STATE VISION PLAN SUMMARY OF BENEFITS

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[1] Any available frame at provider location	$150 Allowance,** Member pays difference[1]	Reimbursement up to $38.25, $7.50 Copay, Member pays difference[1]
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
LENS OPTIONS Tint (Solid and Gradient)	100% of EyeMed approved amount, $0 Copay	Not covered
Photochromic/Transitions	100% of EyeMed approved amount, $0 Copay	Not covered

[1]One $7.50 Copay per complete pair of glasses (lenses and frame).

*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. **Frame allowance remains $100 for MSPTA-represented employees and individuals that retired from the State Police Enlisted Unit on or after 10/1/87.

STATE VISION PLAN SUMMARY OF BENEFITS

Routine Vision Plan

Vision Care Services	Member In-Network Coverage	Member Out-of-Network Reimbursement*
CONTACT LENSES		
Includes fit, follow-up and materials		
Conventional	$0 Copay; $130 Allowance, Member pays difference	Reimbursement up to $100, $0 Copay, Member pays difference
Disposable	$0 Copay; $130 Allowance, Member pays difference	Reimbursement up to $100, $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	Frequency (In-Network and Out-of Network)
Examination	Once every 12 months
Glasses [Frame and Lens; in lieu of contact lenses] [2]	Once every 24 months; Once every 12 months if prescription changes
Contact Lenses [in lieu of Glasses] [2]	Once every 24 months; Once every 12 months if prescription changes

[2] Members may obtain either eyeglasses or contact lenses, but not both.

*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

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 $100	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 Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$40	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 $130	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 complete pair eyeglass purchases*

*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.

Additional Discounts: Subject to exclusions, member receives a 20% discount on items not covered by the plan at network Providers. 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.