

Retiree Vision Insurance

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More often than not, vision deteriorates with age. You'll likely take more trips to the eye doctor and replace your eyeglasses more frequently. CSEA-Sponsored Retiree Vision Insurance can save you money by helping you cover your vision related expenses.

Plan Highlights:

- Your choice of a new pair of eyeglasses (\$25 copay) or new contact lenses (\$25 copay) every year
- One full eye examination per year (\$10 copay)
- One year eyeglass breakage warranty included on plan eyewear for no additional cost
- Discounts on various lens and coating options
- Spouse coverage available

Learn More

Call and speak to a CSEA Insurance Representative today at:

[877-VIP-CSEA \(847-2732\)](tel:877-VIP-CSEA(847-2732))

Applications & Brochures

Application

[Retiree Vision Application](#)

Brochure

[Retiree Vision Brochure](#)

Rates:

Rates	Monthly	Annually
Member	\$11.96	\$143.52
Member & Spouse	\$20.50	\$246.00
Member & Family	\$20.50	\$246.00

CSEA Group Insurance Program Administrator
13 Airline Dr.
Albany, NY 12205

ph. 800.697.2732
fx. 518.640.8108

#1822099

Designer Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can't afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts (after applicable co-pays)!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.¹

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.¹

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:



Contact Pearl Insurance today to enroll.

For more details about the plan, just visit www.davisvision.com, select the MEMBER option and enter Client Code 4926, or call Pearl Insurance at 1.877.VIP.CSEA to enroll!

¹ The Davis Vision Collection is available at most participating independent provider locations.

² Transitions® is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, Covered in full after \$10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, Covered in full For standard single-vision, lined bifocal, or trifocal lenses after \$25 copayment
Frames	Every 12 months, Covered in full Any Fashion or Designer frame from Davis Vision's Collection ¹ (value up to \$160) covered in full or any Premier frame for an additional \$25 copayment. OR \$130 retail allowance toward any frame from provider, plus 20% off balance
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months, Covered in full For Collection Contacts: after \$25 copayment
Contact Lenses (in lieu of eyeglasses)	Every 12 months, Covered in full Any contact lenses from Davis Vision's Contact Lens Collection ¹ OR \$130 retail allowance toward provider's lenses, plus 15% off balance

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS

MOST POPULAR OPTIONS <small>Savings based on in-network usage and average retail values.</small>	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	\$20	\$0
Polycarbonate Lenses	\$64	\$0
Standard Anti-Reflective (AR) Coating	\$62	\$35
Standard Progressives (no-line bifocal)	\$154	\$0
Plastic Photosensitive (Transitions ^{®2})	\$126	\$65

Lower costs and more benefits! See the savings!

Service	Without Davis Vision	With Davis Vision
Eye Examination	\$75	\$10
Lenses		
Bifocals	\$80	\$25
Scratch-Resistant Coating	\$20	\$0
Transitions ^{®2}	\$126	\$65
Frame	\$130	\$0
Total	\$431	\$100

Member Contributions	Monthly	Annually
Member	\$11.96	\$143.42
Member plus Spouse	\$20.50	\$246.00

Savings up to:
\$331
per person

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their spouses. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Contact Info

For more details about the plan, just visit www.davisvision.com, select the MEMBER option and enter Client Code 4926, or call Pearl Insurance at 1.877.VIP.CSEA (847.2732) to enroll!

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	\$100	\$0
Designer Frame (from the Davis Vision Collection)	\$160	\$0
Premier Frame (from the Davis Vision Collection)	\$195	\$25
LENSES		
All Ranges of Prescriptions and Sizes	\$60-\$120	\$0
Plastic or Glass Lenses	\$30-\$35	\$0
Oversized Lenses	\$25	\$0
Fashion Gradient Tinting	\$20	\$0
Scratch-Resistant Coating	\$20	\$0
Polycarbonate Lenses	\$64	\$0
Ultraviolet Coating	\$26	\$12
Standard Anti-Reflective (AR) Coating	\$62	\$35
Premium AR Coating	\$76	\$48
Ultra AR Coating	\$114	\$60
Standard Progressive Addition Lenses	\$154	\$0
Premium Progressive Addition Lenses	\$248	\$90
Ultra Progressive Addition Lenses	\$430	\$140
High-Index Lenses	\$121	\$55
Polarized Lenses	\$95	\$75
Photochromic Glass Lenses	\$50	\$20
Plastic Photosensitive Lenses	\$126	\$65

Please Note: An insured who leaves the plan for any reason or stops paying premiums will not be allowed to re-enroll.



DAVIS VISION ENROLLMENT APPLICATION

Complete this section to apply for Member coverage

Name: _____

Address: _____

City: _____ State: NY Zip: _____

Email Address: _____ Phone Number: (_____) _____

Sex: Male Female Date of Birth: _____ Social Security #: _____

Complete this section to add Spouse and/or Dependent coverage

Spouse Name: _____ Date of Birth: _____

Child Name: _____ Date of Birth: _____

Child Name: _____ Date of Birth: _____

Child Name: _____ Date of Birth: _____

Child Name: _____ Date of Birth: _____

Sign and Date

Must be an active CSEA Member to enroll and retain active coverage under the Vision Plan. Members may not re-enroll in coverage if coverage under the vision plan was previously cancelled by the member unless the member is actively at work and applies for coverage within 31 days of a Life Event as defined in the Group Vision Policy Certificate of Insurance. Vision coverage will become effective on the 1st day of the calendar month following receipt of the completed enrollment form and payment, provided they are received prior to the 14th of the month.

