LORD EYE CENTER
COASTAL MANAGED CARE – VISION PLAN FOR BULLOCH CO.

Coastal Vision Care Plan offers a very economical vision care plan that is very appealing to employees.

Vision Examination	This service is covered in full (applicable $10 co-payment)
Frames	An allowance of $110 is given (Patient can select any frame)
Spectacle Lenses	Single Vision, ST-28 Bifocals, and *7/28* Trifocals are covered in full. A $90 allowance is given toward Progressive lenses and any other type of specialty lenses.
Contact Lenses	$130 allowance toward contact lenses and professional fees. (No co-payments apply when using this benefit).
Co-Payments	Exams / Professional Fees $10 Materials (spectacle)[1] $10

[1]Material co-pay is on the first $10 for any materials purchased. (e.g., If frames and lenses are purchased, the co-pay would only apply to one or the other but not both.)

Benefit			**Vision Care Rates**	
Type	Frequency		Coverage	Monthly Cost
Vision Examination	12 months		Employee Only	$11.23
Spectacle Lenses	12 months		Employee / Spouse	$17.91
Frames	12 months		Employee / Family	$25.63
Contact Lenses	12 months			

Initial benefit can be utilized at any time after sign up. Subsequent benefits to be available twelve (12) months after the initial utilization.

Plan Benefit Allowances	
Eye Examination	Covered 100% after applicable $10 co-payment
Lenses: Single Vision Bifocal Trifocal Progressive	After applicable $10 co-payment Covered at 100% Covered at 100% Covered at 100% $90 allowance towards Progressive Lenses
Frame	$110 allowance is given towards the purchase of any frame. A large selection of frames less than this amount are always available.
Contact Lenses	$130 allowance is the total allowance for the contact lenses and any and all vision and fitting fees pertaining to the lenses. Contact Lenses are in lieu of spectacle lenses and frame.

Rates are guaranteed for 12 months. All premiums reflect employer paid contracts. 30% discount to all covered employees for additional frames and lenses.

Locations:
360 Northside Drive East, P. O. Box 1009, Statesboro GA 30458, (912) 764-9147
Savannah Mall #31, 14045 Abercorn Street, Savannah GA 31419, (912) 925-0700
594 South Columbia Avenue, Suite 200, P.O. Box 1339, Rincon, GA 31326, (912) 826-0935
Colonial Glynn Place Mall, 156 Mall Blvd, Brunswick, GA 31525 (912) 554-0010
113 City Smitty Drive, St. Mary's, GA 31558, (912) 882-3040
3440 Wrightsboro Road, Augusta, GA 30909, (706) 766-0020

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Vision Plan Enrollment Form

Hire Date _____ Effective Date _____ Location _____

☐ New Enrollment ☐ Open Enrollment

Employee Name _____ _____
Last Name *First Name* *M.I.* *Date of Birth*

Home Address _____

Social Security Number _____ Date of Birth _____

Fill in the following information for spouse and dependents only if they are being enrolled.

Spouse

Last Name	*First Name*	*M.I.*	*Date of Birth*	*Soc. Sec. #*

Children

Last Name	*First Name*	*M.I.*	*Date of Birth*	*Soc. Sec. #*

My employer has informed me of all definitions required to complete this form. I hereby apply for vision group benefits provided under my employer's group plan and authorize payroll deductions for the cost of coverage.

☐ Accept Enrollment ☐ Decline Enrollment

STATEMENT AND SIGNATURE
If my choice is to decline coverage at this time, I understand that I have been given the opportunity to enroll now and that I will be given the opportunity to enroll at the next open enrollment period. I also understand that my spouse, dependents and I (if my spouse and dependents are enrolled) must remain in the plan for no less than 12 months from the coverage effective date unless I terminate my employment.

Total number in family that you are enrolling including yourself: _____

Employee Signature _____ Date _____