INDIVIDUAL Advantage

The Allied Association brings benefits and services to individuals – allowing them to save money and make life easier

Vision/Hearing

Valued Ancillary Products

Maintaining your vision and hearing are an important part of your health. Do you know most health plans, including Medicare, don't cover glasses or hearing aids? Vision/Hearing Insurance can save you hundreds on these and other services!

Benefits include

- Eye Exam Every 12 Months
- Frames Every 24 Months
- Standard Plastic Lenses Every 12 Months
- Standard Progressives
- Contact Lenses
- Hearing Aid Allowance
- Hearing Screening/Exam Every 24 Months

avēsis a GUARDIAN company

amplifon Hearing Health Care

ALLIED NATIONAL A 90 Degree Benefits Company

Since 1978, Avesis has been providing vision, dental, and hearing health insurance services for millions of Americans. Amplifon Hearing Health Care makes it easy by connecting health and ancillary plans and their members with quality care, superior products, and an exceptional service experience. Allied National, a 90 Degree Benefits Company, along with the Allied Association, is working with trusted brands to provide individuals with the insurance and coverage they need.

INDIVIDUAL Advantage

Vision/Hearing

Do you know most health plans, including Medicare, don't cover glasses or hearing aids? Avesis, Amplifon and Med Supp's companion insurance products helps seniors save hundreds on services.

The plan includes:

- **Eye Exam** (every 12 months, plus one additional post-operative exam benefit if patient receives corneal transplant)
- **Frames** (every 24 months)
- **Standard Plastic Lenses** (every 12 months, plus one additional post-operative exam benefit if patient receives corneal transplant)
- **Standard Progressives**
- **Contact Lenses** (every 12 months, in lieu of eyeglasses)
- **Lens options**
- **Corneal tissue preparation fee** (in the event of cornea transplant)
- **Hearing Screening/Exam (Plan 130 only)** (every 24 months)
- **Hearing device allowance**
- **Hearing device, batteries, and maintenance plan discounts** provided by Amplifon participating providers

The amount of premium and benefits provided depend on the plan selected.

When utilizing in-network provider
Network providers have agreed to a negotiated, discounted dollar amount for each coverage charge. You may be billed the difference if charges for in-network services exceed the maximum allowable.

When utilizing out-of-network providers
If you receive services from a provider that is not included in the network, you will receive reimbursement based upon the out-of-network benefit schedule. You will receive a bill from the provider if out-of-network expenses exceed the maximum allowable charge.

The vision PPO network varies by state. Please refer to the provider directory at *www.avesis.com* for a complete list of available network providers in your area. Premiums vary by state. Not all plans or combinations of all benefits are available in all states.

This is an invitation to inquire about the Vision/Hearing Plan. This is a limited description of the plan. See the Enhanced Association Benefits information for complete details.

See and Hear Your Best!

Regular exams can identify correction needs and even signs of disease before problems appear. You can significantly reduce these costs with an insurance plan that provides cash allowances and negotiated discounts.

Plan Designs	100 Plan	130 Plan
Eye Exam *(Every 12 months)* *[1 additional post-operative exam benefit if patient receives corneal transplant]*	**In-Network:** Covered in full after $10 copay **Out-of-Network:** Up to $35 benefit	**In-Network:** Covered in full after $10 copay **Out-of-Network:** Up to $35 benefit
Frames *(Every 24 months)*	**In-Network:** $100 retail allowance after $25 combined materials copay **Out-of-Network:** Up to $25 benefit	**In-Network:** $130 retail allowance after $10 combined materials copay **Out-of-Network:**Up to $25 benefit
Standard Plastic Lenses *(Every 12 months)* *[1 additional post-operative lens benefit if patient receives corneal transplant]*	**In-Network:** 1 pair covered in full after $25 combined materials copay, Single vision, Lined bifocal, Lined trifocal, Lenticular **Out-of-Network:** Up to $25 benefit for standard, $40 for Lined bifocal, $50 for Lined trifocal, $80 for Lenticular	**In-Network:** 1 pair covered in full after $10 combined materials copay; Single vision, Lined bifocal, Lined trifocal, Lenticular **Out-of-Network:** Up to $25 benefit for standard, $40 for Lined bifocal, $50 Lined trifocal; $80 for Lenticular
Standard Progressives	**In-Network:** $50 retail allowance **Out-of-Network:** Up to $40 benefit	**In-Network:** $50 retail allowance **Out-of-Network:** Up to $40 benefit
Contact Lenses *Plan 100 is $25 copay and Plan 130 is $10.* *(Every 12 months, in lieu of eyeglasses)*	**In-Network:** Covered up to allowance. Conventional or disposable $110 allowance, CLEFFU[1] not covered, Medically necessary covered in full **Out-of-Network:** Conventional or disposable up to $80, medically necessary up to $250	**In-Network:** Covered up to allowance. Conventional or disposable $110 allowance. CLEFFU not covered, medically necessary covered in full. **Out-of-Network:** Conventional or disposable up to $80, medically necessary up to $250
Corneal Tissue Preparation Fee *(In the event of a corneal transplant)*	Covered up to $8,000	Covered up to $8,000
Cornea Post Operative Vision Exam *(Every 12 months)*	**In-network:** Covered in full after $10 copay **Out-of-Network:** Up to $35 benefit	**In-network:** Covered in full after $10 copay **Out-of-Network:** Up to $35 benefit
Hearing Screening/Exam *(Every 24 months)*	**In-Network:** No coverage **Out-of-Network:** No coverage	Hearing exam - $48 benefit (Comprehensive test to determine type and location of hearing loss) $48 reimbursement
Hearing Device Allowance	No coverage	$300 (per ear) every 5 years, plus additional discounts
Hearing Device, Batteries, and Maintenance Plan Discounts Provided by Amplifon Participating Providers*	• One year of follow-up care • Two years of free batteries • Three-year hearing aid warranty • Loss and damage protection	• One year of follow-up care • Two years of free batteries • Three-year hearing aid warranty • Loss and damage protection
Monthly Premium - per covered person	$10.20	$15.96

