Plan Benefits

(Descriptions of specific benefits may vary by state.)

In-Network Benefits (Network Available at www.davisvision.com)	Plan 4 (Standard)
Service Type	**Frequency - Once Every:**
Eye Examinations with Dilation (as necessary)	Once Every 12 months
Spectacle Lenses	Once Every 12 months
Frame	Once Every 24 months
Contact Lens (In lieu of eyeglasses)	Once Every 12 months
In Network	
Eye Examination	$10
Retinal Imaging	$39
Spectacle Lenses	$25
Non-elective (visually required) Contact Lens Evaluation, Fitting & Follow-Up Care	$0
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	Up to $130 Up to $180 at VisionWorks
Additional Pairs	30% discount on additional pairs at select retailers
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level/Designer level/Premier level	$0 / $0 / $25
Eyeglass Benefits - Spectacle Lenses	**Member Co-Pays**
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	$0
Tinting of Plastic Lenses	$0
Scratch Resistant Coating	$0
Polycarbonate Lenses (Children/Adults)	$00/$30
Digital Single Vision (Intermediate)	$30
Ultraviolet Coating	$12
Blue Light Filtering	$15
Anti-Reflective (AR) Coatin (Standard/Premier/Ultra/Ultimate)	$35/$48/$60/$85
Progressive Lenses (Standard/Premier/Ultra/Ultimate)	$50/$90/$140/$175
High Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision/Multifocal Lenses	$20/$40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	Up to $130 plus 15% discount

Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	4 boxes/multi-packs
Planned Replacement: up to	2 boxes/multi-packs
Evaluation, Fitting & Follow Up Care	$0

Out-of-Network Reimbursement Allowance Schedule: Up to	
Eye Examination	Up to $40
Frame	Up to $50
Lenses - Single Vision	Up to $40
Lenses - Bifocal/Progressive	Up to $60
Lenses – Trifocal	Up to $80
Lenses – Lenticular	Up to $100
Elective Contact Lenses	Up to $105
Visually Required Contact Lenses	Up to $225

Benefit and Premium Rates

Premiums			
Members/Coverage	**Lives**	**Monthly Rate**	**Annual Premium**
Employee Only	58	$6.99	$4,865.04
Employee and 1 Dependent	29	$13.22	$4,600.56
Employee and Family	49	$18.69	$10,989.72
TOTALS	136		$20,455.32

Note:

- If participation changes by more than 15%, we reserve the right to review and adjust premiums based on final participation
- The rates and product availability indicated in this proposal are subject to change as a result of final underwriting

LIMITATIONS AND EXCLUSIONS

Limitations and exclusions vary by state. Please see the master policy for full and complete information. All benefit descriptions, limitations and exclusions appear regardless of the benefit options chosen. Appearance of benefit descriptions, limitations or exclusions does not necessarily indicate inclusion of the corresponding benefits in your plan design. Descriptions of specific benefits may vary by state.

LIMITATIONS

Eyeglass lenses and frames are paid in lieu of the contact lenses benefit.

Contact lenses are payable in lieu of eyeglass lenses and frames.

Coverage for a late entrant or re-enrollee is limited to the vision exam benefit during the first 24 months after such person's effective date of coverage.

Dilation is covered in full under the vision exam benefit only if required by state law or done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

EXCLUSIONS

No benefits are payable for any of the following conditions, services, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

- Replacement frames and/or lenses, except at normal intervals when covered services or materials are otherwise available;
- Plano lens or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Frame cases;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Charges incurred after (a) the policy ends; or (b) the insured person's coverage under the policy ends, except as stated in the policy;
- Any eye examination or corrective eyewear required by an employer as a condition of employment;
- Services and materials provided by another vision plan except for coordination of benefits;
- Services for which benefits are paid by worker's compensation;
- Benefits provided under the employee's medical insurance except for coordination of benefits;
- Blended bifocal lenses;
- Groove, drill or notch, and roll and polish;
- Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
- Coating on lenses (factory scratch coat, anti-reflective, sunglass colors, etc.);
- Cosmetic items;
- Faceted lenses;
- High-index lenses;
- Laminated lenses;
- Oversize lenses – any lens with an eye size of 61mm or greater;
- Photochromic (transition) lenses;
- Polaroid lenses;
- Polished bevel lenses;
- Polycarbonate lenses, except for insured members under 19;
- Prism lenses;
- Slab-off lenses;
- Tints (except pink tint #1 and #2);
- Ultra-violet tint or coating;
- Additional cost for contact lenses over the allowance;
- Additional cost for a frame over the allowance;
- Progressive power lenses;

No benefits are payable for services performed by a member of the insured person's family. Insured person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents.

Notices

This proposal is a brief description of coverage, not a contract. Read your policy and riders (as applicable) carefully for exact plan language, terms, and conditions.

This is a limited benefit plan and provides vision benefits only. Aflac's contracts of insurance, including Aflac's network dental and vision plans, provide limited-scope and/or supplemental benefits only and do not constitute comprehensive health insurance coverage. Aflac's contracts of insurance do not satisfy the requirement of minimum essential coverage under the Patient Protection and Affordable Care Act (ACA) and are not designed to meet any of the essential health benefit requirements mandated by the ACA or federal law, including pediatric oral or vision care services. Aflac's contracts of insurance are not an alternative to, or a substitute for, comprehensive health insurance coverage and should only be used to supplement comprehensive health insurance coverage.

Coverage is underwritten by American Family Life Assurance Company of Columbus (Aflac).

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