Agreement: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information above.

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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Signature: _____ Date: _____



Voluntary Vision Program

CSEA Retiree Designer Vision Plan is a comprehensive benefit plan ensuring low out-of-pocket cost to members and their spouses. The CSEA Designer Vision Plan offers convenient network locations of credentialed preferred providers throughout the 50 states.

MONTHLY RATES *All States*

Rates effective through December 31st, 2020

Member: \$11.96

Member + Spouse: \$20.50

Down Payment Amounts for EFT or Pension Deduction

Member: \$23.92

Member + Spouse: \$41.00

Down Payment Amounts for Direct Bill

Quarterly: Submit 3 months premium

Semi-Annual: Submit 6 months premium

Annual: Submit 12 months premium

CSEA Retiree Payment Options

You have 3 easy payment options as described below. Please note that to begin coverage, and with all payment options, **we first require a payment with your signed and dated application(s)**. Specific payment requirements for each payment option are listed below.

OPTION 1: Electronic Funds Transfer (EFT)

With Electronic Funds Transfer (EFT), you authorize your bank or financial institution to automatically deduct your monthly insurance premiums from your checking account. Paying your premiums by EFT is easy and convenient...save time writing checks and the postage cost to mail them...and there's no extra fee for installment payments!

Automatic withdrawals

- All withdrawals authorized will appear on your bank statement as "Pearl Insurance."
- Withdrawals will be taken on the first business day of the month.
- If your account does not have enough money, your bank may charge you for insufficient funds when we try to withdraw your payment. We will try to withdraw the money up to two times. If we are unsuccessful, we will notify you by mail of the missed payment and you may risk cancellation of the payment plan.
- If you cancel your policy before the current month's withdrawal date, we will notify you by mail of any balance due.

PAYMENT REQUIREMENT: First 2 months premium for initial payment

OPTION 2: Direct Bill Sent to Your Home

You may opt to have a bill sent to your home based on the billing cycle you choose: Quarterly, Semi-Annually or Annually.

PAYMENT REQUIREMENT: Your initial premium payment will depend on the billing cycle you choose.

- For quarterly billing, please include 3 months premium.
 - For semi-annual billing, please include 6 months premium.
 - For annual billing, please include 12 months premium.
-

OPTION 3: Pension Deduction

You may opt to have your payments deducted from your New York State pension. **Please note that if you are a new retiree not yet receiving a pension, you will be placed on direct bill for the first 5 months until pension deductions can begin.**

PAYMENT REQUIREMENT: First 2 months premium for initial payment

Effective Date Rules:

Application received before 15th of month, Effective date is the 1st of following month.

Application received after 15th of month, Effective date is the 1st of the consecutive month.

POLICYHOLDER INFORMATION Please print



Insured's Name (First, MI, Last Name) _____

Home Address (Street, City, State, Zip) _____

Daytime Phone _____ Email Address _____

OPTION 1: Electronic Funds Transfer (EFT) If you choose to have your monthly premium deducted from your bank account, please complete below with your banking information and **include a check for your initial premium payment** - made payable to Pearl Insurance.

Bank Routing Number _____ Bank Account Number _____

Bank Name _____ Bank Account Owner's Name
(if different than Policyholder) _____

AUTHORIZATION & SIGNATURE: I certify that I am the owner and/or authorized signer for this bank account, and I authorize Pearl Insurance NY ("Pearl Insurance") to make electronic debit entries for payment of insurance premiums for my policy(ies) from this account. The entries shall constitute my receipt for the transactions(s). I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account. I recognize that this authorization allows Pearl Insurance to adjust my scheduled deductions to reflect any premium changes. I understand that it is my responsibility to make sure that there are sufficient funds in this account at the monthly withdrawal date. I also understand that the policy(ies) may cancel or expire if there are insufficient funds in the account, pursuant to the terms of the policy(ies). This authorization is to remain in effect until Pearl Insurance receives written notification of its termination and has sufficient time to act on it.

Bank Account Owner's Signature _____ Date _____

Option 2: Direct Bill If you choose to have your bill sent to your home, please select your billing cycle and **include a check for your initial premium payment** - made payable to Pearl Insurance. **Your initial premium payment will depend on the billing cycle you choose.**

CHECK ONE: Quarterly Bill Semi-Annual Bill Annual Bill

Member Signature _____ Date _____

Option 3: Pension Deduction If you choose to have your monthly premium deducted from your New York State Pension check, **please include a check for the first 2 months premium** - made payable to Pearl Insurance (your Pension Deductions will begin after the first 2 months) and sign the Pension Deduction Authorization below.

Pension Deduction Authorization: Pursuant to Section 110-c and 410c of the Retirement and Social Security Law, I hereby authorize deductions to be made from my monthly allowance from the New York State and Local Employees Retirement Systems in the amount necessary to cover membership dues and insurance on my behalf to CSEA, Local 1000, AFSCME, AFL-CIO. Authorization is also given to make any changes the Union certifies to the Retirement System as necessary in the amount of such dues and insurances. I, the undersigned, do hereby authorize you to deduct from my monthly allowance the amount of \$3.00 for payment of dues, or any amount as may be certified to you by the Union as my dues and or insurance. I understand that CSEA, Local 1000, AFSCME, AFL-CIO is my agent and all request to begin, modify, or revoke deductions must be submitted through the Union. This authorization shall remain in effect until revoked by me by written notice through the Union or until otherwise revoked pursuant to law.

Pensioner Signature _____ Date _____

Retirement Number (Required number printed on pension check) _____ Pensioner SSN# _____