



The Camden Insurance Agency

An affiliate of Vision Plan of America

## **Camden/Avesis Advantage Plus**

**PPO Vision Plan C (12/24/24/24)**

Monthly **Employer Paid** 5+ enrolled

**TripleChoicePlan**

### **Camden Advantage Plus Benefit Frequency & Plan Design**

|               | <u>EXAMINATION</u> | <u>SPECTACLE LENSES</u> | <u>FRAME</u>     | <u>CONTACT LENSES</u> |
|---------------|--------------------|-------------------------|------------------|-----------------------|
| <b>PLAN C</b> | <b>12</b>          | <b>24 months</b>        | <b>24 months</b> | <b>24 months</b>      |

### **Advantage Plus Schedule of Benefits**

|                                | <u>IN-NETWORK</u>   | <u>OUT-OF-NETWORK</u>            |
|--------------------------------|---|----------------------------------|
| <b>EXAMINATION</b>             | Covered in full*  | Reimbursed up to \$45.00         |
| <b>Spectacle Lenses (pair)</b> |   |                                  |
| -Standard Single Vision        | Covered in full*  | Reimbursed up to \$35.00         |
| -Standard Bifocal              | Covered in full*  | Reimbursed up to \$45.00         |
| -Standard Trifocal             | Covered in full*  | Reimbursed up to \$55.00         |
| -Standard Lenticular           | Covered in full*  | Reimbursed up to \$120.00        |
| -Progressive                   | 20% off U&C, minus \$50 allowance*<br>*after stipulated co payment  | Reimbursed up to \$45.00         |
| <b>Lens Options</b>            | Preferred Pricing (20% off retail)  | Reimbursed up to \$0.00          |
| <b>Frame</b>                   | <b>\$50 wholesale allowance (approx. retail of \$100 to \$150) *</b>  | Reimbursed up to \$40.00         |
| <b>Contact Lenses</b>          | <i>(In lieu of frame and spectacle lenses)</i>  |                                  |
| -Elective                      | <b>\$130 allowance</b>  | Reimbursed up to <b>\$130.00</b> |
| -Medically Necessary           | Covered in full <b>(with prior approval)</b>  | Reimbursed up to \$250.00        |
| <b>LASIK Surgery Benefit</b>   | <i>In lieu of all other services for the benefit year. This is a one-time lifetime allowance. In Network Provider discounts up to 25% plus \$150 allowance.</i> | Reimbursed up to \$150           |

### **Plan Highlights**

- ✓ National Provider Network available at [www.AVESIS.com](http://www.AVESIS.com)
- ✓ Online Administration Available
- ✓ Comprehensive Interactive Website
- ✓ Member Website Allows (Printing Replacement ID Cards, Verifying Eligibility, Searching for a National Provider Network)
- ✓ Frame allowance approximately \$100 - \$150 (In Network)
- ✓ Cosmetic Contact Lens allowance up to \$130 (In & Out of Network)
- ✓ 100% coverage of Medically Necessary Contact Lenses (In Network)
- ✓ LASIK Refractive Surgery at Discounted Rates
- ✓ Mail Order Contact Lenses at Discounted Rates
- ✓ **UNIQUE Progressive Lens** benefit included
- ✓ **Specialty Lens Benefit Included**
- ✓ 20% OFF additional eyewear

### **MONTHLY EMPLOYER PAID RATES**

| <b>PLAN C (12/24/24/24)</b>    | <b>\$0 EXAM</b>      | <b>\$10 –EXAM</b>    | <b>\$10-EXAM</b>      |
|--------------------------------|----------------------|----------------------|-----------------------|
| <b><u>ANNUAL CO-PAY'S:</u></b> | <b>\$0 MATERIALS</b> | <b>\$0 MATERIALS</b> | <b>\$20-MATERIALS</b> |
| <i>Employee Only</i>           | \$7.57               | \$7.05               | \$6.40                |
| <i>Employee + Spouse</i>       | \$13.27              | \$12.33              | \$11.20               |
| <i>Employee + Children</i>     | \$15.92              | \$14.80              | \$13.44               |
| <i>Employee+ Family</i>        | \$19.71              | \$18.33              | \$16.63               |

- Policies and rates are guaranteed for two (2) years.
- **Minimum group size & participation of five (5) eligible employees. Groups with fewer than ten (10) eligible employees will be required to maintain eligibility and receive a monthly bill via Avesis' On-line E-billing & Eligibility Maintenance Program.**
- Rates assume an employer contribution of 75% or 50% employer contribution if enrollment is tied to the medical program.
- Rates assume **100% participation** by all-eligible employees or medical program enrollment.
- Co Payments do not apply for Out of Network or Contact Lens Benefit.



