



## CSI OPTIONAL VISION PLAN

Approximately 60 percent of Americans require some form of vision correction and almost one out of every six children wears eyeglasses. Do you or a family member wear glasses or contacts? Who might need them in the future? With the CSI Optional Vision Plan, you can budget for your eye care needs by purchasing vision coverage rather than paying a lump sum up front at the time you or a family member needs eye care.

This optional vision plan is being offered to insured employees and retirees under the CSI Insurance Plan. A network of participating providers through Vision Service Plan (VSP) provides benefits. You may obtain a list of participating providers online at [www.vsp.com](http://www.vsp.com). Coverage is elected in twelve-month blocks. The coverage period is from September 1 through August 31 with the enrollment occurring once each year. Monthly premiums can be paid on a pretax basis through a Section 125 plan like the CSI Flexible Benefits Plan.

Vision Plan Benefit Highlights (In-Network Benefits)	
Co-pay	The Plan includes a \$10/\$25 split co-payment. The first \$10 applies to the examination and the second \$25 co-payment applies to materials.
Eye Examination	100 percent covered every 12 months after \$10 exam co-payment
Lenses	100 percent covered every 12 months after \$25 materials co-payment
Frame	More than 11,000 frames covered in full every 24 months
Contact Lenses	\$120 allowance toward materials and professional services in lieu of lenses and frame
Cosmetic Options	20 percent savings for progressive lenses, anti-reflective coating, scratch coating, etc.
Added Value	20 percent discount on additional complete pairs of prescription glasses and sunglasses.
Savings	VSP coverage shields patients from retail mark-ups. Employees save through VSP's wholesale pricing and cost-controlled options in addition to pretax savings.
Laser Vision Correction	Discounts for laser vision correction available through contracted laser centers. See your VSP member doctor for more details.
Monthly Premium	Single \$8.50    Emp+One \$12.75    Family \$22.75

### ENROLLMENT FORM – CSI OPTIONAL VISION PLAN

September 1, 2008 - August 31, 2009

Employee Name	Birth Date	Social Security Number
School Name	School Number	
Coverage Selection <input type="checkbox"/> Single Coverage <input type="checkbox"/> Employee + One <input type="checkbox"/> Family Coverage Coverage Termination <input type="checkbox"/> Terminate current coverage as of 8/31/08		

I have been given the opportunity to participate in the Contributory (Optional) Vision Plan with VSP. I understand that I am electing to participate in the CSI Optional Vision Plan for a twelve-month period beginning September 1.

I request my employer to arrange for the Group Coverage which I elect and authorize my employer to deduct from my earnings the required contributions.

Employee's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_