

# Vision Insurance Plan 3

## Good news about vision benefits for employees of Joseph F. McWherter MD DBA Fem Centre

### Did you know?

- 50% of the U.S. population requires corrective lenses.<sup>1</sup>
- Nearly 40% of consumers fear not being able to afford adequate vision treatment without a vision plan, so they may postpone or avoid care because of the cost.<sup>2</sup>

### Your Vision Insurance Plan

As a valued employee of Joseph F. McWherter MD DBA Fem Centre, you have the opportunity to enroll in a payroll-deduction vision program.

### Plan Features:

- Doctors who offer flexible hours and office settings
- Eyewear choices we believe you'll love
- Access to the largest national network<sup>3</sup> of private-practice eye care doctors in the industry through Vision Service Plan (VSP).

### How the Plan Works

Employees get the most from their vision benefits when they visit a VSP doctor. VSP's doctor network offers a wide choice of private practice optometrists, ophthalmologists, and opticians. A VSP provider can be located by visiting [vsp.com](http://vsp.com) or call VSP's Member Services department at 800.877.7195.

If you visit an in-network provider for services and materials, you don't need an ID card or have forms to complete. If you visit an out-of-network provider for services and materials, you'll be required to pay the full amount to the provider at that time. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

### IMPORTANT:

**Coverage for eligible employees will begin March 1, 2016. You must sign up by the Initial Enrollment Deadline, or forfeit the opportunity until the next plan anniversary date.**

<sup>1</sup>*Transitions Optical, Inc. 2009*

<sup>2</sup>*Rein, David, et al. The economic burden of major adult visual disorders in the United States. Arch Ophthalmology. 2006; 124:1754-1760.*

<sup>3</sup>*Netminder as of March 29, 2010*

The issued policy provides vision insurance only. It does not provide basic hospital, accident or major medical coverage. Plans contain limitations, exclusions and restrictions. Plan frequencies and limitations apply. We can cancel the policy after giving the policyholder advance written notice.

**This notice only applies to small employers as defined by your state.** This coverage does not include and is not required to include the pediatric vision essential health benefit as required under the federal Patient Protection and Affordable Care Act.

**Assurant Employee Benefits is the brand name used for insurance products underwritten and issued by Union Security Insurance Company.**

# Assurant Employee Benefits Plan 3

A summary of vision care benefits for the employees of Joseph F. McWherter MD DBA Fem Centre

## Cost for Vision Insurance

	MONTHLY Cost*
For you	\$10.87
For you and one dependent	\$25.43
For you and two or more dependent	\$32.38

\* Your actual cost may vary depending upon your employer's contribution towards the cost of the plan.

## Vision Insurance Schedule

Benefit	Frequency	In-Network Member Cost	Out-of-Network Benefit
<b>Vision Exam</b> – focuses on your eye health and overall wellness	Every 12 months	\$10 copay	Up to \$52
<b>Laser Vision Correction Discount</b>	Once per eye per lifetime	<ul style="list-style-type: none"><li>Average 15% off the regular price or 5% off the promotional price.</li><li>Discounts only available from contracted facilities.</li></ul>	N/A
<b>Lenses</b> Single Lined Bifocal Lined Trifocal Lenticular	Every 12 months	\$25 copay (for lenses and frame)	Up to \$55 Up to \$75 Up to \$95 Up to \$125
<b>Frames</b>	Every 12 months	\$130 allowance for frames of your choice and 20% off the amount over your allowance.	\$57
<b>Elective Contact Lenses</b>  <i>Contact lenses are in place of lenses and frame.</i>	Every 12 months	\$130 allowance for contact lens exam (fitting and evaluation) and materials. If you choose contact lenses you will be eligible for frames 12 months from the date the contact lenses were obtained.	Up to \$105
<b>Additional Glasses and Sunglasses Discount</b>	30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or get 20% off from any VSP doctor within 12 months of your last exam.		N/A

## Locating an In-Network VSP Doctor

You get the most from your vision benefits when you visit a VSP doctor. You'll find a listing of doctors at [vsp.com](http://vsp.com) or by calling 800.877.7195. VSP doctors offer flexible hours, a variety of office settings, and eyewear choices.

