by the Management Benefits Fund (MBF), are eligible.

Who is <u>not</u> eligible for this program?

Employees of the Department of Education (DOE), City University of New York (CUNY), NYC Transit Authority and Unified Court System employees are not eligible.

What is the standard benefit the program offers?

A VDT vision examination is available every twenty-four (24) months, when performed at the same time as a regular vision examination through your Welfare Fund/Union vision care benefit. An employee may obtain an additional pair of corrective lenses and frames for VDT work if the prescription differs from the employee's standard glasses. Please note that the benefit is available to employees only and not to dependents.

How do you utilize the VDT Benefit?

To use the benefit, you must obtain a vision care voucher "VDT Occupational Vision Care Program Benefit Authorization Form" from your Welfare Fund (e.g., DC 37, MBF, OSA, etc.).

1. Complete Sections II and IV on the form and present it to your agency unit supervisor/manager, who will complete Section III certifying that you are eligible for the benefit.
2. Arrange for an appointment and take the voucher and the agency approved "VDT Occupational Vision Care Program Benefit Authorization Form" to a participating provider. (Contact your Welfare Fund/Union for a list of approved providers.)
3. Agencies will allow up to two hours of excused time to take the baseline examination and follow-up examinations. The provider will determine whether you have a need for special lenses.
4. Participating providers have agreed to accept the Program's allowances for vision examinations, and necessary lenses and frames, as full payment.

Exception to the Standard Benefit:

If an employee has already utilized the Welfare Fund/Union benefit and if it is not otherwise possible to postpone an examination until the regularly scheduled Welfare Fund/Union entitlement, an exception to the policy may be made only once, on an individual basis, to allow the employee to receive VDT benefits. After this exception, you may only receive the VDT benefit with your Welfare Fund/Union entitlement.

Please note that the benefit is only available from approved participating providers as a paid-in-full benefit.

Participating Welfare Funds	
• Communications Workers of America (CWA), Local 1180 Security Benefits Fund	212-966-5353
• DC 37 Health and Security Plan	212-815-1234
• International Brotherhood of Teamsters, Local 237 Welfare Fund	212-924-7220
• Management Benefits Fund (MBF)	800-999-5431 / 212-306-7290 (DV)
• Organization of Staff Analysts (OSA)	800-999-5431 / 212-686-1229 (DV)
• Service Employees International Union (SEIU) Local 300, AFL-CIO, Employees' Welfare Fund	718-383-8945 / 212-505-5050 Ext. 0
• Social Services Employees Union, Local 371	212-777-9000 / 212-677-3900

Authorized Welfare Fund VDT Vision Care Panels	
• CWA 1180	General Vision Services (GVS), Comprehensive Professional Systems (CPS), Vision Screening (VS), Vision World (VW)
• DC 37	Comprehensive Professional Systems (CPS), Vision Screening (VS), General Vision Services (GVS)
• Local 237 Welfare Fund	Comprehensive Professional Systems (CPS)
• MBF	Davis Vision (DV)
• OSA	Davis Vision (DV)
• SEIU Local 300	Comprehensive Professional Systems (CPS), General Vision Services (GVS), Vision Screening (VS), Supplemental Benefits Services (SBS) Inc.
• Social Services Employees Union, Local 371	Comprehensive Professional Systems

If you have additional questions concerning the VDT Program, please contact the Office of Labor Relations' Employee Benefits Program at (212) 306-7760.

VDT OCCUPATIONAL VISION CARE PROGRAM
BENEFIT AUTHORIZATION FORM
(NOT AVAILABLE FOR DEPENDENTS OF EMPLOYEES.)

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This form must be completed by employee, employee's Welfare Fund/Union, employee's agency and participating provider. Participating provider must send this form to employee's Welfare Fund/Union vision administrator directly.

Instructions for utilizing the VDT benefit:

1. You must utilize this benefit in conjunction with your regular Welfare Fund/Union vision benefit.
2. After obtaining vision care vouchers from your Welfare Fund/Union, complete Sections II and IV of this form and present it to your agency unit supervisor/manager who will complete Section III certifying that you are eligible for this benefit.
3. Arrange for an appointment and take these vouchers to a participating provider. (Contact your Welfare Fund/Union for a list of approved providers.)
4. During your appointment, the vision provider will complete Section V of this form and the provider will submit it directly to your Welfare Fund's/Union's vision administrator for payment.

City University of New York (CUNY), Dept. of Education (DOE), NYCTA, and Unified Court System employees are <u>not</u> eligible for this benefit.

