

## Desoto County School Board

**Open your eyes to high-quality vision care!** The average family spends close to **\$600 each year** on routine eye health care. Using CompBenefits' VisionCare Plan, you will receive your routine eye health care with just a small copayment.

CompBenefits' **VisionCare** Plan provides benefits for covered:

- **Eye health examinations**
- **Frames**
- **Eyeglass Lenses**
- **Contact Lenses**

Plus you will receive:

- **LASIK surgery discount**
- **Preferred member pricing for other frame and lens options\***

When ordering from one of our network eye doctors, you will also receive in the year of your eye exam:

- **A 20% discount** on a second pair of eyeglasses
- **A 15% discount** on your contact lens fitting fee

### MONTHLY RATES

Employee only:           **\$ 6.50**  
 Employee + Family:   **\$18.60**

### SERVICE FREQUENCY

Vision exam:   Once every **12** months  
 Lenses:        Once every **12** months  
 Frame:         Once every **24** months

### COPAYMENTS

Exam:           **\$10**  
 Materials:     **\$20**

## SAVINGS! SEE THE DIFFERENCE

You can save money two ways with VisionCare. First, the cost of plan services and materials is discounted and prepaid. So **except for any co-payments**, you have **no out-of-pocket expenses** for covered services and supplies when you use one of our network doctors. Second, your coverage costs are deducted from your pay *before* any federal income or FICA taxes are taken out. This makes your taxable wage base lower, so you would pay less tax.

Here's an **example** of how the plan helps you save over the course of a year:

If You Get:	You Pay:	
	VisionCare Doctor	Typical Retail
Eye exam	.00	\$ 85.00
Frame (designer style)	.00	120.00
Lenses: Bifocal	.00	100.00
Option (pink tint #1 or #2)	.00	15.00
Co-payments: \$10 exam/\$20 materials	\$ 30.00	.00
Premium (\$6.50 monthly x 12)	+78.00	.00
	108.00	\$ 320.00
Pre-tax savings (assuming 15% tax bracket & 7.65% FICA)	- 17.67	+ .00
<b>Total Cost</b>	<b>\$90.33</b>	<b>\$ 320.00</b>



## YOUR TOTAL SAVINGS THROUGH VISIONCARE: 72% OFF RETAIL

In this example, you would have saved **\$229.67** in vision care costs with VisionCare Plan. Keep in mind, however, that your actual savings will depend on your plan allowances, your actual premium, the doctors and materials you select, and your own tax situation.

\* This is not a schedule of maximum benefits. For example, the plan covers frames based on the manufacturer's *wholesale* price guide. So while the retail price of a covered frame may vary among plan doctors, the *value* of your covered frame stays the same. Typically, the wholesale frame allowance is equivalent to a retail price of \$80-150. You may be required to pay extra only if you choose a frame that exceeds the covered wholesale price.

Maximum Allowances	Participating Doctor (After copayments/ Up to plan limits)
<b>Eye Exam</b>	Paid in full
<b>Lenses (per pair)</b>	
Single	Paid in full
Bifocal	Paid in full
Trifocal	Paid in full
Lenticular	Paid in full
<b>Contact Lenses</b>	
Elective (exam & lenses)	\$100*
Medically necessary**	Paid in full
<b>Frame</b>	\$33 wholesale
<b>Lasik***</b>	We have contracted with many of the finest LASIK facilities and eye doctors to offer this procedure at substantially reduced fees. The network of LASIK centers features all TLC Laser Center (TLC Vision) facilities as well as many of the leading independent centers in the country.
	Discount Only

\* This allowance is paid with the same frequency as lenses, in place of all other benefits.

\*\* Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

\*\*\* Plan members must first contact CompBenefits for a list of providers and to receive a Refractive Care ID card.

This schedule shows only a few of the covered procedures. Please see your Benefit Administrator for a complete schedule. This schedule is intended for comparison purposes only. The benefits of each plan will be determined by the contract. For a complete listing of benefits and exclusions and limitations, please reference your certificate of coverage.

Out-of-network benefits apply under the VisionCare Plan, but benefits are higher when a participating doctor is utilized.

Limitations and Exclusions apply.

**HOW DOES VISIONCARE PLAN WORK?**

Members simply select any **in-network** optometrist or ophthalmologist and schedule an appointment. You can locate a provider in your area by accessing the current directory online at [www.mycompbenefits.com](http://www.mycompbenefits.com).

The Plan is simple to use. Select a doctor from our provider directory and call for an appointment. At the time of your appointment, present your ID Card to the participating provider. Members will pay only their co-payments and for any extra cosmetic options selected. There are no additional forms to complete or claims to file.

Members can also choose an out-of-network provider. In this case, you will pay the doctor at the time of the visit and submit receipts to CompBenefits for reimbursement.

**CAN I GET CONTACTS INSTEAD OF LENSES?**

Yes. If you prefer contact lenses, the plan provides an allowance of **\$100.00** *in place of all other benefits*.

**HOW DO I GET FURTHER QUESTIONS ANSWERED?**

You may contact CompBenefits Member Services Department with any questions or concerns at: 1-800-865-3676, Monday – Thursday 8am-8pm; and Friday 8am-6pm EST. or locate us on the web at [www.mycompbenefits.com](http://www.mycompbenefits.com).



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# Benefits Enrollment Form

Please complete the following information:				
Social Security No.	Last Name	First	MI	Date Of Birth / /
Home Address		Home Phone ( )		Sex M <input type="checkbox"/> F <input type="checkbox"/>
City	State	ZIP Code	Business Phone ( )	
List All Your Eligible Dependents That Are To Be Covered				
First	MI	Last	Sex	Birthdate
Spouse:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
# Dependents Covered	Plan Code	Group Number VS3182	E-mail Address	
Premium Amount	Amount Paid	Agent Code	Effective Date	

Please circle your choice	
<b>MONTHLY</b>	
<b>RATES:</b>	VISION PLAN
Employee Only	\$6.50
Employee + Family	\$18.60

I wish to enroll in the vision plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_