

## HOW BENEFITS ARE PAID

The following chart compares how the Vision Care Plan covers both Network and Non-Network expenses.

### Comparison of Vision Care Benefits

| Services/<br>Supplies Received   | You Pay                     |   |
|--|-----------------------------|---|
|  | Access Network<br>Provider* | Non-Network Provider                            |
| Routine Eye Exam with<br>dilation as necessary   | \$0                         | Full cost; you may be<br>reimbursed up to \$30. |
| Contact Lens Fit and Follow-<br>Up Exam<br>Standard**  | Up to \$55                  | N/A   |
| Premium***   | 10% off retail price        | N/A   |
| Standard Plastic Lenses<br>Single  | \$0                         | Full cost; you may be<br>reimbursed up to \$30. |
| Bifocal  | \$0                         | Full cost; you may be<br>reimbursed up to \$50. |
| Trifocal   | \$0                         | Full cost; you may be<br>reimbursed up to \$60. |
| Lenticular   | \$0                         | Full cost; you may be<br>reimbursed up to \$80. |
| Standard Progressive   | \$35 copay                  | Full cost; you may be<br>reimbursed up to \$55. |
| Frames   | 80% of amount over \$70     | Full cost; you may be<br>reimbursed up to \$40. |
| Contact Lenses****<br>(materials only)   |                             |   |
| Conventional   | 85% of amount over \$80     | Full cost; you may be<br>reimbursed up to \$80. |
| Disposable   | 100% of amount over \$80    | Full cost; you may be<br>reimbursed up to \$80. |
| Medically Necessary  | \$0                         | Full cost; you may be<br>reimbursed up to \$80. |
| <p>* See "Network Limitations" below for the <b>covered</b> expenses from participating Network providers that may be reimbursed up to the amounts shown in the schedule of benefits, subject to <b>reasonable and customary</b> charge rules, as determined by the <b>Claims Administrator</b>.</p> <p>** Spherical clear contact lenses in conventional wear and planned replacement (examples include but not limited to disposable, frequent replacement, etc.)</p> <p>*** All lens designs, materials and specialty fittings other than Standard Contact Lenses (examples include tonic, multifocal, etc.)</p> <p>**** The Vision Care Plan covers one pair of contact lenses or one supply of disposable contact lenses in a 24-month period in lieu of frames and lenses up to a maximum of \$80.</p> |                             |   |

### **Network Limitations**

Network providers are allowed to charge Vision Care Plan participants up to the **reasonable and customary** charge as determined by the **Claims Administrator** (see “Important Contacts”) for the following services and supplies:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Vision Care Plan
- Services provided as a result of any Workers’ Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Two pairs of glasses in lieu of bifocals
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim, and Pro Design.

The benefits provided by the Vision Care Plan may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balance may be used for additional pairs. Lost or broken materials are not covered.

You are responsible for all applicable taxes.

In each of these cases, you may be reimbursed for **covered** expenses as dictated in the schedule of benefits (see “Comparison of Vision Care Benefits”).

### **Non-covered Items/Limited Charges**

The following items are not **covered** under the Vision Care Plan. However, Access Network providers have agreed to limit their charges for the following services and supplies:

| <b>Service/Supply</b>                                | <b>You Pay a Network Provider</b> |
|--|-----------------------------------|
| Solid Tint (#1 and #2)                               | \$ 10                             |
| Gradient Tint  | \$ 10                             |
| Standard Scratch Resistant Coating                   | \$ 15                             |
| Ultraviolet Coating                                  | \$ 15                             |
| Standard Polycarbonate                               | \$ 30                             |
| Standard Anti-Reflective                             | \$ 45                             |
| Other Add-ons, including Non-prescription Sunglasses | 80% of retail cost                |

### **Laser Vision Benefit**

You are entitled to a 15% discount on retail pricing or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and you elect to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which you will be responsible for and such fees are not subject to the 15% discount on retail pricing or the 5% discount on promotional pricing.

### **Accessing the Laser Vision Benefit**

1. To locate the nearest U.S. Laser Network provider, you must call 1-877-5LASER6.
2. After you have located a U.S. Laser Network provider, you should contact the U.S. Laser Network provider and identify yourself as an EyeMed Member. You should schedule a consultation with a U.S. Laser Network provider to determine if you are a good candidate for laser vision correction.
3. If it is determined that you are a good candidate for laser vision correction, you should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, you must call the U.S. Laser Network again at 1-877-5LASER6 with your scheduled treatment date.

5. At the time the treatment is scheduled, you will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If you should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time you remit the deposit, U.S. Laser Network will issue you an authorization number confirming the EyeMed discount. This authorization number will be sent to your U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is your responsibility to pay or arrange to pay the balance of the fee.
8. After the treatment, you should follow all post-operative instructions carefully. In addition, you are responsible for scheduling any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

If you receive any of the above materials from a non-network provider, you are responsible for paying the full cost. Since these items are not **covered** under the Vision Care Plan, you will not receive reimbursement. However, you may be eligible for reimbursement of such non-covered expenses through The Avaya Inc. Health Care Reimbursement Account Plan if you are a participant in that Plan.