Your Avesis Vision Plan

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 insured under the plan, as shown in the summary of benefits, the member will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions: There are no benefits paid under the plan for services or materials connected with and arising from: 1) Orthoptics or vision training; 2) Subnormal vision aids and any supplemental testing; 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; 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.

Notes and Disclaimers

Notes and Disclaimers: Dilation is covered based on the following conditions: central vision loss, photopsia, floaters, history of ocular surgery, history of ocular trauma, history of ocular disease high myopia or diabetes. If these conditions do not exist, members will receive Avesis' Preferred Pricing (20% off retail).

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, or both contact lenses and professional services (fitting fees).

Laser vision correction is considered Refractive Surgery, an elective procedure, and may involve potential risks to patients. Avesis is not responsible for the outcome of any refractive surgery.

Only one co-pay applies to either frame or lenses.

Termination Provisions: Coverage will end on the earliest of: the date the policy ends, the end of the last period for which any required contribution agreed to in writing has been made, the date you are no longer eligible for insurance, the date the NE Farm Bureau terminates the plan, the date you are no longer a member of the Nebraska Farm Bureau.

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

Using your In-Network Vision Benefit

When you need to see an eye care professional, simply visit www.avesis.com or contact Avesis' Customer Service Monday through Friday, 7AM to 8PM (EST) at 1-800-828-9341 to receive a listing of providers in your area.

1 Select a provider

2 Contact provider for an appointment

3 Visit provider for service

4 Pay any co-pays or additional uncovered expenses

Important Information

Avesis Website: **avesis.com**
Customer Service Number: **1-800-828-9341**
LASIK Provider Number: **1-888-314-4619**

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

Avēsis
A National Vision, Dental and Hearing Company

AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company *Kansas City, Missouri*

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth	*Social Security Number*	*Sex*
/ /	- -	☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code*
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name FIRST	LAST	*Date of Birth*
Spouse / Domestic Partner			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /

☐ *I would like to cover additional eligible dependents* (PLEASE LIST ON A SECOND ENROLLMENT FORM)

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.
I certify that I am eligible to participate and that the above information is correct.
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature	*Date* / /

A-00713VA M-9059VA

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ○ Dependent(s)	☐ **Change** ○ Address ○ Phone ○ Name ○ COBRA	☐ **Cancel Coverage** ○ Policy Holder ○ Dependent(s)

Reason for Change ☐ Employment Status
☐ Qualifying Event: (PLEASE STATE) ____________________

Member Effective Date / /	*Date of Employment* / /

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