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CITY OF LEXINGTON
New Vision Plan Announcement

We are pleased to announce that we are now offering a standalone vision plan effective 7/1/2024. City of Lexington will be removing vision coverage (exam and hardware allowance) from the medical plan through UMR. We are excited to offer a more robust standalone vision plan through EyeMed. This guide is intended to provide a summary of the new vision benefit available to all benefit eligible retirees. It is only an overview and you must review specific plan brochures and plan documents for full program details, limitations and exclusions. If you have comments, questions, or other inquiries, please contact Human Resources at 336-248-3955.

Please complete the election form attached to enroll and return to Angie Fishel by email, mail or fax before May 24, 2024. *Please note that you must complete this form even if you intend to waive coverage.*

Email: COLBenefits@lexingtonnc.gov

Fax: Addressed to Angie Fishel at: (336) 248-4545

Mail: City of Lexington Human Resources, Attn: Angie Fishel
28 W Center Street, Lexington, NC 27292

Vision Plan

www.eyemed.com | 866.939.3633

	IN-NETWORK	OUT-OF-NETWORK
Eye Exam (Once every 12 months)	$10 Copay	Up to $40 Allowance
Lenses (Once every 12 months)		
Single Vision	$10 Copay	$30 allowance
Bifocal	$10 Copay	$50 allowance
Trifocal	$10 Copay	$70 allowance
Progressive – Standard	$65 Copay	$50 allowance
Progressive – Premium Tier I, II, III	$95, $105, or $120 Copay	$50 allowance
Progressive – Premium Tier IV	$225 Copay	$50 allowance
Frames (Once every 12 months)	Up to $180 allowance (20% off remaining balance)	Up to $126 allowance
Contact Lenses (Once every 12 months)	Conventional: Up to $180 plus (15% off remaining balance) Disposable: Up to $180	Up to $126 allowance

The plan allows members to receive either contacts and frame/ frames and lenses.

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Vision Benefit Election Form

July 1, 2024 Plan Year

Retiree Information

First Name: ________________________________ MI: ______ Last Name: _________________________________

SSN: __________________ Date of Birth: _____________________ Primary Phone: (______) _______-_________

Mailing Address: _______________________________ City: _______________ State: _____ Zip: _________

Email Address: ____

Please note, only spouse and/or child(ren) currently enrolled in the retiree medical plan are eligible for enrollment in the new standalone vision plan.

BENEFIT ELECTIONS

Vision Plan: EyeMed (Monthly Rates)
I elect the following coverage:
☐ Retiree Only $2.00
☐ Retiree/Spouse $4.00
☐ Retiree/Child $4.00
☐ Retiree/Children $6.00
☐ Family $8.00

☐ **I decline coverage**

PLEASE READ AND SIGN BELOW
I acknowledge that I have received and read the enrollment materials for the City of Lexington. I understand that the benefits for which I will be eligible are those described in my employer's plan documents. I understand that the monthly premium for the benefits elected above will be drafted from my existing UMR Retiree Direct Billing account beginning July 1, 2024. I understand that my contributions for the benefits elected above will be deducted from my pay. I understand that only spouses and children currently enrolled in the retiree medical plan are eligible for enrollment in the new standalone vision plan. I acknowledge that all sections of this enrollment form and the elections made above are true to the best of my knowledge.
SIGNATURE: ____ DATE: ______________________________

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