

Aflac Vision Insurance

Plan benefit highlights for: Wiseburn Unified School District

Effective Date: 10/01/2023

| 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/\$10 |
| Eyeglass Benefit-Frame | |
| Frame allowance (retail) 20% overage discount ¹ | Up to \$150 OR Up to \$200 ² |
| Davis Vision Frame Collection (in lieu of allowance) | |
| Fashion level Designer level Premier level | \$0/ \$0/ \$0 |

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at 1-855-819-1873. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Servicios de Idiomas sin costo alguno. Usted puede conseguir un intérprete. Usted puede obtener los documentos leer a usted y algunos enviados a usted en su idioma. Para obtener ayuda, llame al 1-855-819-1873. Para obtener más información puede llamar al Departamento de Seguros al 1-800 -927-4357.

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 | \$55 |
| 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 vision (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 |
| Evaluation, fitting and follow-up care – standard lens types (in lieu of eyeglasses) | Covered in Full |
| Evaluation, fitting and follow-up care – specialty lens types (in lieu of eyeglasses) | \$60 allowance, plus a 15% discount on any overage ¹ |
| 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 \$40 |
| Frame | Up to \$50 |
| Single-vision lenses | Up to \$40 |
| Bifocal/progressive lenses | Up to \$60 |
| Trifocal lenses | Up to \$80 |
| Lenticular lenses | Up to \$100 |
| Elective contact lenses | Up to \$105 |
| Non-elective (visually required) contact lenses | Up to \$225 |

¹Discounts are not part of insured benefits. 30% discount off additional pair of frames

²At Visionworks® locations.

| 24/7 Online access | Customer care center | Claims address |
|-----------------------------|----------------------|---|
| www.aflac.com/VisionNetwork | 1-855-819-1873 | American Family Life Assurance Company of Columbus Aflac Benefits Solutions, Inc. c/o Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110 |

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

Limitations

Eyeglass lenses and frames are paid in lieu of in addition to the contact lenses benefit.

Contact lenses are payable in lieu of in addition to 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;
- 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;

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- Photochromic (transition) lenses;
- Polaroid lenses;
- Polished bevel lenses;
- Polycarbonate lenses, except for insured members under 19;
- Prism lenses;
- Lab-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;

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.