SECTION G

VISION CARE BENEFITS

G. VISION CARE BENEFITS

ELIGIBILITY

Members and their dependents are eligible for Vision Care Benefits as long as they satisfy the eligibility and enrollment requirements as outlined in the "Fund Eligibility and Membership" section of this booklet.

BENEFIT YEAR

The Vision Care Benefit year runs from January 1st through December 31st.

BENEFIT OPTIONS

There are two options for obtaining vision care benefits through the Vision administrator, General Vision Services (GVS):

- In-Network (PPO) Benefit: You utilize one of the Fund's in-network participating vision care providers for full-service benefits, paid in full directly by the Fund to the provider and without incurring any out-of-pocket expense on your part for most services.
- Out-of-Network Option: You select and directly pay the provider of your choice, file a claim with the Fund's Vision Care Administrator, and you are reimbursed up to the scheduled limits. The maximum benefit is $150 per covered person, per benefit year. In order to be considered for payment, all claims must be submitted within 24 months from the date of services. Claim form can be requested by e-mailing the vision care provider directly at mbfmembers@gvsbenefits.com

Once selected, only one of the above options (In-Network or Out-of-Network) may be used for all services within a benefit year. (In-network/out-of-network benefits do not need to be obtained during a single visit.)

Important: Please refer to the section on "Specific Details of Your Vision Care Benefit Options" (see page G.2) for complete information on the in-network (PPO) and out-of-network options.

SCHEDULE OF BENEFITS

Covered Charges

Covered charges are the usual and customary charges for the services and supplies recommended and made by a legally qualified ophthalmologist(s), optometrist(s), or optician(s) during the benefit year. Covered charges include:

- Lenses (including contact lenses and prescription sunglasses): One pair of glass or plastic spectacle lenses is covered each benefit year, per covered individual. However, if there is a prescription change or accidental breakage during the benefit year, the spectacle lenses (not contact lenses) may be replaced (under the out-of-network option only) with reimbursement limited to the unused portion of the current benefit year maximum payment. There is a one year breakage warranty for collection (plan) frames at in-network locations. In lieu of eyeglasses and at select GVS locations, convention or disposable (2 week) contact lenses will be offered as plan contacts. An allowance will be offered for contact lenses deemed non-plan (outside the plan contact lenses) at all GVS (in-network) locations.

- Frames: One pair of eligible frames is covered per person, per benefit year. At locations where there is a GVS Frame Collection, any collection frame up to a retail value of $300 is included at no charge. For members choosing a frame from the provider's own selection of frames, a $200 credit will be applied. If you choose to utilize your benefit at a Costco Optical location, please note that the frame allowance will be $80.

Note: You will not be covered for frames in the same benefit year for which coverage for contact lenses has been provided by the Vision Care Plan.

CHARGES NOT COVERED

The following charges are not covered under the Vision Care Program:

- Services or supplies that are not provided by a licensed and qualified ophthalmologist, optometrist or optician.
- Sunglasses or other spectacle lenses that do not require a prescription.
- Expenses incurred due to an injury or sickness connected with any employment, or for services which are compensated under Workers' Compensation or similar legislation.
- Repair or replacement of damaged frames or spectacle lenses except under the PPO Option's warranty provisions or under the accidental breakage allowance of the out-of-network option. (See "Schedule of Benefits," page G1.)
- Replacement of lost lenses or frames, or replacement of scratched lenses not covered by the in-network plans warranty provisions.
- Services or supplies for which the covered person incurred no expense.
- For frames in the same benefit year for which coverage for contact lenses has been provided by the Vision Care Plan.
- Medical treatment of eye disease or injury.
- Vision therapy.
- Lasik Surgery (However, discounts are available, see Laser Vision Correction Services section).
- Non-prescription (plano) lenses.