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**PPO Vision Plan C (12/24/24/12)**

Monthly **VOLUNTARY** 10 + enrolled

**Triple Choice Plan**

**Camden Advantage Plus Benefit Frequency & Plan Design**

|               | <u>EXAMINATION</u> | <u>SPECTACLE LENSES</u> | <u>FRAME</u>     | <u>CONTACT LENSES</u> |
|---------------|--------------------|-------------------------|------------------|-----------------------|
| <b>PLAN C</b> | <b>12</b>          | <b>24 months</b>        | <b>24 months</b> | <b>24 months</b>      |

**Advantage Plus Schedule of Benefits**

|                                       | <u>IN-NETWORK</u>   | <u>OUT-OF-NETWORK</u>                   |
|---------------------------------------|---|---|
| <b><u>EYE EXAMINATION</u></b>         | Covered in full*  | Reimbursed up to \$45.00                |
| <b><u>Spectacle Lenses (pair)</u></b> |   |   |
| -Standard Single Vision               | Covered in full*  | Reimbursed up to \$35.00                |
| -Standard Bifocal                     | Covered in full*  | Reimbursed up to \$45.00                |
| -Standard Trifocal                    | Covered in full*  | Reimbursed up to \$55.00                |
| -Standard Lenticular                  | Covered in full*  | Reimbursed up to \$120.00               |
| -Progressive                          | 20% off U&C, minus \$50 allowance*<br>*after stipulated co payment  | Reimbursed up to \$45.00                |
| <b><u>Lens Options</u></b>            | Preferred Pricing (20% off retail)  | Reimbursed up to \$0.00                 |
| <b><u>Frame</u></b>                   | <b><u>\$50 wholesale allowance (approx. retail of \$100 to \$150) *</u></b>   | Reimbursed up to \$40.00                |
| <b><u>Contact Lenses</u></b>          | <i>(In lieu of frame and spectacle lenses)</i>  |   |
| -Elective                             | <b><u>\$130 allowance</u></b>   | Reimbursed up to <b><u>\$130.00</u></b> |
| -Medically Necessary                  | Covered in full <b><u>(with prior approval)</u></b>   | Reimbursed up to \$250.00               |
| <b><u>LASIK Surgery Benefit</u></b>   | <i>In lieu of all other services for the benefit year. This is a one-time lifetime allowance. In Network Provider discounts up to 25% plus \$150 allowance.</i> | Reimbursed up to \$150                  |

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- ✓ Mail Order Contact Lenses at Discounted Rates
- ✓ **UNIQUE Progressive Lens** benefit included
- ✓ **Specialty Lens Benefit Included**
- ✓ 20% OFF additional eyewear

**MONTHLY VOLUNTARY RATES**

| <b>PLAN C (12/24/24/24)</b><br><b><u>ANNUAL CO-PAY'S:</u></b> | <b>\$0 EXAM</b><br><b>\$0 MATERIALS</b> | <b>\$10-EXAM</b><br><b>\$0 MATERIALS</b> | <b>\$10-EXAM</b><br><b>\$20-MATERIALS</b> |
|---|---|--|---|
| <i>Employee Only</i>  | \$10.03                                 | \$9.32                                   | \$8.47                                    |
| <i>Employee + Spouse</i>                                      | \$18.95                                 | \$17.63                                  | \$15.99                                   |
| <i>Employee + Children</i>                                    | \$20.65                                 | \$19.20                                  | \$17.43                                   |
| <i>Employee + Family</i>                                      | \$26.56                                 | \$24.71                                  | \$22.41                                   |

- Policies and rates are guaranteed for two (2) years.
- **Minimum group size & participation of ten (10) eligible employees.**
- Employees enrolling in the group voluntary plan must agree to remain enrolled during the designated plan period.
- Employees who elect not to enroll during the initial plan enrollment period must wait until the next plan enrollment period to enroll.
- Co payments do not apply to out of network or contact lens benefits.