



SCHAEFFER EYE CENTER

	Avg. Retail	Vision Choice Advantage AEA	SEC Discount Plan AFT/ <i>Free</i>	Member Saves
Professional Services				
Comprehensive Exam:	\$99	\$49	*\$20/\$40	89%
Material Benefits				
Frames: (examples)				
Collection	\$69	\$20	\$0	100%
SEC	\$159	\$127	\$110	30%
Flexon	\$199	\$159	\$159	20%
Plastic CR-39 Lenses				
Single Vision	\$89	\$40	\$40	55%
Bifocal	\$119	\$64	\$50	58%
Trifocal	\$169	\$87	\$60	64%
Adaptar	\$199	\$100	\$95	52%
Polycarbonate Lenses				
Single Vision	\$149	\$50	\$50	66%
Bifocal	\$199	\$78	\$64	68%
Trifocal	\$249	\$103	\$76	69%
Adaptar	\$229	\$206	\$183	20%
Lens Options				
Crizal Coating	\$99	\$65	\$65	34%

*Cost of exam will vary, depending on if the member purchases eyewear.

- \$20- if patient purchases a complete pair of glasses (frames and lenses) or purchases contact lenses
- \$40- if patient does not purchase eyewear

SEE THE DIFFERENCE WITH SCHAEFFER EYE CENTER

SCHAEFFER VISION PLAN

Prepaid Plan Savings Summary

	Avg. Retail	SVP Prepaid Plan AFT
-Exam: (with/without) Purchase of Glasses or Contacts.	\$79	\$0
-Visual Fields Test (not part of exam and is voluntary)	\$14	\$14
Monthly Prepayment		
Single	N/A	\$5.95
Family	N/A	\$13.95
Copayments		
Exam	N/A	\$15
Materials	N/A	\$20
Total:		\$35
Material Benefits		
Frames:		
-Collection Frames (up to 150 to choose from)	\$69-\$109	\$0
-SEC Frame	\$159	\$47
-Flexon	\$199	\$79
-Calvin Klein	\$245	\$116
Lenses:		
Plastic		
Single Vision	\$89	\$0
Bifocal	\$119	\$0
Trifocal	\$169	\$0
Progressive-Adaptar	\$199	\$40
Progressive- Varilux Panamic	\$329	\$120
Polycarbonate		
Single Vision	\$149	\$20
Bifocal	\$199	\$36
Trifocal	\$249	\$50
Progressive-Adaptar	\$229	\$48
Progressive- Varilux Panamic	\$359	\$152
High Index 1.60		
Single Vision	\$209	\$96
Bifocal	\$279	\$128
Trifocal	N/A	N/A
Progressive-Adaptar	\$299	\$150
Progressive- Varilux Panamic	\$399	\$184
All other lenses and lens options		(Retail x 80%)-covered lens allowance
Lasik Discount		
-Evaluation	\$99	\$0
-Basic Lasik Surgery	\$1399 (per eye)	\$1299 (per eye)

**Please fill in all areas of the enrollment form. We must know the school system and worksite for processing. Thank you.



Schaeffer Eye Center
300 CAHABA PARK CIRCLE, SUITE 202
Birmingham, AL 35242
205.995.2020
1-888-491-2020

EMPLOYER/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)

		Group Number AFT	Work Facility	Effective Date *	Date of Hire
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone ()	Work Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)

<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student? Yes No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No

Do you or any of your dependents have other vision insurance? Yes No
 If yes, please give: Policyholder _____ and Insurance Company _____
 Employee Signature: _____ Date: _____

I elect the following coverage(s):

<input type="checkbox"/> Vision	<u>Employee Paid Rates</u>
<input type="checkbox"/> Employee Only	\$ 5.95
<input type="checkbox"/> Employee & Family	\$ 13.95
<input type="checkbox"/> Waived	

Declination of coverage must be accompanied by the employee's signature above.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.