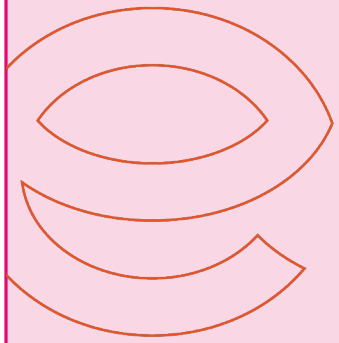
Addepar, Inc.

Insight network

FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	*once every plan year*	*once every plan year*
Frame (in lieu of contacts)	*once every plan year*	*once every plan year*
Lens (in lieu of contacts)	*once every plan year*	*once every plan year*
Contact Lens (in lieu of frame and lenses)	*once every plan year*	*once every plan year*
Additional Glasses Allowance	*once every plan year*	*once every plan year*
Plan allows member to receive frame and lens services or contacts.		

Vision Care Services	In-Network Member Cost at PLUS Provider	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam	*$0 copay*	*$10 copay*	*Up to $40*
Retinal imaging	*Up to $39*	*Up to $39*	*Not covered*
CONTACTS LENS FIT AND FOLLOW-UP			
Fit and Follow-up - Standard	*Up to $40*	*Up to $40*	*Not covered*
Fit and Follow-up - Premium	*10% off retail price*	*10% off retail price*	*Not covered*
FRAME			
Tier - Standard Frame	*$0 copay; 20% off balance over $250 allowance*	*$0 copay; 20% off balance over $200 allowance*	*Up to $140*
Tier - Smart Frame	*$0 copay; 20% off balance over $300 allowance*	*$0 copay; 20% off balance over $250 allowance*	*Up to $175*
Tier - Hearing Frame	*$0 copay; 20% off balance over $400 allowance*	*$0 copay; 20% off balance over $350 allowance*	*Up to $245*
STANDARD PLASTIC LENSES			
Single Vision	*$25 copay*	*$25 copay*	*Up to $30*
Bifocal	*$25 copay*	*$25 copay*	*Up to $50*
Trifocal/Lenticular	*$25 copay*	*$25 copay*	*Up to $70*
Progressive - Standard	*$90 copay*	*$90 copay*	*Up to $50*
Progressive - Premium Tier 1 - 3	*$110 - 135 copay*	*$110 - 135 copay*	*Up to $50*
Progressive - Premium Tier 4	*$90 copay, 20% off retail price less $120 allowance*	*$90 copay, 20% off retail price less $120 allowance*	*Up to $50*
LENS OPTIONS			
Anti Reflective Coating - Standard	*$45*	*$45*	*Not covered*
Anti Reflective Coating - Premium Tier 1 - 2	*$57 - 68*	*$57 - 68*	*Not covered*
Anti Reflective Coating - Premium Tier 3	*20% off retail price*	*20% off retail price*	*Not covered*
Photochromic - Non-Glass	*$75*	*$75*	*Not covered*
Polycarbonate - Standard	*$40*	*$40*	*Not covered*
Scratch Coating	*$15*	*$15*	*Not covered*
Tint			*Not covered*
UV Treatment			*Not covered*
All Other Lens Options	*20% off retail price*	*20% off retail price*	*Not covered*
CONTACT LENSES			
Contacts - Conventional	*$0 copay; 15% off balance over $250 allowance*	*$0 copay; 15% off balance over $200 allowance*	*Up to $140*
Contacts - Disposable	*$0 copay; 100% of balance over $250 allowance*	*$0 copay; 100% of balance over $200 allowance*	*Up to $140*
Contacts - Medically Necessary	*$0 copay; paid-in-full*	*$0 copay; paid-in-full*	*Up to $300*
ADDITIONAL GLASSES ALLOWANCE			
Glasses Allowance	*40% off retail*; 100% of balance over $100*	*40% off retail*; 100% of balance over $50*	*Up to $40*
OTHER			
Hearing Care from Amplifon Network	*Discounts on hearing aids; call 1.877.203.0675*	*Discounts on hearing aids; call 1.877.203.0675*	*Not covered*
Lasik or PRK from U.S. Laser Network	*15% off retail or 5% off promo price; call 1.800.988.4221*	*15% off retail or 5% off promo price; call 1.800.988.4221*	*Not covered*

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INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

This information is available broadly and is not plan or state specific.

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency, except for the following Allowance, for which any remaining balance may be used within the same Benefit Frequency: Vision Materials Allowance. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vi-sion Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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, glass-es, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. 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 the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits.