eyeMed

TOWN OF WEYMOUTH

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on www.eyemed.com or call 1-866-804-0982.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Frames	$25 Co-pay; $130 allowance; 80% of charge over $130	Up to $74
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $42
Bifocal	$25 Co-pay	Up to $78
Trifocal	$25 Co-pay	Up to $130
Standard Progressive Lens	$90	Up to $78
Premium Progressive Lens^	$110 - $135	
Tier 1	$110	Up to $78
Tier 2	$120	Up to $78
Tier 3	$135	Up to $78
Tier 4	$90, 80% OF CHARGE LESS $120 allowance	Up to $78
Lenticular	$25 Co-pay	Up to $130
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $12
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$0	Up to $26
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating^	$57-$60	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$25 Co-pay; $130 allowance; 15% off retail price over $130	Up to $104
Disposable	$25 Co-pay; $130 allowance; plus balance over $130	Up to $104
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

*Frame, Lens & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

^Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided for services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens, Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Combined Life Insurance Company of New York. CLICNY Form # VN P46900 0801 The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

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