## Using your Vision Benefit

Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. No ID cards required!

## Out-of-Network Providers

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider call VSP at 800.877.7195 for more details.

## Eligibility

You are eligible to participate if you are a full-time employee, as defined by your employer, at active work and working in the United States. Other policyholder-defined eligibility requirements may apply. Temporary or seasonal workers are not eligible.

## Dependent Eligibility

Those qualified to be covered under your vision plan include your spouse and children from live birth but less than age 26. See your certificate or group insurance policy for additional eligibility details.

**Late Entrants**

If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

*This information is a summary of your benefit. In the event of a discrepancy between this information and the insurance contract, the terms of the contract will prevail.*

# Limitations & Exclusions

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## Limitations

In no event will coverage exceed the lesser of.

- the actual cost of the examination or materials, or
- the limits of coverage shown in the Vision Insurance Schedule.

The allowance for lenses shown in the Vision Insurance Schedule is for two lenses. If only one lens is needed, coverage will be 50% of the allowance shown for two lenses.

Benefits will not be payable for replacement of lost or broken materials until the next eligible benefit period.

The plan is designed to cover visually necessary materials rather than cosmetic materials. When you or a covered dependent select any of the following extras, the plan will pay the basic cost of the allowed lenses, and you or the covered dependent will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations may apply to low vision care benefits.
- A frame that costs more than the plan allowance.
- Contact lenses (except as noted in the Vision Insurance Schedule).

## General Exclusions

Covered vision expenses do not include, and we will not pay benefits for, the following:

- Orthoptic or vision training and any associated supplemental testing.
- Plano lenses.
- Two or more pairs of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes, or supporting structures, except for laser surgery as shown under the Vision Insurance Schedule.
- Materials, services or options not shown in the Vision Insurance Schedule.
- Treatment or materials of an experimental nature.

# Employee Application

Please print clearly in blue or black ink.



**ASSURANT** Employee  
Benefits®

## ISSUE

### Check one – Employer Use

☐ New Employee ☐ Change ☐ COBRA

**EMPLOYEE INFORMATION**—Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name ( <i>last, first, initial</i> )		Employer <b>Joseph F. McWherter MD DBA Fem Centre</b>		Employment location			
Group policy/participant # <b>5459307/0</b>		Account # or Bill Group Name		Cert. #	Employee SSN	Employee birthdate	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Job title or position	Employee hire date	# hours per week	Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other \$		Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		City		State		Zip	

**ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.**

### DEPENDENT INFORMATION—Required if Dependent coverage applies

Name (Last Name, First Name)	Date of Birth	Gender	Relationship	Facility ID

**NOTE — Coverage not elected will be assumed refused even if not specifically refused**

**DENTAL BENEFITS**— You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

#### Coverage

Employee  
Employee + 1 Dependent  
Employee + 2 or more dependents

#### EMPLOYEE MONTHLY COST

☐ \_\_\_\_\_  
☐ \_\_\_\_\_  
☐ \_\_\_\_\_

☐ **Refuse Dental Benefits**

Were you covered under another dental plan within the last 31 days?

If "Yes," termination date

Reason for termination of coverage

☐ Yes

☐ No

**Union Security Insurance Company**

Mail to: Assurant Employee Benefits P.O. Box 981624 El Paso, TX 79998-1624

**ISSUE**

Employee name		Employer <b>Joseph F. McWherter MD DBA Fem Centre</b>
Group policy/participant no. <b>5459307/0</b>	Account no.	Cert. no.

**VISION BENEFITS—** You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

**Coverage**

Employee  
Employee + 1 Dependent  
Employee + 2 or more dependents

**EMPLOYEE  
MONTHLY COST**

<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

☐ **Refuse Vision Benefits**

**ISSUE**

Employee name

Employer

**Joseph F. McWherter MD DBA Fem Centre**

Group policy/participant no.

**5459307/0**

Account no.

Cert. no.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:**

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy. (3) Authorize any required deductions from my earnings. (4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed. (8) Understand that coverages include waiting periods, limitations, and exclusions that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Employee's signature \_\_\_\_\_

Date \_\_\_\_\_