Nevada Landscape Association Dental and Vision Plans

Dental Care Services	Premier Choice Network (PCN)	PPO	Out of Network	DHMO 400
Deductable (Applies to Basic and Major)	$25	$50	$50	$0
Class I Oral Exams, Prophylaxis (Cleanings), Flouride, X-rays	100%	100%	100%	Copays: $0–$80.00
Class II Emergency, Space Maintainers, Fillings, Oral Surgery, Sealants, Periodontics, Endodontics (Root Canal)	90%	80%	80%	Copays: $8.00–$365.00
Class III Inlays, Onlays, Crowns, Bridges, Dentures, Repairs	60%	50%	50%	Copays: $200.00–$350.00
Calendar Year Maximum	Plus Plan 6: $1,500 (MAC). Plus Plan 21: $2,000 (MAC).			Unlimited
Ortho Lifetime Maximum Child(ren) only	50% $1,500			Copay Child: $2,250 Copay Adult: $2,500
Waiting Period	12-month waiting period for major services for groups with fewer than 10 enrolled and no prior coverage.			N/A

Plus Plan 6

($1,500 calendar maximum, MAC)

		Region 1: 890, 891 Employee participation 65%	
		No Child Ortho	$1,500 Child Ortho
3 to 99 EEs	EE	$23.70	$23.70
	ES	$48.10	$48.10
	EC	$58.02	$67.90
	EF	$90.51	$102.71

		Region 2: 893, 894, 895, 897, 898 Employee participation 65%	
		No Child Ortho	$1,500 Child Ortho
3 to 99 EEs	EE	$27.12	$27.12
	ES	$55.05	$55.05
	EC	$65.98	$75.86
	EF	$103.06	$115.25

Plus Plan 21

($2,000 calendar maximum, MAC)

		Region 1: 890, 891 Employee participation 65%	
		No Child Ortho	$1,500 Child Ortho
3 to 99 EEs	EE	$25.36	$25.36
	ES	$51.49	$51.49
	EC	$60.19	$70.06
	EF	$94.84	$107.05

		Region 2: 893, 894, 895, 897, 898 Employee participation 65%	
		No Child Ortho	$1,500 Child Ortho
3 to 99 EEs	EE	$29.04	$29.04
	ES	$59.85	$59.85
	EC	$68.78	$78.65
	EF	$108.03	$120.23

DHMO 400

		All Regions, All Contributions
2 to 99 EEs	EE	$15.62
	ES	$31.23
	EC	$42.46
	EF	$64.39

Plan summary available upon request

*For Plus Plans: Charges in excess of our maximum covered fee will not be considered covered under this policy.

**Premier Access does not guarantee all services can be rendered by a contracted PCN or PPO provider. You may be subject to a deductible and coinsurance for an out-of-network specialist.

Vision Care Services	In-Network	Out-of-Network
Vision Examination	Covered in full after exam copay	Up to $35
Contact Lens Fitting	Standard – Up to $50 copay Premium – Up to $75 copay	N/A N/A
Frame Allowance*	$130 retail allowance + up to 20% discount	Up to $45
Standard Spectacle Lenses		
Single Vision	Covered in full after materials copay	Up to $25
Bifocal	Covered in full after materials copay	Up to $40
Trifocal	Covered in full after materials copay	Up to $50
Lenticular	Covered in full after materials copay	Up to $80
Progressives	$50 allowance + 20% discount	Up to $40
Youth Polycarbonate	Covered in full after materials copay	Up to $10
Other Lens Options‡	Avēsis Preferred Pricing	N/A
Contact Lenses§ (in lieu of frame and spectacle lenses)		
Elective	$130 allowance	Up to $110
Medically Necessary	Covered in full	Up to $250
LASIK	Provider discount up to 25% $150 one-time/lifetime allowance	Up to $150

*Participating Walmart and Sam's Club locations cover frames up to a $68 retail value. Participating Costco locations cover frames up to a $74.99 retail value. No discounts apply.

†Values provided may be more or less, depending on the provider's retail pricing.

‡Discounts are not insured benefits.

§Prior authorization is required for medically necessary contacts.

Copays	
Vision Examination	$10
Materials	$25

Frequency	
Eye Examination	12 Months
Lenses or contact lenses	12 Months
Frame	24 Months

Monthly Rates Employee Participation 65%	
Employee Only	$5.79
Employee and Spouse	$10.13
Employee and Child(ren)	$12.15
Employee + One	N/A
Employee and Family	$15.05

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 Avēsis 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.

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.

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. 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.

Premium is subject to adjustment in the event of changes in benefits, contributions, or the number of eligible employees, or any future additional tax, fee or assessment imposed by the Federal or State governments with associated administrative costs and expenses.

Avēsis E-Series Vision Plan is underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Policy Form #VC-16.

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Premier Access
P.O. Box 659010
Sacramento, CA 95865

www.premierlife.com