

Group Number:

Plan Number:

Member Copay		Frequency	
Vision Exam		Vision Exam	
Materials Applies to frame or spectacle lenses, if applicable.		Lenses or Contact Lenses	
		Frame	

Vision Care Services	In-Network Member Cost*	Out-of-Network Reimbursement
Vision Exam		
Includes refraction		
Retinal Imaging		
Contact Lens Fit and Follow-up (CLEFFU)		
Standard CLEFFU		
Custom CLEFFU		
Frame Allowance		
Up to 20% discount above frame allowance.*		
Standard Spectacle Lenses		
Single Vision		
Bifocal		
Trifocal		
Lenticular		
Preferred Pricing Options*		
Polycarbonate (Single Vision/Multi-Focal)		
Standard Scratch-Resistant Coating		
Ultraviolet Screening		
Solid or Gradient Tint		
Standard Anti-Reflective Coating		
Standard Progressives†		
Premium Progressives		
Plastic Photochromic (Single Vision/Multi-Focal)		
Polarized		
PGX/PBX		
Other Lens Options	Provider discount up to 20%*	N/A
Contact Lenses‡		
Elective		
Medically Necessary	Covered in full	
Refractive Laser Surgery		
Up to 25% provider discount.*		

Rates

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 Quasight (visit quasight.com/-avesis for more information).

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

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 Examination and Vision Materials. Fees charged by a Provider for services other than Vision Examination or 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.

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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