GVS | GENERAL® VISION SERVICES

YOUR VISION **BENEFIT**

CSA WELFARE FUND (use benefit #)

ACTIVES # 6024, RETIREES # 6025, DCC # 6026

CONCIERGE LINE 888.346.1802

1. WHAT YOU GET:

This is your Full Benefits Summary. Please bring it with you to your appointment. If you need any assistance, please call 888-346-1802.

Additional Eyewear Discounts: 30% off any complete pair of glasses for you or family members not covered by your plan.

For Eligibility and to Utilize Your Vision Benefit: Simply call any of the listed providers for a convenient eye exam appointment. All you need is a Valid ID and your Benefit #.

Any additional services that surpass the benefit are the responsibility of the patient.

Out-of-Network Claim: Reimbursement is up to a $150 maximum. Members are required to submit a claim form with an itemized receipt to GVS.

All receipts must be submitted at one time.

* For locations outside of New York, a co-pay for an eye exam may apply.

VISION BENEFITS	CO-PAYS
EYE EXAMINATION	Every 12 Months
Includes Tonometry	Covered in full
FRAME ALLOWANCE	Every 12 Months
Frames	$150 Allowance
GVS Collection (up to $200 retail value)	Covered in full
SPECTACLE LENSES[1]	Every 12 Months
Single Vision	Covered in full
Bi-Focal	Covered in full
Trifocal	Covered in full
Oversize	Covered in full
GVS Progressive	Covered in full
Premium Progressive	$80
Deluxe Progressive	$120
MATERIALS	
Plastic	Covered in full
Polycarbonate for kids (up to 16 years of age)	Covered in full
Polycarbonate	$30
Hi-Index	$55
COATINGS	
Tint	Covered in full
Ultra Violet	Covered in full
Scratch Resistant	Covered in full
Plastic Photosensitive (single vision)	$65
Plastic Photosensitive (bifocal vision)	$95
Polarized	$95
Anti-reflective Standard Coating	$40
Anti-reflective Premium Coating	$90

Please visit generalvision.com and enter your benefit number (6024, 6025, 6026) to receive a complete list of all your vision benefits.

2. HOW YOU BENEFIT:

DISCOVER THE VALUE OF YOUR VISION BENEFITS		
GVS PLAN	**SERVICE**	**AVERAGE RETAIL COST**
INCLUDED	Eye Examination	$60
INCLUDED	GVS Designer Collection Retail	$200
INCLUDED	Standard Progressive Lenses	$195
INCLUDED	Bifocal Lenses	$129
INCLUDED	Cosmetic or Sunglass Tint	$30
INCLUDED	UV Coating	$25

3. HOW YOU GET IT:

GO TO: generalvision.com AND DOWNLOAD THE GVS App

simply enter your respective benefit number to:

- FIND A PROVIDER
- SCHEDULE AN APPOINTMENT
- REVIEW YOUR BENEFITS
- VIEW VIRTUAL ID CARD

or call **800.VISION.1** for more information

Search GVS in the App store and Register with 6024, 6025, or 6026 Now! (IOS or Android Only)

VALUE SAVINGS**

MAIL ORDER CONTACT LENSES

1800AnyLens

15% Off

Every Contact Lens Purchase

Promotion Code: GVS15OFF

Call: 1-800-ANY-LENS
or Visit: 1800anylens.com

LASIK IS NOW EASIER FOR GVS MEMBERS!

Save 40% to 50% off* traditional LASIK services with QualSight LASIK at more than 1,000 locations nationwide. Savings also available on newer technologies such as Custom Bladeless (all laser) LASIK.

Call 888-568-0308
for your FREE consultation.

Visit qualsight.com/-gvs for more information.

*Savings based on overall national average price.

ADDITIONAL SAVINGS

GVS | GENERAL® VISION SERVICES

30% off additional eyewear or items not covered under your optical program

Call 800-VISION-1
for more information.

