E Y E C A R E   B E N E F I T S

6054

MANAGEMENT BENEFITS FUND, THE CITY OF NEW YORK ACTIVE AND RETIREES

Below you will find your Full Benefits Summary including your Vision Benefits, Enhanced Benefits, and Bonus Benefits. Please print this document and bring it with you to your appointment. If you need any assistance, please call 1-855-653-0586.

VISION BENEFITS SUMMARY

Description	Co-pays
EXAMINATION	
Includes Tonometry	INCLUDED
Dilation when professionally indicated	INCLUDED
FRAMES	
Non-Collection Frame Allowance (In Lieu of Collection Frame)	U&C less $200
Non Covered Frame Allowance at COSTCO	U&C less $80
GVS Collection - Classic	INCLUDED
GVS Collection - Metropolitan	INCLUDED
GVS Collection - Premier	INCLUDED
LENSES	
Single Vision Lenses	INCLUDED
Bifocal Lenses (FT28)	INCLUDED
Trifocal Lenses	INCLUDED
Standard Progressives	INCLUDED
Premium Progressives	INCLUDED
Oversize	INCLUDED
Ultra Progressives	$50.00 co-pay
Prism Lenses	INCLUDED
MATERIALS	
Plastic	INCLUDED
Polycarbonate- Single Vision Lenses	INCLUDED
Polycarbonate for dependent children (up to age 19)	INCLUDED
Plastic Photosensitive - Single Vision Lenses	INCLUDED
Intermediate Lenses	INCLUDED
Blended Segment Lenses	INCLUDED
COATINGS	
Cosmetic or Sunglass Tint	INCLUDED
Scratch Resistant Coating	INCLUDED
Ultra Violet	INCLUDED
Anti-Reflective - Standard Coating	INCLUDED
Anti-Reflective - Premium Coating	$13.00 co-pay
Anti-Reflective - Ultra Coating	$25.00 co-pay
Blue Light Filtering	$25.00 co-pay
Polarized	INCLUDED
CONTACTS	
Colored Contact Lenses are **NOT** included	
Fitting and Dispensing Included for the following Lenses	INCLUDED
Fitting Fee for Upgraded Lenses	$50.00 co-pay
Spherical Disposables- 12 month supply	INCLUDED
Non Covered Contact Lenses	U&C less $200
Medically Necessary Contacts	U&C less $200

LENS BENEFITS CO-PAYS

MATERIALS/HI-INDEX LENSES	
Hi-Index Single Vision	INCLUDED
PLASTIC PHOTOSENSITIVE LENSES	
Plastic Photosensitive - Single Vision Lenses	INCLUDED
Plastic Photosensitive - Bifocal Lenses	INCLUDED
Plastic Photosensitive - Standard Progressives	INCLUDED

Please make an appointment. Doctors hours may vary from store hours.
For Florida locations, eye exams may have a co-pay.
Any additional services that surpass the benefit are the responsibility of the patient.

30% Discount on all optical services not listed above, including 2nd pairs.

Updated: 02/03/2026

GVS | GENERAL® VISION SERVICES

Management Benefits Fund

Member Name: ______________________ ID #: ______________ Account #: ____________

Service Date: ______________________ Authorization #: ______________ Store Receipt #: ____________

Location Address: ____

BENEFIT OUTLINE	CO-PAYS	PATIENT PAYS
EYE EXAMINATION		
Provider Office **MUST NOT Bill Medical Insurance Plan** for Eye Exam or Office Visit		
☐ Eye Exam (including dilation when professionally indicated)	INCLUDED	
FRAME ALLOWANCE		
☐ GVS Collection Frame	$300 allowance	
☐ Non-Collection Frame	$200 allowance	
SPECTACLE LENSES		
☐ Single Vision	INCLUDED	
☐ Bifocal	INCLUDED	
☐ Trifocal	INCLUDED	
☐ Oversize	INCLUDED	
☐ Standard Progressive	INCLUDED	
☐ Premium Progressive	INCLUDED	
☐ Ultra Progressive	$50	
☐ Plastic Photosensitive Lenses (single vision)	INCLUDED	
☐ Plastic Photosensitive Lenses (bifocal)	INCLUDED	
MATERIALS		
☐ Plastic	INCLUDED	
☐ Polycarbonate for dependent children (up to age 19)	INCLUDED	
☐ Polycarbonate	INCLUDED	
☐ High-Index	INCLUDED	
☐ Photochromic Lenses	INCLUDED	
☐ Intermediate Lenses	INCLUDED	
☐ Blended Segment Lenses	INCLUDED	
COATINGS		
☐ Tints	INCLUDED	
☐ Ultra Violet	INCLUDED	
☐ Scratch Resistant Coating	INCLUDED	
☐ Polarized	INCLUDED	
☐ Anti-reflective - Standard Coating	INCLUDED	
☐ Anti-reflective - Premium Coating	$13	
☐ Anti-Reflective - Ultra Coating	$25	
☐ Blue Light Filtering	$25	
CONTACT LENSES		
☐ Non Plan Contact Lenses	$200	
☐ Non Plan Evaluation, Fitting and Follow-up	$50 copay	
☐ Plan Contact Lenses	12 Month Supply	
☐ Plan Contact Lenses Eval, Fitting and Follow-up	INCLUDED	
☐ Medically Necessary Contacts	$200	
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: ______________________________

GVS GENERAL® VISION SERVICES

Management Benefits Fund

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Service Date: ____________ Authorization #: ____________ Store Receipt #: ____________

Location Address: ____

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SPECTACLE LENSES		
☐ Single Vision	INCLUDED	
☐ Bifocal	INCLUDED	
☐ Trifocal	INCLUDED	
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☐ Premium Progressive	INCLUDED	
☐ Ultra Progressive	$50	
☐ Plastic Photosensitive Lenses (single vision)	INCLUDED	
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MATERIALS		
☐ Plastic	INCLUDED	
☐ Polycarbonate for dependent children (up to age 19)	INCLUDED	
☐ Polycarbonate	INCLUDED	
☐ High-Index	INCLUDED	
☐ Photochromic Lenses	INCLUDED	
☐ Intermediate Lenses	INCLUDED	
☐ Blended Segment Lenses	INCLUDED	
COATINGS		
☐ Tints	INCLUDED	
☐ Ultra Violet	INCLUDED	
☐ Scratch Resistant Coating	INCLUDED	
☐ Polarized	INCLUDED	
☐ Anti-reflective - Standard Coating	INCLUDED	
☐ Anti-reflective - Premium Coating	$13	
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☐ Blue Light Filtering	$25	
CONTACT LENSES		
☐ Non Plan Contact Lenses	$200	
☐ Non Plan Evaluation, Fitting and Follow-up	$50 copay	
☐ Plan Contact Lenses	12 Month Supply	
☐ Plan Contact Lenses Eval, Fitting and Follow-up	INCLUDED	
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