YOUR CUSTOM VISION QUOTE

Town of Bellingham

More of what's best, not more of the same

Get the most out of your vision plan with these EyeMed highlights

- Ability to use the frame and contact lens allowances in the same benefit year-worth up to an extra $130.00[1]
- Separate contact lens fit & follow-up coverage leaving the entire allowance for materials

Plus, with us, you always get

NETWORK Reinventing choice and convenience	BENEFITS Redefining flexibility and value	EASY Reimagining simple and transparent
• America's Largest vision network[2]	• The freedom to choose any prescription frame, lens or contact lens without restrictions at any of our retail and independent provider locations, or at one of our many online options.	• Cost transparency with our Know Before You Go cost estimator
• The right mix of independent eye doctors and national and regional retail providers – so members can go where they want, when they want	• Complimentary HealthyEyes wellness program that keeps the focus on eye health with online tools, articles and videos to make the conversation around vision even easier.	• Digital Tools like online scheduling[4], a mobile app and personalized text alerts
• In-network options for buying glasses and contacts online at glasses.com, lenscrafters.com, contactsdirect.com, targetoptical.com and rayban.com – with benefits applied directly in the shopping cart	• Members enjoy exclusive savings on LASIK at preferred providers, including $800 off or 5% off the in-store promotional price.[3]	

We can't wait to work with you-
Contact at eyemedvisioneast@eyemed.com with questions

1 This document provides highlights of one or more EyeMed plans. Frame allowances may vary by plan. Please consult your EyeMed representative for more information.
2 Based on the EyeMed Insight network, Spring 2022.
3 Preferred lasik providers include LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute
4 At select locations

DF-2206-CB-591

BENEFITS

Town of Bellingham

Benefits

2024 Renewal OON Updates
Exam & Materials
Insight Network
Fully Insured
Employee Paid

Monthly rates

Subscriber
$7.34

Subscriber + 1
$13.95

Subscriber + Family
$20.48

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES once every plan year		
Exam	$10 copay	Up to $57
FRAME once every plan year		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $104
STANDARD PLASTIC LENSES *in lieu of contacts* once every plan year		
Single Vision	$25 copay	Up to $47
Bifocal	$25 copay	Up to $79
Trifocal/Lenticular	$25 copay	Up to $130
Progressive – Standard	$25 copay	Up to $140
Progressive – Premium Tier I	$55 copay	Up to $196
Progressive – Premium Tier II	$65 copay	Up to $196
Progressive – Premium Tier III	$80 copay	Up to $196
Progressive – Premium Tier IV	$200 copay	Up to $196
LENS OPTIONS		
Anti Reflective Coating – Standard	$45 copay	Up to $36
Anti Reflective Coating – Premium Tier I	$57 copay	Up to $52
Anti Reflective Coating – Premium Tier II	$68 copay	Up to $52
Anti Reflective Coating – Premium Tier III	$85 copay	Up to $52
Polycarbonate – Standard < 26 years of age	$0 copay	Up to $32
CONTACT LENSES *in lieu of lenses* once every plan year		
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 $300

All plans are based on a 48 month contract and 48 month rate guarantee. Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier.

Plan Details

Quote for group situsedin the State of MA and will be valid until the 01/01/2024 implementation date. Date Quoted 09/25/2023. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Exclusions/Limitations

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 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.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If Town of Bellingham has chosen this benefit design, attach this document to the group application and sign here

Signature _____ Date _____

MEMBER SAVINGS

Town of Bellingham

We're committed to keeping money in our members' pockets. That's why we offer our members additional discounts above the proposed plan benefits

VISION CARE SERVICES	IN-NETWORK MEMBER COST
EXAM SERVICES	
Retinal Imaging	Up to $39
CONTACT LENS FIT AND FOLLOW-UP	
Fit and Follow-Up – Standard	Up to $40
Fit and Follow-Up – Premium	10% off retail price
LENS OPTIONS	
Photochromic – Non-Glass	$75
Polycarbonate – Standard	$40
Scratch Coating – Standard Plastic	$15
Tint – Solid or Gradient	$15
UV Treatment	$15
All Other Lens Options	20% off retail price

40%OFF

additional pairs of glasses

20%OFF

any item not covered by the plan, including non-prescription sunglasses

15%OFF

retail price or 5% off promotional price for Lasik or PRK from US Laser Network

UP TO 64%OFF

hearing aids, with an extended warranty and free batteries through Amplifon Hearing Health Care Network

Members can get exclusive additional discounts and deals that are often stackable with their vision benefits at *member.eyemedvisioncare.com*

DISCOUNT DETAILS

Discounts are not insured benefits. Member receives a 20% discount on items not covered by the insurance plan at EyeMed In-Network locations. 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 EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

P201603 TC10 Q-C0045130 QL-0000103531

Enrollment/Change Form

Please print in all capitol 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** ___ / ___ / ____

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

Group Number*

Subgroup*

Location Code

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** ___ - ___ - ____

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

Employee Email Address:

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.