Aflac Vision Insurance

Plan benefit highlights for: Sharyland ISD

Group Number: AFCA2516738
Effective Date: 01/01/2025

In and Out-of-Network benefits	
Service type	**Frequency**
Eye examinations inclusive of dilation (when professionally indicated)	Once every 12 months
Eyeglass lenses	Once every 12 months
Frame	Once every 24 months
Contact lens evaluation, fitting and follow-up care (in lieu of eyeglasses)	Once every 12 months
In-Network benefits	
Covered services	**Member co-pays**
Eye examination/ Eyeglass lenses	$10 / $25
Eyeglass Benefit-Frame	
Frame allowance (retail) 20% overage discount**	Up to $150 OR Up to $200*****
Davis Vision Frame Collection (in lieu of allowance)	
Fashion level/Designer level/Premier level***	$0/ $0/ $0

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999 | 1.855.819.1873

Materials – Eyeglass Lenses********	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$0
Tinting of plastic lenses	$0
Scratch-resistant coating	$0
Polycarbonate lenses children****/adults	$0/$30
Ultraviolet coating	$12
Antireflective (AR) coating (standard/premium/ultra/ultimate)	$35/$48/$60/$85
Progressive lenses (standard/premium/ultra/ultimate)	$50/$90/$140/$175
High-index lenses 1.6/1.74	$55/$120
Polarized lenses	$75
Plastic photochromic lenses	$65
Scratch-protection plan: single vision/multifocal lenses	$20/$40
Retinal imaging	$39
Blue light filtering	$15
Digital single vison (intermediate)	$30
Contact Lenses Benefit (in lieu of eyeglasses) – Standard and Specialty Lens Types	
Contact lens material allowance – plus 15% discount on any overage [1]	Up to $150 + 15% off balance**
Evaluation, fitting and follow-up care – standard lens types (in lieu of eyeglasses)	15% discount**
Evaluation, fitting and follow-up care – specialty lens types (in lieu of eyeglasses)	15% discount**
Collection Contact Lenses Benefit (in lieu of contact lens material allowance)***	
Materials disposable: up to	8 boxes/pairs
Planned replacement: up to	4 boxes/pairs
Evaluation, fitting and follow-up care	$0 co-pay
Non-Elective (Visually Required) Contact Lenses (with prior approval)	
Materials, evaluation, fitting and follow-up care	$0 co-pay

Out-of-network benefits	
Covered services	**Reimbursement allowance schedule**
Eye examination	Up to $35
Frame	Up to $50
Single-vision lenses	Up to $25
Bifocal/progressive lenses	Up to $40
Trifocal lenses	Up to $50
Lenticular lenses	Up to $80
Elective contact lenses	Up to $128
Non-elective (visually required) contact lenses	Up to $250

** Additional discounts not applicable at Glasses.com, 1-800 Contacts, Walmart locations, Sam's Club locations, or Costco locations or where limited by law or manufacturer restrictions. Discounts are not part of insured benefits. 30% discount off additional pair of frames
*** Collection is available at most participating independent provider offices. Collection is subject to change.
**** Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
***** Enhanced frame allowance is available at all Visionworks locations nationwide.
******** Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and
subject to change without notice.

24/7 Online access	Customer care center
www.aflac.com/VisionNetwork	**1-855-819-1873**

Monthly rates		
EMP	EMP + 1 Dependent	EMP & Family
$4.85	$8.47	$12.41

We make it easy to find a provider. You can visit www.aflac.com/VisionNetwork and click "Provider Search" or visit DavisVision.com to search for a provider or call Davis Vision directly at 1.800.999.5431**.**

Benefits and/or premiums may vary based on the state and benefit option selected. The plan has limitations and exclusions that may affect benefits payable. The plan may contain a waiting period. Refer to the policy and certificate for complete benefit details, definitions, limitations and exclusions. This is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions as well as a complete list of the Schedule of Benefits payable under the plan.

LIMITATIONS AND EXCLUSIONS

State references within this brochure refer to the state of your group and not your resident state.

Limitations

Eyeglass lenses and frames are paid in lieu of the contact lenses benefit.
Contact lenses are payable in lieu of eyeglass lenses and frames.
Coverage for a late entrant or re-enrollee is limited to the vision exam benefit during the first 24 months after such person's effective date of coverage.
Dilation is covered in full under the vision exam benefit only if required by state law or done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

Exclusions

No benefits are payable for any of the following conditions, services, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:
• Replacement frames and/or lenses, except at normal intervals when covered services or materials are otherwise available;
• Plano lens or non-prescription lenses or sunglasses;
• Orthoptics, vision training and any associated supplemental testing;
• Frame cases;
• Low (subnormal) vision aids or aniseikonic lenses;
• Medical and surgical treatment of the eyes;
• Charges incurred after (a) the policy ends; or (b) the insured person's coverage under the policy ends, except as stated in the policy;
• Any eye examination or corrective eyewear required by an employer as a condition of employment;
- In Arkansas, this exclusion does not apply.
•Services for which benefits are paid by worker's compensation;
• Blended bifocal lenses;
• Groove, drill or notch, and roll and polish;
• Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
• Coating on lenses (factory scratch coat, anti-reflective, sunglass colors, etc.);
• Cosmetic items;
• Faceted lenses;
• High-index lenses;
• Laminated lenses;

• Oversize lenses – any lens with an eye size of 61mm or greater;
• Photochromic (transition) lenses;
• Polaroid lenses;
• Polished bevel lenses;
• Polycarbonate lenses, except for insured members under 19;
• Prism lenses;
• Slab-off lenses;
• Tints (except pink tint #1 and #2);
• Ultra-violet tint or coating;
• Additional cost for contact lenses over the allowance;
• Additional cost for a frame over the allowance;
• Progressive power lenses;
    • In Texas:
    - Services and procedures performed by an ophthalmologist, optician, and optometrist who is the insured person, or a family member.

No benefits are payable for services performed by a member of the insured person's family. Insured person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents.

NOTICE: The coverage offered is not a qualified health plan (QHP) under the Patient Protection and Affordable Care Act (ACA) and is not required to satisfy essential health benefits mandates of the ACA. The coverage provides limited benefits.

Vision Network: Davis Vision | Capital Region Health Park, Suite 301 | 711 Troy-Schenectady Road | Latham, NY

Applies to Policy Series QNV1000.
In Arkansas, policy form QNV1100MAR. In Oklahoma, policy form QNV1100MOK. In Oregon, policy form QNV1100MOR and QNV1100MORS. In Pennsylvania, policy form QNV1100MPA. In Texas, policy form QNV1100MTX.