** These Value added programs are included with your vision plan.

SCHEDULE AN APPOINTMENT
+
USE YOUR BENEFIT
—
GVS DONATES GLASSES

As part of our ongoing commitment to promote eye health and wellness, GVS is helping the world see clearly. Every time you take advantage of your GVS vision benefits, we'll donate a pair of glasses to someone in need.

Just by making an appointment, you can make a difference. Call us or visit our website now:

800.VISION.1 • generalvision.com

Be sure to click the "See Well, Do Good" icon to learn more about our charitable donations.

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CSA Welfare Fund

First Name: ______________ Last Name: ______________ ID #: ______________

Account #: ______________ Service Date: ______________ Store Code: ______________

BENEFIT OUTLINE	CO-PAYS	PATIENT PAYS
EYE EXAMINATION		
Provider Office **MUST NOT Bill Medical Insurance Plan** for Comprehensive Eye Exam or Office Visit		
☐ Eye Examination (includes tonometry)	Included	
☐ Dilation (when professionally indicated)	Included	
FRAME ALLOWANCE		
☐ GVS Collection Frame	$200 allowance	
☐ Non-Collection Frame	$150 allowance	
SPECTACLE LENSES		
☐ Single Vision	Included	
☐ Flat Top FT28 & FT35	Included	
☐ Trifocals	Included	
☐ Oversize	Included	
☐ Standard Progressive	Included	
☐ Premium Progressive	$80	
☐ Deluxe Progressive	$120	
MATERIALS		
☐ Plastic Lenses	Included	
☐ Polycarbonate	$30	
☐ Polycarbonate for kids (up to 16 years of age)	Included	
COATINGS		
☐ Cosmetic Tint	Included	
☐ Sunglass Tint	Included	
☐ Scratch Resistant Coating	Included	
☐ UV Coating	Included	
☐ Anti-reflective Standard Coating	$40	
☐ Anti-reflective Premium Coating	$90	
☐ Plastic Photosensitive Single Vision	$65	
☐ Plastic Photosensitive Bifocal	$95	
☐ Hi-Index Single Vision	$55	
☐ Polarized	$95	
CONTACT LENSES		
Colored Contact Lenses are **NOT** included. Fitting and Dispensing Included for the following Lenses.		
☐ Spherical Disposables 6 Month Supply	Included	
☐ Non-Covered Contact Lenses	$150 allowance	
☐ Fitting Fee for Upgraded Lenses	$50 co-pay	
ANY SERVICE NOT LISTED ABOVE RECEIVES A 30% DISCOUNT		
List any additional upgraded services below		
TOTAL PATIENT RESPONSIBILITY		

By signing below, I acknowledge that I have received the above services and materials and that I am responsible for the amount listed above.

Patient Signature: ______________

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REIMBURSEMENT FORM

PLEASE FOLLOW THESE INSTRUCTIONS FOR REIMBURSEMENT:

1. Confirm information in Part 1 and Part 2 are correct. To make changes, please call I-800-VISION-1 (1-800-847-4661).
2. Sign Part 3 where indicated.
3. Return this form to General Vision Services, Attn: OON-Dept, 520 Eighth Avenue, Suite 900, New York, NY 10018 or email to oon@gvsbenefits.com with an **itemized receipt** for optical services. General Vision Services will issue reimbursement checks to the MEMBER.

PART 1: MEMBER INFORMATION

Account #: ______________________

Member's Name: ______________________ ID# ______________________

Street Address: ______________________

City & State: ______________________ Zip Code: ______________________

Telephone: ______________________

PART 2: PATIENT INFORMATION

Patient's Name: ______________________

Patient's DOB: ______________________

Relationship to Member: ☐Member ☐Spouse ☐Domestic Partner ☐Child

PART 3: AUTHORIZED SIGNATURES *(18 years old and older)*

Patient's Signature: ______________________

Member's Signature: ______________________

FOR INTERNAL GVS USE:

Record Card # OUT: ______________________

Authorization #: ______________________ Date Processed: _____/_____/_____

Exam: ______________ Frame: ______________ Lenses: ______________

Total: ______________

(COMPLETE AND RETURN TO GVS WITH RECEIPT)