### Vision Care Services

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Reimbursement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with Dilation as Necessary</td>
<td>$0 Copay</td>
<td>$50</td>
</tr>
<tr>
<td>Retinal Imaging Benefit</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Exam Options:**

| Standard Contact Lens Fit and Follow-Up:        | Up to $55              | N/A                           |
| Premium Contact Lens Fit and Follow-Up:         | 10% off Retail Price   | N/A                           |

**Frames:**

Any available frame at provider location

$0 Copay; $130 Allowance; 20% off balance over $130

$40

**Standard Plastic Lenses**

| Single Vision                                    | $0 Copay              | $70                           |
| Bitical                                         | $0 Copay              | $80                           |
| Trifocal                                         | $0 Copay              | $90                           |
| Lenticular                                       | $0 Copay              | $90                           |
| Standard Progressive Lens                        | $65 Copay             | $80                           |
| Premium Progressive Lens                         | See attached Fixed Premium Progressive list | N/A                           |

**Lens Options:**

| UV Treatment                                     | $0 Copay              | $5                            |
| Tint (Solid and Gradient)                       | $0 Copay              | $5                            |
| Standard Plastic Scratch Coating                | $0 Copay              | $5                            |
| Standard Polycarbonate - Adults                  | $40                   | N/A                           |
| Standard Polycarbonate - Kids under 19          | $40                   | N/A                           |
| Standard Anti-Reflective Coating                 | $45                   | N/A                           |
| Polarized                                        | 20% off Retail Price   | N/A                           |
| Photocolormetric / Transitions Plastic           | $75                   | N/A                           |
| Premium Anti-Reflective                          | See attached Fixed Premium Anti-Reflective Coating list | N/A                           |
| Other Add-Ons                                    | 20% off Retail Price   | N/A                           |

**Contact Lenses**

| Conventional (Contact lens allowance includes materials only) | $0 Copay; $150 allowance, 15% off balance over $150 | $150 |
| Disposable                                                   | $0 Copay; $150 allowance, plus balance over $150   | $150 |
| Medically Necessary                                          | $0 Copay, Paid-in-Full                               | $210 |

**Laser Vision Correction**

| Lasik or PRK from U.S. Laser Network                    | 15% off Retail Price or 5% off promotional price   | N/A   |

**Additional Pairs Benefit:**

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

N/A

**Frequency:**

| Examination / Lenses or Contact Lenses / Frame         | Once every 12 months                                 |                               |

and not the negotiated discount rate with certain participating providers. Please see Eyemeds online provider locator to determine which participating providers have agreed to the discounted rate

**Additional Discounts:**

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.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use.

Certain brand name Vision Materials in which the manufacturer is Rates are valid only when the quoted plan is the sole stand-alone

Rates are valid for groups domiciled in the State of MI.

Rates assume greater than 80% Employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York.

Policy number HC-19/VC-30, form number H-9083

**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. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear;
4. 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;
5. Plane (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses;
6. Two pair of glasses in lieu of bifocals;
7. 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;
8. 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,
9. Services or materials provided by any other group benefit plan providing vision care;
10. 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.

N/A

**Sample Plans:**

Livonia Public Schools

EyeMed Insight Plan H

**Option 1**

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

<table>
<thead>
<tr>
<th>Option 1</th>
<th>EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company</th>
<th>Livonia Public Schools</th>
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| Examination / Lenses or Contact Lenses / Frame         | 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

Fees quoted will be valid until the 1/1/2016 plan implementation date. Date quoted: 10/7/2015.

Rates are valid for groups domiciled in the State of MI.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group

Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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