Aflac Vision Insurance

Plan benefit highlights for: Katy ISD

Effective Date: 01/01/2026

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 12 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	$0/$0
Eyeglass Benefit-Frame	
Frame allowance (retail) 20% overage discount[1]	Up to $130 OR Up to $180[2]
Davis Vision Frame Collection (in lieu of allowance)	
Fashion level/Designer level/Premier level[3]	$0/$0/$25
Materials – Eyeglass Lenses[5]	
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[4]/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

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

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 $130
Evaluation, fitting and follow-up care – standard lens types (in lieu of eyeglasses)	15% discount[1]
Evaluation, fitting and follow-up care – specialty lens types (in lieu of eyeglasses)	15% discount[1]
Collection Contact Lenses Benefit (in lieu of contact lens material allowance)	
Materials disposable: up to	4 boxes pairs[3]
Planned replacement: up to	2 boxes pairs[3]
Evaluation, fitting and follow-up care	$0
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 $45
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 $110
Contact Lens Evaluation, Fitting and Follow-up Care (standard/specialty)	Up to $45
Exclusive Collection Contact Lenses Materials (Disposable/Planned Replacement)[3]	Up to $45
Non-elective (visually required) contact lenses	Up to $250

[1]Discounts are not part of insured benefits. 30% discount off additional pair of frames 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.
[2]At Visionworks® locations. Enhanced frame allowance is available at all Visionworks locations nationwide.
[3]Collection is available at most participating independent provider offices. Collection is subject to change.
[4]Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
[5]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.

Semi-Monthly Rates		
Employee	Employee + 1 Dependent	Family
$4.32	$7.26	$10.92

Customer care center
1-800-999-5431

We make it easy to find a provider. You can 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 ofin addition to the contact lenses benefit.
Contact lenses are payable in lieu ofin 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;
  - 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.