



# AlwaysVision<sup>SM</sup> Insurance for Louisiana State University System



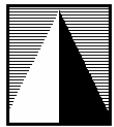
**Why should you enroll?** You receive a vision exam and eye glass lenses every 12 months, and eye glass frames every 12 months. As an alternative to eye glasses, you may choose elective contacts annually. You receive your exam benefit at participating providers for a small \$10.00 co-pay and materials at no co-pay when you visit Wal-Mart Vision Centers and \$15.00 at other participating providers.

**Real, Repeatable Savings:** With Wal-Mart's renowned "Everyday Low Pricing" and savings at many other participating providers Members receive real, dependable value on exams, lenses, frames and contacts. Most people who wear glasses purchase additional eyewear, from spares to reading glasses and sunglasses. With many participating providers, Members have repeatable savings: they benefit from lower fees any time they present their membership card for direct purchases, regardless of how much or how frequently they use their savings benefit. Members always benefit from Everyday Low Pricing at Wal-Mart.

Vision Care Services	Wal-Mart Vision Centers	Other Participating NVA Optometrists, Ophthalmologists, & Retail Outlets	Out-of-Network Allowance
<b>Exam</b>	\$10 Co-pay	\$10 Co-pay	Up to \$30
<b>Materials</b>	\$0 Co-pay	\$15 Co-pay	See below
<b>Standard Plastic Lenses:</b> Single Vision Bifocal Trifocal Lenticular Progressive	Covered Covered Covered \$80 allowance \$70 allowance	Covered by Co-pay Covered by Co-pay Covered by Co-pay \$80 allowance \$70 allowance	Up to \$25 Up to \$40 Up to \$50 Up to \$50 Up to \$40
<b>Lens Options:</b> Scratch resistant coating Polycarbonate Lenses for children	Covered Covered	N/A N/A	N/A N/A
<b>Frames:</b> Members choose from any frame available at provider locations.	No Co-pay Up to \$74 retail allowance, depending on plan selected. \$74 covers two-thirds of frames available at Wal-Mart.	A minimum \$100 retail frame (retail amount may vary at some providers). Covers a wide selection of frames.	Up to \$40 retail
<b>Contact Lenses:</b> (Includes fit, follow-up and materials) Elective Comprehensive Plan Allowance Medically Necessary	No Co-pay Up to \$130 retail Up to \$210 retail	After Co-pay Up to \$130 retail Up to \$210 retail	Up to \$130 retail Up to \$210 retail
<b>Laser Vision Correction:</b>	20% discount on Lasik or PRK retail prices performed by participating surgery providers.		

Frequency	
Examination	Once every 12 Months
Spectacle Lenses	Once every 12 Months
Frames	Once every 12 Months
Contact Lenses	Once every 12 Months

Monthly Premiums:	
Employee Only	\$ 8.29
Employee + Spouse	\$13.96
Employee + Child(ren)	\$14.26
Employee + Family	\$22.98



## Enrollment Form (Please type or print in ink. This form may be photocopied.) Effective Date of Coverage: \_\_\_\_\_

**AlwaysVision<sup>SM</sup> Insurance Plan** (Policy Form # D00-200 & #V99-004 AL, AZ, AR, FL, IN, KS, LA, MO, OH, TN)

Underwritten by: Starmount Life Insurance Company, Inc., P.O. Drawer 14389, 7800 Office Park Blvd., Baton Rouge, LA 70898-4389

Group: **LSU System**

Location: \_\_\_\_\_

### TO BE COMPLETED BY EMPLOYEE (Please Print)

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male  Female

Employee's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_  
Month Day Year

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Permanent Full-time Date Employed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Hrs. worked/wk. \_\_\_\_\_  
Month Day Year

NAME OF DEPENDENT(S)	RELATIONSHIP	BIRTH DATE
_____	_____	_____
_____	_____	_____

### EMPLOYEE ELECTION(S)

		REVIEW & CHECK AS APPLICABLE		Premiums	
Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Employee Only	Employee + Spouse	Employee + Children
			\$ 8.29	\$ 13.96	\$ 14.26
				\$ 22.98	

### DEPENDENTS ELECTION(S)

		REVIEW & CHECK AS APPLICABLE		Spouse & Child(ren)	
Vision	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Children <input type="checkbox"/>	Spouse & Child(ren) <input type="checkbox"/>	No <input type="checkbox"/>

(Dependents continued)

NAME OF DEPENDENT(S)	RELATIONSHIP	BIRTH DATE
_____	_____	_____
_____	_____	_____

**Instructions:** Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If plan is contributory, this form **MUST** be signed and dated to authorize payroll deductions. **Should you decline coverage(s), you MUST complete the reverse of this form.** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

### Signature of Employee

### Date

_____	_____	_____	_____	_____	_____	_____
Campus	HRM Rep	Pay Type	Effective Date	P/R Rep	Payroll Deduction	Date Processed

## Limitations & Exclusions

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under this plan. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits of the policy.