I. Welfare Fund Section (To be completed by the Welfare Fund/Union.)

EMPLOYEE CITY ID OR SOCIAL SECURITY #	LAST NAME:	FIRST NAME:	MI:

❑ Standard
❑ Non Standard* Voucher No: _____ * This employee is not yet eligible to receive a standard Welfare Fund/Union voucher.

DATE OF LAST EXAM: / /

WELFARE FUND NAME:

AUTHORIZED SIGNATURE:	DATE: / /	This form expires _____ from this date**

** Please contact your Welfare Fund to obtain a new VDT authorization form.

II. Employee Information (Must be completed by the employee for processing. If this section is incomplete, this form will not be processed.)

EMPLOYEE CITY ID OR SOCIAL SECURITY #	LAST NAME:	FIRST NAME:	MI:

AGENCY NAME (NOT DIVISION):	WORK PHONE NUMBER: - -	HOME PHONE NUMBER: - -

I understand that this is a biennial benefit subject to eligibility restrictions. I certify that I have read and understand the VDT benefits.

EMPLOYEE SIGNATURE: _____ DATE: / /

III. Agency Authorization (To be completed by the agency unit supervisor/manager and returned to the employee.)

AGENCY NAME: (Dept of education, CUNY, NYCTA and Unified Court System employees are <u>not</u> eligible):	AGENCY PAYROLL CODE:	UNIT:

EMPLOYEE CIVIL SERVICE JOB TITLE:	TITLE CODE:

VDT Hours/Week (Must work twenty (20) hours or more per week on a VDT to be eligible): _____ hours/week

I certify that the above employee meets the job requirements for the City's VDT Vision Care Benefit (Works at a VDT at least twenty (20) hours or more per week):

Agency Unit Supervisor/Manager (Print Name): _____

SIGNATURE: _____ DATE: / /

IV. Employee Questionnaire (Must be completed by the employee.)

1. Do problems with your eyes reduce your efficiency or accuracy of your work? ❑ Yes ❑ No
2. Do you currently use eyeglasses or contact lenses at work? ❑ Yes ❑ No

   If YES, indicate type: ❑ bifocal eyeglasses ❑ contact lenses ❑ trifocal eyeglasses ❑ regular single vision eyeglasses
   ❑ other (describe): _____

   Indicate when worn: ❑ for entire workday ❑ only when doing desk work ❑ typing (VDT work)
3. What are the visual demands on your job? Indicate percent of your work week spent on these different tasks:
   a. Data enrty or typing on computer terminal _____ %
   b. Viewing data on computer terminal _____ %
   c. Computer programming _____ %
   d. Other office and work duties _____ %
   Total ---------- **100** %
4. You may wish to inspect the VDT that you use regularly before answering the following questions:
   a. Are the characters clear on the screen? ❑ Yes ❑ No
   b. Are there reflections from the screen that affect your eyes? ❑ Yes ❑ No
   c. How many inches are your eyes from the VDT screen when working? _____ Inches
   d. Is the computer screen level with your eyes? ❑ Same level ❑ Higher ❑ Lower

V. Vision Care Provider Section (To be completed by the vision care provider and provider must submit this form directly to the employee's Welfare Fund/Union Vision Administrator for payment i.e., participating VDT panel.)

I. VDT service provided (check all appropriate boxes):
   A. ❑ VDT testing only
      1. ❑ In conjunction with Welfare Fund's standard voucher benefit
      2. ❑ No (If patient was examined by you within past 12 months <u>without</u> voucher for Welfare Fund's/Union's standard benefit)
   B. ❑ Full examination and VDT testing <u>without</u> Welfare Fund's/Union's standard voucher benefit (give reason)
      1. ❑ New patient
      2. ❑ More than 12 months since last examined in your office
      3. ❑ Other (explain): _____

II. I have provided occupational eyeglasses as follows:
   C. ❑ Frame (check (1, 2, or 3) ❑ 1. Plan Frame ❑ 2. Employee Frame ❑ 3. Provider Frame
   D. ❑ Single Vision Lenses
   E. ❑ Bifocal Lenses
   F. ❑ Trifocal Lenses
   G. ❑ Tint
   H. ❑ Executive/33 mm.seg

III. VDT service provided (check all appropriate boxes):
   ❑ Rx ❑ Lense Type ❑ Seg Height ❑ Tint

Vision Provider Name: _____ Vision Provider #: _____

Vision Provider Signature: _____ Date: ____/____/____

Reminder:

- ✓ Is Section I completed by your Welfare Fund/Union?
- ✓ Did you complete and sign Section II?
- ✓ Is Section III completed by the agency unit supervisor/manager?
- ✓ Did you complete Section IV?

Clear Fields

Print Form