YOUR OPTICAL BENEFIT

What Is the Optical Benefit

The Fund will provide you, your spouse and eligible children a maximum of $125 per person per calendar year for eligible optical benefits. The benefit is limited to a maximum of four claims per family, per calendar year.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Benefit Summary Plan Description.
- Services are obtained while you, your spouse or your children are eligible for coverage (See the section entitled "**Eligibility**").
- Services are medically necessary and covered hereunder.
- Services are not otherwise excluded.

What Expenses Are Covered By The Optical Benefit?

Reimbursements will be made for:

- Eye exams, whether or not vision correction lenses are prescribed.
- Eye glass frames, prescription lenses, tinting (if prescribed), sunglasses (if prescribed) or contact lenses.
- Use any ophthalmologist, optometrist or optician you choose.

Getting Your Benefit

Follow these simple steps:

- Obtain a claim form from the Fund Office.
- Visit any ophthalmologist, optometrist or optician of your choice.
- After your optical service is completed and you pay for the service, obtain an itemized bill, marked "paid" which indicates the name of the patient, the date services were provided and the services rendered.
- Submit your paid bill and the completed claim form to the Fund Office within 90 calendar days after the expense is incurred. Claims submitted after the 90-day limit will be denied.

No-Cost Option

The Fund has arranged with certain participating providers to make covered optical 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:**

- A Comprehensive Eye Exam
- A wide choice of eyeglass frames
- A choice of lenses, tinting and UV coating
- Instead of eyeglasses, choose contact lenses (stand soft or spherical contacts, or disposable lenses).

To obtain these benefits:

- Contact the Fund Office for a list of participating providers and their locations
- To avoid out-of-pocket costs, ask the participating provider to show you the lenses, frames and services covered by the program.
- No claim forms are required.
- Plan limitations apply (See “What Is The Optical Benefit”).

What's Not Covered

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).

PLEASE NOTE

The Fund does NOT recommend or endorse specific providers. The no-cost option is made available to offer you potential cost savings. The decision to use this service is entirely up to you. As with any provider of services, you should apply the same criteria and care in choosing this provider that you would apply in choosing any other service you require.