**SUMMARY OF BENEFITS**

### Vision Care Services

<table>
<thead>
<tr>
<th>Exam With Dilation as Necessary</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 Co-pay</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Frames

- **Complete pair of prescription eyeglasses**
  - $0 Co-pay, $150 Allowance, plus 80% of balance over $150
  - Up to $90

### Standard Plastic Lenses

- **Single Vision**
  - $20 Co-pay
  - Up to $42

- **Bifocal**
  - $20 Co-pay
  - Up to $78

- **Tri-focal**
  - $20 Co-pay
  - Up to $130

- **Lenticular**
  - $20 Co-pay
  - Up to $130

- **Standard Progressive Lens**
  - $75 Co-pay
  - Up to $140

- **Premium Progressive Lens**
  - Tier 1: $105 Co-pay - $195 Co-pay
  - Tier 2: $115 Co-pay
  - Tier 3: $130 Co-pay
  - Tier 4: $195 Co-pay
  - Up to $196

### Lens Options

- **UV Treatment**
  - $0 Co-pay
  - Up to $12

- **Tint (Solid and Gradient)**
  - $0 Co-pay
  - Up to $12

- **Standard Polycarbonate**
  - $20 Co-pay
  - Up to $32

- **Standard Polycarbonate–Kids under 26**
  - $0 Co-pay
  - Up to $32

- **Standard Anti-Reflective Coating**
  - $45 Co-pay
  - Up to $5

- **Premium Anti-Reflective Coating**
  - Tier 1: $57 Co-pay – $85 Co-pay
  - Tier 2: $57 Co-pay
  - Tier 3: $57 Co-pay
  - Tier 4: $57 Co-pay
  - Up to $5

### Contact Lens Fit and Follow-Up

- **Standard Contact Lens Fit & Follow-Up**
  - $40 Co-pay
  - Up to $12

- **Premium Contact Lens Fit & Follow-Up**
  - $90 Co-pay
  - Up to $12

### Contact Lenses

- **Conventional**
  - $0 Co-pay, $150 Allowance, plus 85% of balance over $150
  - Up to $120

- **Disposable**
  - $0 Co-pay, $150 Allowance, plus balance over $150
  - Up to $120

- **Medically Necessary**
  - $0 Co-pay, paid-in-full
  - Up to $210

### Lasik Vision Correction

- **LASIK or PRK from U.S. Laser Network**
  - 15% off the retail price or 5% off the promotional price
  - N/A

### Hearing Care

- **Hearing Health Care from Amplifon Hearing Network**
  - 40% off hearing exams and a low price guarantee on discounted hearing aids
  - N/A

### Frequency

- **Examination**
  - Once every 12 months

- **Lenses (in lieu of contact lenses)**
  - Once every 12 months

- **Contact Lenses (in lieu of lenses)**
  - Once every 12 months

- **Frame**
  - Once every 24 months

- **Laser Vision correction**
  - Once per lifetime

### Premiums—Monthly Rate

<table>
<thead>
<tr>
<th></th>
<th>Subscriber</th>
<th>Subscriber + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$757</td>
<td>$19.30</td>
</tr>
</tbody>
</table>

**Benefits are not provided from services or materials arising from:**
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing,
- Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures,
- Any Vision Examination, or any corrective eyewear required by a Policy holder as a condition of employment, safety eyewear,
- Services provided as a result of any workers’ compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof,
- Any corrective eyewear required by a Policy holder as a condition of employment,
- Services provided as a result of any workers’ compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof,
- Plano (non-prescription) lenses,
- Non-prescription sunglasses,
- Two pairs of glasses in lieu of bifocals,
- Services or materials provided by any other group benefit plan providing vision care,
- Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
- Benefits may not be combined with any discount, promotional offering, or other group benefit plans.
- Standard/Premium Progressive lens not covered — fund as a Bifocal lens.
- Benefit allowance provides no remaining balance for future use within the same benefits year.
- Fees charged for a non-insured benefit must be paid in full to the Provider.
- Such fees or materials are not covered.
- Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60615, except in New York.
- This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.
- Premium progressives and premium anti-reflective designs are subject to annual review by EyeMed’s Medical Director and are subject to change based on market conditions.
- Fixed pricing is reflective of brands at the listed product level.
- Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

**Additional discounts**

- **40% OFF** Complete pair of prescription eyeglasses
- **20% OFF** Non-prescription sunglasses
- **20% OFF** Remaining balance beyond plan coverage

**Take a sneak peek before enrolling**

- You’re on the INSIGHT Network
- For a complete list of in-network providers nearby, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6
What’s in it for me?
Options. It’s simple really. We’re dedicated to helping you see clearly—and that’s why we’ve built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

And now it’s time for the breakdown . . .
Here’s an example of what you might pay for a pair of glasses with us vs. what you’d pay without vision coverage. So, let’s say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let’s see the difference...

<table>
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<tr>
<th>Benefits Snapshot</th>
<th>With EyeMed</th>
<th>Out-of-Network Reimbursement</th>
</tr>
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<tbody>
<tr>
<td>Exam, with dilation as necessary (once every 12 months)</td>
<td>$0 Co-pay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Frames (once every 24 months)</td>
<td>$0 Co-pay, $150 Allowance; plus 80% of balance over $150</td>
<td>Up to $90</td>
</tr>
<tr>
<td>Single Vision Lenses (once every 12 months) or Contacts (once every 12 months)</td>
<td>$20 Co-pay</td>
<td>Up to $42</td>
</tr>
<tr>
<td></td>
<td>$0 Co-pay, $150 Allowance; plus balance over $150</td>
<td>Up to $120</td>
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92% SAVINGS with us*

Download the EyeMed Members App
It’s the easy way to view your ID card, see benefit details and find a provider near you.

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.