# Base Plan - Leon County Schools

Group Number: 30790-1886
Plan Number: 150150FY3-L1

avēsis

| Member Copay | |
|---|---|
| Vision Exam | $10 copay |
| Materials<br>Applies to frame or spectacle lenses, if applicable. | $15 copay |

| Frequency | |
|---|---|
| Vision Exam | Once every 12 months |
| Lenses or Contact Lenses | Once every 12 months |
| Frame | Once every 12 months |

| Vision Care Services | In-Network Member Cost* | Out-of-Network Reimbursement |
|---|---|---|
| **Vision Exam** | | |
| Includes refraction | Covered in full after $10 copay | Up to $35 |
| Retinal Imaging | Up to $45 member out-of-pocket (OOP) maximum | N/A |
| **Contact Lens Fit and Follow-up (CLEFFU)** | | |
| Standard CLEFFU | Covered in full | N/A |
| Custom CLEFFU | Covered in full | N/A |
| **Frame Allowance** | | |
| Up to 20% discount above frame allowance.* | $150 allowance | Up to $50 |
| **Standard Spectacle Lenses** | | |
| Single Vision | Covered in full after $15 copay | Up to $25 |
| Bifocal | Covered in full after $15 copay | Up to $40 |
| Trifocal | Covered in full after $15 copay | Up to $50 |
| Lenticular | Covered in full after $15 copay | Up to $80 |
| All Other Progressives | Balance after $50 allowance + up to 20% off retail | Up to $40 |
| **Preferred Pricing Options*** | **Level 1 Option Package** | |
| Polycarbonate (Single Vision/Multi-Focal) | $40/$44 member OOP maximum | N/A |
| Standard Scratch-Resistant Coating | $17 member OOP maximum | N/A |
| Ultraviolet Screening | $15 member OOP maximum | N/A |
| Solid or Gradient Tint | $17 member OOP maximum | N/A |
| Standard Anti-Reflective Coating | $45 member OOP maximum | N/A |
| 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 |

Avēsis vision insurance products are underwritten by Fidelity Security Life Insurance Company® (FSL), Kansas City, MO, when insured by FSL. Approved by FSL 4/23. Administered by Avēsis. Policy # VC-16, Form M-9059.

## Rates

**Employee Paid - 10 Month Rates**

| | |
|---|---|
| Employee Only | $ 7.84 |
| Employee + One | $ 15.24 |
| Employee + Family | $ 22.38 |

## Rates

**Employee Paid - 12 Month Rates**

| | |
|---|---|
| Employee Only | $ 6.53 |
| Employee + One | $ 12.70 |
| Employee + Family | $ 18.65 |

## 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 L1 progressives or $110 for L2 progressives.

‡In lieu of frame and spectacle lenses.

§Enhanced benefit for certain conditions.

¥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 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.

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.

**Avēsis**
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