SUPERIOR VISION

See yourself healthy.

Superior Vision of Texas Proposal for Yorktown ISD

Proposed Effective Date: December 1, 2015

Voluntary

Tier	Monthly Premiums
Employee	$7.64
Employee + Family	$15.37

Co-pays		Services	Frequency
Exam[1]	$10	Exam	12 Months
Eyewear[2]	$25	Frame	12 Months
		Lenses	12 Months
		Contact Lenses	12 Months

Benefits	In-Network	Out-of-Network
Exam	Covered In Full	Up to $35
Frame	$130 retail allowance	Up to $70
Lenses (Clear, Standard, Glass or Plastic) Per Pair:		
Single Vision	Covered In Full	Up to $25
Bifocal	Covered In Full	Up to $40
Trifocal	Covered In Full	Up to $45
Progressive[3]	Allowance at standard trifocal level	Up to $45
Lenticular	Covered In Full	Up to $80
Polycarbonate	Covered In Full	Up to $20
Scratch Resistant	Covered In Full	Up to $25
Contact Lenses[4]	$130 retail allowance	Up to $80
Medically Necessary Contact Lenses	Covered In Full	Up to $150
Laser Vision Correction[5]	$200 retail allowance	$200 retail allowance

Rate Assumptions

- Rates are guaranteed for 4 years.
- Minimum requirements:
  - Minimum 2 enrolled employees.
  - The employer pays 0% of the employee premium and 0% of the dependent premium.

This quote is valid for effective dates within 90 days of the proposed effective date noted above. The proposed rates are based on the information provided to prepare this quote and the parameters outlined in this quote. This quote is subject to adjustment if actual information is materially different than that provided, or if there are changes from the parameters outlined in this quote.

Co-pays are due in full to in-network providers at the time of service. Co-pays associated with services provided by out-of-network providers will be deducted from member reimbursements.
All allowances are at a retail value; the member is responsible for any charges in excess of this retail allowance.

[1] *Eye exam co-pay is a single payment due to the provider at the time of service.*

[2] *Eyewear co-pay applies to eyeglass lenses / frame and contact lenses. Eyewear co-pay is a single payment that applies to the entire purchase of eyeglasses (frame and lenses) or contacts in lieu of glasses. Services and eyewear obtained through out-of-network providers are subject to the same co-payment and limitations as services through participating providers.*

[3] *If progressives are purchased, Member receives an allowance equal to the in-network provider's usual and customary retail charge for standard trifocal lenses.*

[4] *Contact lenses and related professional services (fitting, evaluation and follow-up) are in lieu of eyeglass lenses and frame benefit.*

[5] ***Members may elect to receive laser vision correction services ("LASIK Services") in lieu of the prescription eyewear described above (eyeglass lenses / frame or contact lenses) during** a single benefit period. Members electing to receive LASIK Services are entitled to an allowance as outlined above if received from a participating provider **OR** if received from from a non-participating provider. When LASIK Services are received from a participating provider in the National Lasik Network, the member is also entitled to receive the participating **provider's program pricing. The LASIK Services allowance will be paid only one time per member and is subject to certain exclusions and limitations.***

SUPERIOR VISION

SUPERIOR VISION OF TEXAS

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ENROLLMENT/CHANGE FORM

☐ Initial Enrollment (Print and complete all sections) ☐ Change (print employer name, enrollee name and SSN and all changes)

EMPLOYER/EMPLOYEE INFORMATION

Employer Name	Group Number	Location	Effective Date	Date of Hire
Yorktown ISD				

Sex	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth (DOB)	Social Security Number (SSN)
☐ M ☐ F					

Home Street Address	City/State/Zip	Home Phone	Work Phone

FAMILY INFORMATION (Only those eligible may be enrolled.)

Sex	Last Name (spouse)	First Name	M.I.	DOB & SSN
M ☐ F				
Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	DOB & SSN

Do you or any of your dependents have other vision coverage? ☐ Yes ☐ No

If yes, please give: Policyholder _____ Health Care Carrier _____

Employee Signature: _____ Date: _____

By signing above, you agree to receive plan documents, information, and notices electronically.

Please indicate your primary language _____

Do you have a disability affecting communication or reading? ☐ No ☐ Yes If yes, please specify

_____

I elect the following vision coverage:

- ☐ Employee only $ 7.64
- ☐ Employee + spouse $ N/A
- ☐ Employee + child(ren) $ N/A
- ☐ Family $ 15.37
- ☐ Waived

Plan Type:

- ☒ Full service (exam and eyewear)

Declination of coverage must be accompanied by the employee's signature above.

I am aware of and accept the following coverage conditions:

1. I (we) authorize the use of my (our) medical records for the quality assurance program conducted by Superior Vision of Texas or its designees, as permitted by law. A copy of this authorization will be valid as the original.
2. I (we) will abide by the terms of the contract in which I (we) enrolled.