STATE VISION PLAN SUMMARY OF BENEFITS FOR RETIREES

# Routine Vision Plan

| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **EXAM WITH DILATION AS NECESSARY** | 100% of EyeMed approved amount, $5 Copay | Reimbursement up to $34, $5 Copay, Member pays difference |
| **FRAMES** | | |
| Any available frame at provider location | $150 Allowance, Member pays difference | Reimbursement up to $38.25, Member pays difference |
| **STANDARD PLASTIC OR GLASS LENSES** | | |
| Single vision | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $17, $7.50 Copay, Member pays difference |
| Bifocal | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| Trifocal | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $43, $7.50 Copay, Member pays difference |
| Lenticular | 100% of EyeMed approved amount, $7.50 Copay | Not covered |
| Standard Progressive Lens | 100% of EyeMed approved amount, $7.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

STATE VISION PLAN SUMMARY OF BENEFITS FOR RETIREES

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| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **LENS OPTIONS** | | |
| Polycarbonate | 100% of EyeMed approved amount, $0 Copay | Not covered |
| Tint (Solid and Gradient) | 100% of EyeMed approved amount, $0 Copay | Not covered |
| Photochromic/Transitions | 100% of EyeMed approved amount, $0 Copay | Not covered |
| **CONTACT LENSES** | | |
| *Includes fit, follow-up and materials* | | |
| Conventional | $0 Copay; $150 Allowance, Member pays difference | Reimbursement up to $115, $0 Copay, Member pays difference |
| Disposable | $0 Copay; $150 Allowance, Member pays difference | Reimbursement up to $115, $0 Copay, Member pays difference |
| Medically Necessary | $7.50 Copay, 100% of EyeMed approved amount | Reimbursement up to $210, $7.50 Copay, Member pays difference |

| Vision Care Services | |
|---|---|
| Lasik | Lifetime maximum reimbursement for retirees and spouses up to $1,000 each for Lasik surgery; dependent children are not eligible** |

| Vision Care Services | Frequency (In-Network and Out-of Network) |
|---|---|
| Examination | Once every 12 months |
| Glasses [Frame and Lens; in lieu of contact lenses] | Once every 12 months |
| Contact Lenses [in lieu of Glasses] | Once every 12 months |

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

**Lasik reimbursement benefit is limited to a single laser surgery encounter per eye. Follow-up care enhancements or secondary procedures are excluded from coverage under the state vision benefit.

# EyeMed: Value added savings

| Vision Care Services | Member In-Network Coverage | Member Out-of-Network Reimbursement* |
|---|---|---|
| **RETINAL IMAGING BENEFIT** | Up to $39 | N/A |
| **FRAME** | | |
| Any available frame at provider location | 20% off balance over $150 | N/A |
| **STANDARD PLASTIC OR GLASS LENS** | | |
| Premium Progressive Lens–Tiers 1–3 | $27.50–$52.50 Copay | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| Premium Progressive Lens–Tier 4 | $7.50 Copay, 80% of charge less $120 Allowance | Reimbursement up to $30, $7.50 Copay, Member pays difference |
| **LENS OPTIONS** | | |
| UV Treatment | $15 | N/A |
| Standard Plastic Scratch Coating | $15 | N/A |
| Standard Anti-Reflective Coating | $45 | N/A |
| Premium Anti-Reflective–Tier 1–2 | $57–$68 | N/A |
| Premium Anti-Reflective–Tier 3 | 20% off Retail Price | N/A |
| Other Add-Ons | 20% off Retail Price | N/A |
| **CONTACT LENSES** | | |
| Conventional | 15% off balance over $150 | N/A |
| **LASER VISION CORRECTION** | | |
| Lasik or PRK from U.S. Laser Network | 15% off Retail Price or 5% off promotional price | N/A |

**Members also receive a 40% discount off additional complete pair eyeglass purchases and 20% off non-covered items, including non-prescription sunglasses**

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

# Disclaimers

**Additional Discounts:** Subject to exclusions, discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice are not eligible for discount.

**Plan Exclusions:** 1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2. Medical and/or surgical treatment of the eye, eyes or supporting structures; 3. 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; 4. Plano (non-prescription) lenses and/or contact lenses; 5. Non-prescription sunglasses; 6. Two pair of glasses in lieu of bifocals; 7. Services rendered after the date a member ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order; 8. Services or materials provided by any other group benefit plan providing vision care; 9. 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.