Vision Plan

For: TWU Local 556

Buy-Up plan

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
Vision Examination		
(includes Refraction)	Covered in full after $10 copay	Up to $35
Retinal Imaging	Up to $45 member out-of-pocket maximum	N/A
Contact Lens Fit and Follow-up		
Standard Contact Lens Fitting	Up to $50 member out-of-pocket maximum	N/A
Custom Contact Lens Fitting	Up to $75 member out-of-pocket maximum	N/A
MATERIALS*	$0 copay(Materials copay applies to frame or spectacle lenses, if applicable.)	
Frame Allowance (Up to 20% discount above frame allowance.)	$150 allowance	Up to $50
Standard Spectacle Lenses		
Single Vision	Covered in full after $0 copay	Up to $25
Bifocal	Covered in full after $0 copay	Up to $40
Trifocal	Covered in full after $0 copay	Up to $50
Lenticular	Covered in full after $0 copay	Up to $80
Prefered Pricing Options Level T7 Option Package		
Polarized	$75 member OOP maximum	N/A
PGX/PBX	$40 member OOP maximum	N/A
Plastic Photochromic (Single Vision/Multi-Focal)	Covered in Full	Up to $30
Polycarbonate (Single Vision/Multi-Focal)	Covered in Full	Up to $10
Solid or Gradient Tint	Covered in Full	Up to $4
Standard Anti-Reflective Coating	Covered in Full	Up to $24
Standard Scratch-Resistant Coating	Covered in Full	Up to $5
Ultra-Violet Screening	Covered in Full	Up to $6
Premium Progressives	$140 allowance + up to 20% discount off retail	Up to $70
Standard Progressives (Level 1/2)	Covered in Full	Up to $60
Other Lens Options	Provider discount up to 20%	N/A
Contact Lenses † (in lieu of frame and spectacle lenses)		
Elective(10% discount on amount exceeding allowance)	$150 allowance	Up to $128
Medically Necessary	Covered in full	Up to $250
Refractive Laser Surgery	$600 allowance	$600 allowance
PLAN DETAILS		
Contribution	Voluntary	
Frequency		**Rates**
Eye Exam Lenses and Contact Lenses Frame	Once every 12 months Once every 12 months Once every 12 months	EE Only : $12.24 EE and Spouse : $23.34 EE and Children : $24.50 EE and Family : $32.18

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Discounts are not insured benefits.
*At participating Walmart/Sam's locations, retail pricing for your plan is $82.00. At participating Costco locations, retail pricing is $84.99
†Prior Authorization is required for medically necessary contacts.

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 Av#sis for reimbursement. 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 Av#sis provider. Out-of-network claim forms can be obtained by contacting Av#sis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

LIMITATIONS AND EXCLUSIONS

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence. Limitations: "This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Av#sis provider. Benefits are payable only for services received while the group and individual member's coverage is in force." Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from: 1) Orthoptics or vision training; 2) Subnormal vision aids and any supplemental testing, aniseikonic lenses; 3) Plano (non-prescription) lenses, sunglasses; 4) Two pair of glasses in lieu of bifocal lenses; 5) Any medical or surgical treatment of eye or supporting structures; 6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services; 7) Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear; 8) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State, or subdivision thereof. 9) Services or materials provided by any other group benefit plan providing vision care.

TERMINATION PROVISIONS

Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

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. Av#sis 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.

Insured benefits are administered by Avesis Third Party Administrators, LLC, Phoenix, AZ