



| Vision Care Services | Member Cost In-Network | Out-of-Network Reimbursement* |
|---|---|--|
| Exam with Dilation as Necessary | \$10 Copay | \$40 |
| Retinal Imaging Benefit | Up to \$39 | N/A |
| Exam Options: Standard Contact Lens Fit and Follow-Up: Premium Contact Lens Fit and Follow-Up: | Up to \$40 10% off Retail Price | N/A N/A |
| Frames: Any available frame at provider location | \$0 Copay; \$150 Allowance, 20% off balance over \$150 | \$45 |
| Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens | \$20 Copay \$20 Copay \$20 Copay \$20 Copay \$85 Copay See attached Fixed Premium Progressive price list | \$40 \$60 \$80 \$80 \$60 \$60 |
| Lens Options: UV Treatment Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate - Adults Standard Polycarbonate - Kids under 19 Standard Anti-Reflective Coating Polarized Photocromatic / Transitions Plastic Premium Anti-Reflective Other Add-Ons | \$15 \$15 \$0 Copay \$40 \$40 \$45 20% off Retail Price \$75 See attached Fixed Premium Anti-Reflective Coating list 20% off Retail Price | N/A N/A \$8 N/A N/A N/A N/A N/A N/A N/A |
| Contact Lenses (Contact lens allowance includes materials only) Conventional Disposable Medically Necessary | \$0 Copay; \$125 allowance, 15% off balance over \$125 \$0 Copay; \$125 allowance, plus balance over \$125 \$0 Copay, Paid-in-Full | \$125 \$125 \$210 |
| Laser Vision Correction Lasik or PRK from U.S. Laser Network | 15% off Retail Price or 5% off promotional price | N/A |
| Amplifon Hearing Health Care | Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids. | 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 Once every 12 months Once every 24 months | |
| Monthly Rate Subscriber Subscriber + Spouse Subscriber + Child(ren) Subscriber + Family | \$3.66 \$6.91 \$7.23 \$13.51 | |

All plans are based on a 48-month contract term and 48-month rate guarantee.

Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* 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:

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 within the same Benefit Frequency.

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

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

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

Fees quoted will be valid until the 1/1/2021 plan implementation date. Date quoted: 2/21/2020.

Rates assume Employer contribution of 20% or less for employees and dependents

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

Policy number VC-19/VC-20, form number M-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) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 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, and the services rendered to the Insured Person are within 31 days from the date of such order; 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.

If Houston ISD has chosen this benefit design with the attached supplement, sign here:

Signature

Date

TCO

Houston ISD
 Supplement
 Option Base as is

| Progressive Price List* | Member Cost In-Network (Includes Lens Copay) |
|---|---|
| Standard Progressive | \$85 Copay |
| Premium Progressives as Follows: | |
| Tier 1 | \$105 Copay |
| Tier 2 | \$115 Copay |
| Tier 3 | \$130 Copay |
| Tier 4 | \$85 Copay, 80% of charge less \$120 allowance |
| Anti-Reflective Coating Price List* | Member Cost In-Network |
| Standard Anti-Reflective Coating | \$45 |
| Premium Anti-Reflective Coatings as Follows: | |
| Tier 1 | \$57 |
| Tier 2 | \$68 |
| Tier 3 | 80% of charge |
| Other Add-ons Price List | Member Cost In-Network |
| Photochromic (Plastic) | \$75 |
| Polarized | 80% of charge |
| EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. | |
| *Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. | |

For a current listing of brands by tier, go to:
<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>