[1] *CLEFFU = Contact Lens Evaluation, Fitting, and Follow-Up Care*

* *Follow-up care - for one year following purchase. Batteries - two-year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply.*

Discounts are not insured benefits. Pricing and discounts may vary per provider.

The amount of premium and benefits provided depends on the plan selected.
The vision PPO network varies by state. Please refer to the provider directory at *www.avesis.com* for a complete list of available network providers in your area. Premiums vary by state. Not all plans or combinations of all benefits are available in all states.

TEN-DAY RIGHT TO EXAMINE POLICY
If the Insured is not satisfied for any reason, the Insured may return this Policy to the Company or to the Company's authorized representative within 10 days after receipt. Premium will then be refunded. When so returned, this Policy will be void from the beginning. For LA, SC and UT 30 day free look.

INDIVIDUAL Advantage

Vision Coverage

Effective Date
The plan will be effective the first of the month following request for coverage, or a future selected effective date not more than 60 days following enrollment. Due date for payment will be the same as the effective date.

Termination of Coverage
This policy will end on the earliest of the following dates:

- The last day for which the required premium is not paid, subject to the Grace Provisions
- The date it is determined by a court of competent jurisdiction that an Insured Person has committed fraud against the Company
- Any premium date due on or after the first Policy Anniversary Date. The Company will give at least a 31-day written notice of the Company's intent to non-renew
- Any date on or after the date the Company receives written notice of the Insured's intent to cancel

Vision Exclusions
No benefits will be paid for services or materials connected with or charges arising from:

- Orthoptic or vision training, subnormal vision aids an any associated supplemental training; Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment and safety eyewear
- Services provided as a result of any Workers' Compensation law, similar legislation or required by a governmental agency or program whether federal, state or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid)
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Two pairs of glasses in lieu of bifocals. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Period when Vision materials would next become available
- Any services provided free of charge in the absence of insurance
- This is a general list of Exclusions. Exclusions may vary by state.

Pan-American Life Insurance Group is a leading provider of insurance and financial services throughout the Americas. Individual Vision insurance is issued by Pan-American Life Insurance Company on Policy form PAN-AM-POL-0519, Hearing Benefits Rider form PAN-AM-HBR-0519 and Cornea Health Benefits Rider form PAN-AM-CHB-0519. This is not a Medicare Supplement Policy. THIS PLAN PROVIDES LIMITED BENEFITS. Coverage is not available in all states. Like most insurance benefit programs, our products have exclusions, limitations, waiting periods and terms for keeping them in force. Full details of the coverage are contained within the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern. Allied Association and Amplifon are not affiliated with Pan-American Life.

INDIVIDUAL Advantage

Cornea Health

- Exclusions List: In addition to the exclusions in the Policy, no benefits will be paid under this Rider for services or materials:
- provided free of charge in the absence of insurance;
- payable under any governmental plan or program whether Federal, state or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid);
- for any Corneal Transplant medical or surgical treatment not listed in the Schedule of Benefits; or
- Any charge unrelated to tissue preparation for the purpose of Corneal Transplant; or
- Any service or material not listed in the Schedule of Benefits.

Hearing Coverage (Plan 130)

Hearing

The Company will pay the benefit shown in the Schedule of Benefits for a Hearing Aid prescribed by a physician or audiologist. The hearing aid must be ordered and received while the Insured's coverage under this Rider is in force.

Hearing Exclusions

In addition to the exclusions in the Policy, no benefits will be paid under this Rider for services or materials:

- Provided free of charge in the absence of insurance
- Payable under any governmental plan or program whether Federal, state, or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid)
- For the medical and/or surgical treatment of the internal or external structures of the ear(s)
- Provided by a Hearing Aid Dispenser
- Required by an employer as a condition of employment
- Not prescribed by a Physician or Audiologist
- For Hearing Aid batteries, cleaning supplies, or accessories
- For ear protection devices or plugs
- For Assistive Listening Devices
- For replacement due to loss, theft, of or damage to the Hearing Aid
- This is a general list of Exclusions. Exclusions may vary by state.

This is an invitation to inquire about the Vision/Hearing Plan. This is a limited description of the plan. See the Enhanced Association Benefits information for complete details.

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