



Monthly Rates
 Subscriber \$5.59
 Subscriber + Spouse \$10.07
 Subscriber + Child(ren) \$10.63
 Subscriber + Family \$16.78

Town of Raynham

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	\$10 copay	Up to \$57
Retinal Imaging	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to \$40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$104
STANDARD PLASTIC LENSES		
Single Vision	\$25 copay	Up to \$47
Bifocal	\$25 copay	Up to \$79
Trifocal	\$25 copay	Up to \$113
Lenticular	\$25 copay	Up to \$113
Progressive - Standard	\$80 copay	Up to \$73
Progressive - Premium Tier 1 - 4	\$110 - 200 copay	Up to \$77
LENS OPTIONS		
Anti Reflective Coating - Standard	\$45 copay	Up to \$23
Anti Reflective Coating - Premium Tier 1 - 3	\$57 - 85 copay	Up to \$23
Photochromic - Non-Glass	\$75	Not covered
Polycarbonate - Standard	\$40	Not covered
Scratch Coating - Standard Plastic	\$15	Not covered
Tint - Solid and Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$104
Contacts - Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$104
Contacts - Medically Necessary	\$0 copay; paid-in-full	Up to \$210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY		
	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year
(Plan allows member to receive either contacts and frame, or frame and lens services)		

QL-0000042584



40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor (Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits.

Log into eyemed.com/member to see all plans included with your benefits.

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

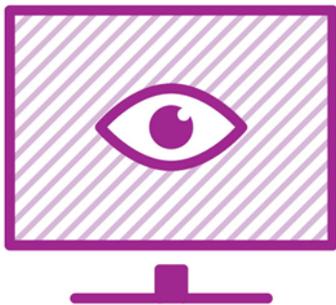
Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,¹ but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

¹Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS®

PEARLE
VISION
EST. 1961

OPTICAL®



Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.

Required sections are marked with an *.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name* / / Effective Date** / /

Group Number* Subgroup*

Location Code

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Employee Information: to be completed by Employee

Change Type*: Add Term Update Member ID:

Last Name* Date of Birth* / /

First Name* MI Gender* Male Female Phone Number () -

Street Address*

City* State* Zip Code* Social Security Number** - -

Employee Email Address:

^Last four digits of Employee's Social Security Number are required.

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 2 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 3 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 4 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Employee Signature*: _____

Date*: / /

For additional dependents, please complete a second form.