Polk County, IA

Group Number: 63000-49
Plan Number: 150150LZ1L3

Member Copay	
Materials Applies to frame or spectacle lenses, if applicable.	$10 copay

Frequency	
Lenses or Contact Lenses	Once every 12 months
Frame	Once every 24 months

Vision Care Services	In-Network Member Cost*	Out-of-Network Reimbursement
Frame Allowance		
Up to 20% discount above frame allowance.*	$150 allowance	Up to $50
Standard Spectacle Lenses		
Single Vision	Covered in full after $10 copay	Up to $25
Bifocal	Covered in full after $10 copay	Up to $40
Trifocal	Covered in full after $10 copay	Up to $50
Lenticular	Covered in full after $10 copay	Up to $80
Preferred Pricing Options*	**Level 3 Option Package**	
Polycarbonate (Single Vision/Multi-Focal)	Covered in full	Up to $10
Standard Scratch-Resistant Coating	Covered in full	Up to $5
Ultraviolet Screening	Covered in full	Up to $6
Solid or Gradient Tint	Covered in full	Up to $4
Standard Anti-Reflective Coating	Covered in full	Up to $24
Standard Progressives†	$50 allowance	Up to $40
Premium Progressives	Balance after $50 allowance + up to 20% off retail	Up to $40
Plastic Photochromic (Single Vision/Multi-Focal)	$70/$80 member OOP maximum	N/A
Polarized	$75 member OOP maximum	N/A
PGX/PBX	$40 member OOP maximum	N/A
Other Lens Options	Provider discount up to 20%*	N/A
Contact Lenses‡		
Elective	$150 allowance	Up to $128
Medically Necessary	Covered in full	Up to $250
Refractive Laser Surgery		
Up to 25% provider discount.¥	Onetime/lifetime $150 indemnity allowance	Onetime/lifetime $150 indemnity allowance

Rates

Employer Paid - See your H.R.

Here's How It Works

1. Find a provider at www.avesis.com.
2. Make an appointment.
3. Visit the provider for service.
4. Pay any copays or additional expenses.

How can we help you?

Avēsis Website:
www.avesis.com

Customer Service:
855-214-6777
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

^Hearing Provider:
844-366-0039 TTY: 711

*Discounts are not insured benefits.

†After $50 allowance, the member's out of pocket cost is $75 for Standard progressives or $110 for Premium progressives.

‡In lieu of frame and spectacle lenses.

¥Save up to 25% on average LASIK prices when you use Qualsight (visit qualsight.com/-avesis for more information).

^Discounts available on hearing tests and hearing aids via Amplifon.

At participating Walmart/Sam's locations, retail pricing for your plan is $82. At participating Costco locations, retail pricing is $84.99.

Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement, unless the provider accepts an assignment of benefits. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Avēsis provider. Out-of-network claim forms can be obtained by contacting Avēsis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

Termination Provisions

The coverage will continue as long as the group policy remains in force, the premiums are paid, and as long as the employee and any covered dependents remain eligible and the employees coverage remains in force.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avēsis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations

Vision Materials. Fees charged by a Provider for services other than covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

With the exception of the contact lens allowance, benefit allowances provide no remaining balance for future use within the same Benefit Period.

Exclusions

No benefits will be paid for services or materials connected with or charges 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 an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy;
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; or
8. Services or materials provided by any other group benefit plan providing vision care.
9. Any vision examination.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

Refractive Surgery Vision Benefit Exclusions

Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2. Medical or surgical procedures, services, or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance
   c. payable under any Workers' Compensation law or similar statutory authority
   d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

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