EMPLOYEES HIRED ON OR AFTER 7/1/2019

STAND ALONE VISION PLAN
VALLEY STREAM TA WELFARE FUND

In-network benefits

		Custom Plan
Examination Once every 12 months[1]		
		Covered 100%
Lenses	**Once every 12 months[1]**	
	Single vision	**Covered 100%**
	Bifocal vision	**Covered 100%**
	Intermediate vision	**Covered 100%**
	Trifocal	**Covered 100%**
	Lenticular	**Covered 100%**
Lens Option	**Once every 12 months[1]**	
	Scratch resistant coating	**Covered 100% after $10 copay**
	Fashion/gradient tint	**Covered 100%**
	Solid tint	**Covered 100%**
	Glass photogrey	**Covered 100% after $15 copay**
	Glass photogrey bifocal and trifocal lens	**Covered 100% after $25 copay**
	Ultraviolet (UV) coating	**Covered 100% after $10 copay**
	Standard anti-reflective (AR) coating	**Covered 100% after $33 copay**
	Polarized lenses	**Covered 100% after $60 copay**
	Polycarbonate lenses	**Covered 100% after $20 copay[3]**
	Standard progressive lenses	**Covered 100% after $50 copay**
	Premium progressive lenses	**Covered 100% after $85 copay**
Frames	**Once every 12 months[1]**	
	Frame allowance	**$100 retail allowance[6] (20% overage discount)**
Contacts	**Once every 12 months[1]**	
In lieu of eyeglasses	Maximum allowance for conventional lenses	**$100 retail allowance [4] (15% overage discount)**
	Maximum allowance for disposable lenses	**$100 retail allowance [4] (10% overage discount)**
	Medically necessary contact lenses[5]	**Covered 100%**
	Evaluation, fitting, and follow-up care - standard lens	**Covered 100% after: $20 copay (daily wear lenses)[7]**
		Covered 100% after: $30 copay (ext. wear lenses) [7]
	Evaluation, fitting, and follow-up care -	**Covered 100% after $50 copay[7]**

Out-of-network maximum reimbursements

Examination	**Once every 12 months[1]**	
		Up to $50
Lenses	**Once every 12 months[1]**	
	Single vision	**Up to $35**
	Bifocal vision	**Up to $85**
	Intermediate vision	**Up to $85**
	Trifocal	**Up to $165**
	Lenticular	**Up to $165**
Frames	**Once every 12 months[1]**	
	Frame allowance	**Up to $35**
Contacts	**Once every 12 months[1]**	
In lieu of eyeglasses	Maximum allowance for lenses	**Up to $200**

[1] Benefit year is based on member's last date of service.
[7] Only covered if member chooses contact lenses.
[2] Actual discounted amounts may vary.
[3] Prior authorization required. Polycarbonate lenses are covered in full for:
Dependent children to age 26, monocular patient, and patients with prescription +/- 6.00 diopters or greater. All others (Polycarbonate SV discounted
[4] Does not apply at Contact Fill or Cole corporate locations (if applicable) and where prohibited by law. Prohibited by some manufacturers.

[5] Prior authorization required.
[6] Does not apply for certain proprietary frame brands and where prohibited by law.

GRANDFATHERED FOR EMPLOYEES HIRED PRIOR TO 7/1/2019, CLOSED PLAN NOT OFFERED TO NEW HIRES AFTER 7/1/2019

EXCESS MAJOR MEDICAL (EMM)
VALLEY STREAM TA WELFARE FUND

This plan was designed to supplement the NYSHIP-Empire Plan's Out of Network Benefits.

Benefits under this program: (see brochure for full explanation of benefits of each benefit)

1. Out of Network Coinsurance Benefit
2. In-Hospital Private Duty Nursing Benefit
3. Out of Network Outpatient Rehabilitation Benefit
4. Nursing Home Benefit
5. In-Hospital Benefit -employees only
6. AD&D Benefit - employees only
7. **Vision Benefit - see below**

The vision benefit in this plan does not have an in-network/out of network option. It is an indemnity plan.

This means you can go to which ever provider you want to and then submit for the below reimbursements.

Procedure		Reimbursement Amt
a) complete pair of eyeglasses (including eye exam) with frame and single vision lenses		$90.00
b) complete pair of eyeglasses (including eye exam) with frame and bifocal lenses		$110.00
c) complete pair of eyeglasses (includiny eye exam) with frame and trifocal lenses		$120.00
d) contact lenses, including examination and fitting		$125.00
e) tint where medically indicated -		$7.50
f) unusually heavy or postoperative lenses at precription prices not to exceed American Optical price list. Individual pays amount in excess of insurance company payments.		$75.00
g) eye exam - where no glasses are needed or no change in prescription needed		$28.00
h) lenses only where individual supplies the frame (NOT including exam)		
	single vision lense	$26.00
	bifocal lense	$40.00
	trifocal lense	$52.00
i) contacts (not including exam and/or fitting fee)		$60.00
j) Frame only		$27.00

TO TRANSFER TO THE STAND ALONE VISION PLAN FROM THE EXCESS MAJOR MEDICAL PROGRAM PLEASE FILL IN AND SIGN BELOW. ONLY FILL IN IF YOU WANT TO CHANGE.

I, ____________________________ (PRINT NAME), WOULD LIKE TO TRANSFER FROM THE EXCESS MAJOR MEDICAL PROGRAM TO THE STAND ALONE VISION PROGRAM EFFECTIVE JANUARY 1, 2020.

I UNDERSTAND THAT BY SWITCHING TO THE STANDALONE VISION PROGRAM, I WILL NOT BE ALLOWED TO MOVE BACK TO THE EXCESS MAJOR MEDICAL PROGRAM.

CONFIRM COVERAGE TIER TO BE: _____EMPLOYEE ONLY _____FAMILY COVERAGE

____ ____________________

SIGNATURE OF EMPLOYEE DATE