SPECIFIC DETAILS OF YOUR VISION CARE BENEFIT OPTIONS

Out-of-Network Option

The Out-of-Network Option reimburses eligible members and dependents up to $150 per person per benefit year. Up to $25 can be submitted for the examination and up to $125 for materials (eyeglasses or contact lenses).

Members receive reimbursement under the Out-of-Network Option as follows:

- Select any qualified provider and pay the provider directly for services rendered.
- The provider and the member should complete the appropriate sections of the Vision Care Direct Reimbursement Claim Form (located on the MBF website at nyc.gov/mbf), which should then be mailed to:

  General Vision Services

  520 Eighth Avenue

  9th Floor – Attention Out-of-Network Department

  New York, NY 10018

- Out-of-Network forms can also be requested from GVS and then e-mailed to: Mbfmembers@gvsbenefits.com
- Members are then reimbursed via regular mail by GVS for vision care expenses according to plan guidelines.
- Members may only submit one claim for each covered person during a single benefit year to receive the maximum out-of-network reimbursement amount.
- In order to be considered for payment, claims must be submitted within 24 months of the date of services.

In-Network Option

The In-network option is designed to provide eligible members and dependents with comprehensive services while maximizing value through reduction or elimination of out-of-pocket expenses. Listed below are key features of this option:

- Annual benefit for an eye examination, lenses, and frames.
- No annual deductible.
- For a full listing of in-network PPO providers, please visit www.generalvision.com or call the MBF concierge line at GVS at 888-906-0393. When searching on the GVS app or the website, please use the MBF group number #6054.

Paid-In-Full Benefits:

- Eye Exam
  - One eye examination, including a Dilated Fundus Evaluation when professionally indicated, is covered in full when done by an in-network PPO provider.
- Lenses
  - Lenses available through the in-network (PPO) Option at no out-of-pocket member cost include:

- All prescription ranges in glass or plastic lenses, including prescription sunglasses
- Polycarbonate lenses
- Single vision, bifocal, trifocal and cataract lenses
- Blended Bifocals
- Progressive addition (no-line) multifocals
- Oversized lenses (larger than standard size) for larger frame styles
- Fashion and gradient tints (available for plastic lenses only)
- Photosensitive (plastic) transitions (lenses that darken when exposed to the ultraviolet rays of the sun)
- High-Index lenses (thinner and lighter lenses)
- Polarized lenses
- UV coating
- Reflection-free standard coating - Anti-Reflective Coating (ARC)*
- Scratch-resistant coating
- Premium ARC is available with the $13.00 copayment
- Ultra ARC is available with a $25.00 copayment
- Ultra Progressive Lenses are available with a $50.00 copayment
- Blue Light Filtering Coating is available at a $25.00 copayment

- Frames
  - GVS offers a selection of approximately 200 frames of both metal and plastic construction. This collection includes selected designer frames from GVS exclusive Frame Collection. Any frame up to a retail value of $300 is included at no additional cost.
  - No co-payment is required, and
  - Unconditional one-year warranty against breakage is provided.

In Lieu of Eye Glasses (Annual In-network Option, Member May Only Choose One):

- Contact Lenses

Fund members and eligible dependents can obtain specified plan disposable or frequent replacement contact lenses at no cost. For members prescribed Plan Collection Lenses, up to a 12-month supply is included at no additional cost.

- Non-Plan Contact Lenses or Frames

Under the in-network PPO benefit, the Fund provides a specific allowance ($200) for non-plan frames (i.e. special designer frames) or specialty contact lenses. After this designated allowance is applied, the member is responsible for the difference and will be responsible for any additional cost, paid directly to the participating provider, without reimbursement from the Fund. In the case of non-plan contact lenses, the Fund provides the same allowance (in lieu of eyeglasses) towards purchase. The evaluation, fitting, and follow-up cost has been fixed at a $50.00 co-payment, OR

- Medically Necessary Contact Lenses

Medically necessary contact lenses are prescribed when a patient's vision cannot be corrected by either eyeglasses or standard contact lenses. The following conditions would need to be diagnosed by either an in-network or out of network provider:

