Superior Vision™

SUPERIOR VISION OF TEXAS
11090 White Rock Road Suite 175
Rancho Cordova, CA 95670
1-800-507-3800
commercialgroupadmin@superiorvision.com

ENROLLMENT/CHANGE FORM

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

Please print and complete all sections. See instructions below.

EMPLOYER/EMPLOYEE INFORMATION

Employer Name	Group Number	Location	Effective Date	Date of Hire
Harleton ISD	37691			

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 $_____
- ☐ Employee + spouse $_____
- ☐ Employee + child(ren) $_____
- ☐ Family $_____
- ☐ 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.
3. I (we) will cooperate as required by the Coordination of Benefits procedures.

SuperiorVision™

Vision plan benefits for Harleton ISD

Copays		Monthly premiums		Services/frequency	
Exam[1]	$10	Emp. only	$8.98	Exam	12 months
Eyewear[2]	$25	Emp. + spouse	$15.29	Frame	12 months
		Emp. + children	$16.16	Lenses	12 months
		Emp. + family	$24.26	Contact lenses	12 months

(Based on date of service)

Benefits through Superior Select Southwest network

	In-network	Out-of-network
Exam	Covered in full	Up to $35 retail
Frames	$150 retail allowance	Up to $70 retail
Lenses (standard) per pair		
Single vision	Covered in full	Up to $25 retail
Bifocal	Covered in full	Up to $40 retail
Trifocal	Covered in full	Up to $45 retail
Progressive	See description[3]	Up to $45 retail
Tints	Covered in full	Up to $15 retail
Scratch resistant coating	Covered in full	Up to $25 retail
Ultraviolet coating	Covered in full	Up to $20 retail
Contact lenses[4]	$175 retail allowance	Up to $80 retail
Medically necessary contact lenses	Covered in full	Up to $150 retail
LASIK vision correction[5]	$200 allowance	

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

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

[2] *Eyewear copay applies to eyeglass lenses / frame and contact lenses. Eyewear copay is a single payment that applies to the entire purchase of eyeglasses (frame and lenses)*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay*

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

[5] *Lasik Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations*

Discount features

Non-covered eyewear discount: members may also receive a discount of 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens "extras" such as tints and coatings. Eyewear purchased from a Walmart Vision Center does not qualify for this additional discount because of Walmart's "Always Low Prices" policy.

LASIK

Laser vision correction (LASIK) is a procedure that can reduce or eliminate your dependency on glasses or contact lenses. This corrective service is available to you and your eligible dependents at a special discount (20-50%) with your Superior Vision plan. Contact QualSight LASIK at (877) 201-3602 for more information.

superiorvision.com

(800) 507-3800

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.