Covered Materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from a Participating Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

### **This plan will not cover:**

Orthoptics or vision training and any supplemental testing; Plano (non-prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals.

Medical or surgical treatment of the eyes.

An eye exam or corrective eye wear required by an employer as a condition of employment

Any injury or illness covered under Workers' Compensation or similar law, or which is work related.

Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses.

Sub-normal vision aids.

Services rendered or materials purchased outside the U.S. or Canada, unless: the insured resides in the U.S. or Canada, and the charges are incurred while on a business or pleasure trip.

Charges in excess of Usual and Customary for services and materials. Experimental or non-conventional treatments or devices.

Safety eyewear.

Spectacle lens styles, materials, treatments or "add-ons" not shown in the Schedule of Benefits.

Laser Vision Correction Network

Membership provides access to Preferred Pricing. Transactions for laser correction are handled directly between Members and Providers. Refractive surgery is an elective procedure and may involve potential risks to patients. Starmount cannot and does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. Providers may not be available in all metropolitan areas.

### **How AlwaysVision<sup>SM</sup> Works**

1. **Call (888) 729-5433 or visit [www.alwaysvision.com](http://www.alwaysvision.com) to find a provider near you.**
2. **To schedule an appointment with your provider, please note the following:**
  - a. When calling a **Pearl Vision Center, Target/Super Target Optical Center, Sears Optical Center, or JCPenneys Optical Center** location, you should mention that your insurance is called AlwaysVision<sup>SM</sup> as this is how these locations will locate details of your coverage in their computer systems.
  - b. When calling an **Eyemasters** location, you should mention NVA-Starmount.
  - c. When calling a **Wal-Mart Vision Center**, Wal-Mart Associates will verify your coverage by using your employer's name in their computer system.
  - d. When calling any other location, identify yourself as an AlwaysVision<sup>SM</sup> and National Vision Administrators (NVA) member. Most providers will recognize the NVA name. If, however, the provider does not recognize AlwaysVision<sup>SM</sup> or NVA, please contact Starmount for assistance and we will work directly with you and the provider.
3. **Present your card for *Easy Access* to your benefits at your Provider. No paperwork is involved; you simply pay your co-payment and any expenses that are not covered.**

\*The contact lens benefit takes the place of spectacle lenses and a frame.

\*\* Frame Allowance for Other Preferred Providers represents Wholesale Pricing.

\*\*\* Lens Pricing based upon CR-39 Plastic Material. Glass lenses may have an additional cost.

**Wal-Mart Frames** include a one year warranty and lifetime adjustments & cleanings (no cost).

**Wal-Mart Lenses** include a one year warranty and lens replacement if your prescription changes within 3 months of your purchase at no charge.

Members will be responsible for sales tax at Wal-Mart vision centers.

Each employee enrolling in the Group Voluntary Plan must agree to remain enrolled during the designated plan period.

Those employees who elect not to enroll during the initial plan enrollment period must wait until the next plan enrollment period to enroll. The plan enrollment period shall be the month prior to the beginning of the next plan year.

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## WAIVER OF GROUP INSURANCE

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Group Policy No.(s) \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Date Employment Began \_\_\_\_\_

I have been given an opportunity to apply for Group Insurance as offered by the Policyholder and, after careful consideration, have decided **not** to enroll in the following coverages:

Vision

For:  Myself (and all eligible dependents if applicable)  
 My eligible dependent spouse and children only

My eligible dependent spouse only  
 My eligible dependent children only

Reason:  Cannot afford

Covered under an alternate health plan provided by my employer

Covered under another employer health plan benefit

Other Insurance/Reason \_\_\_\_\_

Should I apply for a waived coverage in the future, I understand that my dependent(s) and I will be **considered a late enrollee(s)** and evidence of insurability, at my expense, acceptable to the Insurance Company will be required. I also understand that my first year Dental or Vision benefits may be limited.

**The above provisions will apply unless otherwise stated in my policy, or unless prohibited by any applicable state or federal law.**

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature of Employee