- Keratoconus
- Irregular astigmatism
- High ametropia
- Anisometropia
- Aphakia
- Aniridia
- Thygeson Keratitis

Once the condition has been diagnosed, the members would need to complete the following steps for approval to assist with the cost of the lenses:

- Member must contact GVS at the MBF Concierge line at 888-906-0393 or via e-mail to mbfmembers@gvsbenefits.com to request a medical necessary contact lenses approval form.
- Member must bring the form with them to the provider's office (for either in-network or out-of-network).
- Provider must complete the form indicating the reason for the need of medically necessary contact lenses.
- Provider must send the form to mbfmembers@gvsbenefits.com for review and approval.
- Approval will be completed by GVS within 2 business days and GVS will provide the provider with the approval needed to proceed.
- Member will pay for the medically necessary lenses at the time of service and then must send the bill to GVS via e-mail to mbfmembers@gvsbenefits.com and will be reimbursed up to $1,500.

Benefits and participation may vary by retailer location. Costco locations will provide a wholesale equivalent of $80 for frame selections.

Procedure for Obtaining in-network Vision Care Services:

The Fund uses a "paperless" voucher system; no paper claim forms or vouchers are needed when utilizing vision care services from a Fund in-network PPO provider. Just follow these steps to obtain your benefits:

1. Select a provider from the Fund's Vision Care In-Network PPO Directory, which is available by visiting the GVS App, www.generalvision.com, or by calling GVS directly on the MBF concierge line at 888-906-0393.
2. Make an appointment with the in-network PPO provider of your choice and identify yourself as a Management Benefits Fund member. (Verification of Fund and benefit usage eligibility will be conducted directly between the provider you have selected and GVS.) For members using one of the National Retailers, please identify yourself as a VBA member having the GVS/MBF benefit. Please have your virtual ID card available as you will be asked for your ID and plan number when visiting the location. You will be asked to provide the last 4 digits of your Social Security Number for verification.
3. Go to your scheduled appointment, receive your examination, and select your eyewear.
4. Pick up your eyewear when it is ready and sign a Member Record Form verifying your receipt of services and supplies. You do not have to pay the provider unless you selected services or materials that are not covered by the plan or require a co-payment.

Note: All covered services (eye examination and eyewear) provided by an in-network provider must be scheduled as a single visit. The Fund will not, for example, pay for an eye examination on July 1, and eyeglasses on October 1 of the same benefit year under the PPO Option.

CONTACT LENS MAIL-ORDER PROGRAM (FOR REPLACEMENT CONTACTS ONLY AFTER THE BENEFIT HAS BEEN USED)

All members of the Fund and their eligible dependents are eligible to participate in a mail-order contact lens program, which offers savings on all contact lenses and solutions. Replacement contacts (after initial benefit) through 1-800-Any-Lens mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. They can be reached directly at 1-800-ANY-LENS or visit www.1800anylens.com

LASER VISION CORRECTION SERVICES

GVS provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts. All Lasik Benefits are administered by QualSight. Members with questions or who are looking for a participating provider should call 1-888-568-0308 and identify themselves as a General Vision Services (GVS) member.

COBRA OPTIONAL COVERAGE

If coverage of a member or his/her dependent ends, that person has the right to continue coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Notice of each person's rights under this option will be provided by the member's employing agency. Any person who has questions on COBRA optional continuance should contact his/her Agency personnel officer or the Fund Office.

CLAIMS ADMINISTRATOR

The Claims Administrator for the Fund's Vision Care Program is: General Vision Services, 520 Eighth Avenue, 9th Floor, New York, NY 10018.

Please note that the Management Benefits Fund does not endorse or guarantee any of the vision care services covered by the Vision Care Program and does not endorse or guarantee any of the providers offering those services. You should exercise independent judgment in screening and selecting an appropriate service provider. Your decision to receive services and your selection of a particular provider are solely your responsibility.