YOUR OPTICAL BENEFIT

What Is The Optical Benefit?

You and your eligible dependents are entitled to one claim for optical services per individual, per calendar year, but not more than four claims per family, per calendar year. Optical services for:

Age 19 or Older:

Every eligible person age 19 or older is entitled to one eye exam and one pair of prescription eyeglasses per person, per calendar year, up to four pairs of glasses or contact lenses per family, per year. The maximum benefit is $100 per eligible person.

- Eye examinations (for vision correction only). Treatment of illness or injury is not covered.
- Prescription eyeglasses (lenses and frames, including prescription sunglasses or contact lenses).
- Replacement of lenses and/or frames.
- You will be reimbursed up to a maximum of $100 per eligible claim.

VDT glasses are covered by the City. Eligibility verification can be requested by contacting the Benefits Department at benefits@cwa1180.org or 212-966-5353.

Dependents Under Age Nineteen (19):

Children under the age of nineteen (19) are also entitled to one eye exam and one pair of prescription eyeglasses per calendar year and there is no cost or annual dollar limit on benefits the Fund will pay, however, they are only eligible for benefits using an in-network provider- GVS, CPS, Vision, Screening, or Vision World – with a selection of special pediatric carousel of frames covered by the plan. A pair of eyeglasses will be provided without charge if the prescription changes within the year. For broken, lost or stolen eyeglasses, the charge for a second pair of eyeglasses in a year will be $50, $75 or a third pair, and $100 for any beyond that.

What Is Excluded From This Plan?

- Non-prescription sunglasses are not covered.
- Repairs to eyeglasses are not covered.
- Treatment of illness or injury is not covered.
- Services not leading to the purchase of glasses will not be honored.

How Do You File A Claim?

Follow these simple steps to receive the optical benefits:

- Obtain a claim form from the Fund Office.
- Visit **any in-network** ophthalmologist, optometrist or optician of your choice.
- You should check with your employer provided health plan to determine if services of an ophthalmologist, optometrist or optician are covered by their plan.
- You may also visit an out-of-network ophthalmologist, optometrist or optician. However, please note that the cost of services may be greater than the costs for the in-network provider and the same maximum benefit of $100 still applies. If you wish, you may opt out of this out-of-network optical benefit. Please contact the Fund office if you wish to do so.
- After your optical service is completed and you pay for the service, obtain an itemized bill,
- marked "paid" which indicates the name of patient and services rendered.
- Submit your paid bill and the completed claim form to the Fund Office within ninety (90) calendar days after the expense is incurred. Claims submitted after the ninety (90) day limit will be denied.
- You will be reimbursed up to a maximum of $100 per claim for you or your eligible dependents.

What Is The No-Cost Optical Benefit Option?

The Fund has arranged with certain participating providers to make covered vision benefits available to you, your spouse and eligible children. If you choose the no-cost option, you, your spouse and eligible children will receive **at no out-of-pocket expense**. (No claim forms or vouchers are required.)

- A comprehensive eye exam.
- A wide choice of eyeglass frames.
- A choice of lenses, tinting and UV coating.
- Instead of eyeglasses, choose contact lenses (standard soft, spherical contacts, or disposable lenses).

To obtain these benefits:

- Contact the Fund Office for a list of participating providers and their locations, as well as the pan description.
- To avoid out-of-pocket costs, ask the participating provider to show you the lenses, frames and services covered by the program.
- Plan limitations apply. If the costs of the eye examination, eyeglasses or contact lenses exceed $100, you must pay the difference.

Benefits are not provided for:

- Non-prescription sunglasses.
- Repairs to eyeglasses.
- Treatment of illness or injury.
- Expenses for which benefits are payable under any Workers' Compensation Law.
- Upgraded lenses, frames and services.
- Services by a provider whose office is attached to certain hospitals within New York State (call the Fund Office for a list of such providers).