Local 306
Theatrical Employees
Health Fund

Vision Benefits Claim Form

Incurred Between **04/01/2024-3/31/2025**

PO Box 17928, Los Angeles, CA 90017-0928 ■ (323) 993-8806 ■ (888) 993-8806 ■ Fax (323) 993-8834

Office Use Only:

- To Locate a Participating Optical Provider contact:
  www.cpsoptical.com or call (212) 675-5745 or www.generalvision or call (800) VISION1 / (800) 847-4661
- **If you use CPS Optical or General Vision, no claim forms are needed. Use this claim form for out-of-network providers.**
- Instructions for out-of-network claims:
  1. Complete the Participant section of this form and be sure to sign and date the form. Dependents are not covered.
  2. Attach your non-credit card receipt that must include: Provider Name and address, Your name, Date of Service, Description of Charges, Amount you paid.
  3. Return the form to the Plan via email (306@bpidocs.com) or mail using the information above.

❶ Employee Information

ACCT # / SSN _____

Name _____ (Last) _____ (First) ____ (MI)

Address _____

City _____

State, Zip _____ _____

Mobile Phone _____

Alternate Phone _____

Home Fax _____

E-mail _____

New Address ☐ Yes ☐ No

❷ Service Information

Services Rendered	Date of Service	Amount Paid/Charged
Optical Examination		$
Lenses		$
Frames		$
Other		$
Total		$

❸ Provider Status Information

Please check one of the following

Non-participating/Out-of-Network - send claim to:
☐ Plan

Participating/In-Network - send claim to:
☐ Comprehensive Professional Systems
☐ General Vision Services - Acct No 5641

❹ Provider Information— to be completed by Ophthalmologist, Optometrist, or Optician

Name _____

Address _____

City _____

Phone No _____

Invoice or Acct _____

State, Zip _____

Is this claim a result of: Accident/Injury ☐ Yes ☐ No Occupational Injury? ☐ Yes ☐ No

Provider Signature: _____ Date: _____

❺ Important Notice

Any person who knowingly and with intent to defraud files a statement of claim containing any material, false information, or conceals for the purpose of misleading information concerning any fact material there to, commits a fraudulent act, which is a crime punishable by fine, imprisonment, or both.

❻ Authorization to Release Information

I hereby certify that expenses claimed have not been reimbursed and are not reimbursable under any other health plan coverage. I hereby authorize any insurance company, prepayment organization, employer, hospital, or provider to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify that the information I have provided in support of this claim is complete, true, and correct, and that all charges claimed were the amounts paid.

Signature _____ **Date** _____

Vision Benefits are available to you if you qualify for Tier I or Tier II benefits. You must earn a minimum of $2,600.00 in covered earnings in the prior calendar year.

Benefits Provided

General Benefits: The Vision Benefit reimburses up to a maximum of $300.00 between 04/01/2024 - 03/31/2025 for covered services, including:

- One eye examination performed by a licensed optometrist or ophthalmologist
- One pair of lenses prescribed by a licensed optometrist or ophthalmologist, and
- One paid of frames purchased in conjunction with lenses newly prescribed by a licensed optometrist or ophthalmologist

Subnormal Vision Benefits: If your visual acuity is not correctable to 20/70 in the better eye by the use of conventional lenses but can be improved up to 20/70 in that eye by the use of contact lenses, telescopic lenses or other subnormal vision aids, you will be reimbursed 80% of the charges actually incurred (up to $300.00) for such subnormal vision aids, as well as for professional services required to fit, administer or otherwise prepare such subnormal vision aids for your use when recommended by a licensed optometrist or ophthalmologist as being necessary following cataract surgery or to improve your visual acuity in the better eye up to 20/70, **but not to exceed the maximum reimbursement of $300.00 during any coverage period.**

When you use an In-Network Provider

If your obtain services through a provider participating in the Comprehensive Professional Systems, Inc. ("CPS") or General Vision Services ("GVS") network, you pay nothing out-of-pocket for covered services. Please follow these steps to receive your benefit:

1. Complete the *Participant Information* section of the Vision Benefit Claim Form and sign the bottom of the form.
2. Give the claim form to your provider at the time of your visit.
3. Your provider will complete the form and submit it for reimbursement.
4. The Fund will may payment directly to the provider.

To find a participating provider near you, refer to the CPS or GVS provider directory. You may also find a provider online by visiting: www.cpsoptical.com (212) 575-5745, or www.generalvision.com, (800) 847-4661.

When you use an Out-of-Network Provider

If you obtain services through a provider who does not participate in the CPS or GVS network, please follow these steps to receive your benefit:

1. Complete the *Participant Information* section of the Vision Benefit Claim Form and sign the bottom of the form.
2. Have your provider complete the remaining sections of the Vision Benefit Claim Form.
3. Submit the completed Claim Form with your itemized receipt of services rendered to the Fund Office.
4. The Fund will make payment directly to you.

General Exclusions

No payments will be made for the following:

- Non-prescription glasses and contact lenses
- Sunglasses (non-prescription), safety lenses or goggles
- Glass with tinted lenses, unless prescribed by an ophthalmologist for medical reasons
- Post-cataract lenses
- Replacement of broken frames or lenses
- Medical or surgical treatment for diseased entities of the eyes
- Accidental bodily injury arising out of and in the course of employment or from disease compensable under any Workers' Compensation, occupational disease or similar law
- Vision care services/supplies furnished in a hospital owned or operated by the Federal government or for any covered services funded by the Federal government for which the individual is not required to pay
- Vision care services/supplies received from a medical department maintained by mutual benefit association, labor union, trustees, employer or other similar group, or routine yearly examinations required by an employer in connection with the occupation of the insured individual for which the individual is not required to pay
- Expenses incurred for services performed or supplies furnished by an entity other than licensed optometrist or ophthalmologist