

LSC Communications LLC

Vision benefits as you've never seen before

	Get the most out of your vision insurance plan with these EyeMed highlights: • Ability to use the frame and contact lens allowances in the same benefit year—worth up to an extra \$170.00¹ • Separate contact lens fit & follow-up coverage leaving the entire allowance for materials Plus, with us, you always get—
NETWORK	Reinventing choice and convenience • America's largest vision network². • In-network options for buying glasses and contacts online at glasses.com, lenscrafters.com, contactsdirect.com, targetoptical.com, oakley.com and rayban.com – with benefits applied directly in the shopping cart. • The right mix of independent eye doctors and national and regional retail providers – so members can go where they want, when they want. 
BENEFITS	Redefining flexibility and value • The freedom to choose any ophthalmic frame, lens or contact lens without restrictions at any of our retail providers, independent provider locations or online. • Complimentary HealthyEyes wellness program keeps the focus on eye health with online tools, articles and videos. As part of HealthyEyes, the eyeRewards program rewards members for taking care of their vision health with savings, prizes and wellness tips. • Members enjoy exclusive savings on LASIK, including up to \$1000 off at preferred providers or 5% off the in-store promotional price.² 
EASY	Reimagining simple and transparent • Cost transparency with our Know Before You Go cost estimator. • Digital Tools like online scheduling³, a mobile app and personalized text alerts. • Welcome kits, ID cards and open enrollment support to ensure employees understand their benefits. 

We can't wait to work with you—

Contact at msmith9@eyemed.com with questions

¹ This document provides highlights of one or more EyeMed plans. Frame allowances may vary by plan. Please consult your EyeMed representative for more information

² Preferred lasik providers include LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute

³ At select locations

LSC Communications LLC

BENEFITS

- Base
- Exam & Materials
- Custom network
- Fully Insured
- Employee Paid

MONTHLY RATES

- Subscriber \$5.61
- Subscriber + Spouse \$10.25
- Subscriber + Child(ren) \$9.98
- Subscriber + Family \$13.80

SUMMARY OF BENEFITS

Vision Care Services

In-Network Member Cost

Out-of-Network
Member Reimbursement**EXAM SERVICES** once every calendar year, twice every calendar year kids <19

Exam	\$10 copay	Up to \$35
Retinal Imaging	\$0 copay	Up to \$20

FRAME once every calendar year

Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$65
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STANDARD PLASTIC LENSES in lieu of contacts once every calendar year

Single Vision	\$20 copay	Up to \$25
Bifocal	\$20 copay	Up to \$40
Trifocal/Lenticular	\$20 copay	Up to \$55/\$80
Progressive – Standard	\$85 copay	Up to \$40
Progressive – Premium Tier I, II, or III	\$105, \$115, \$130 copay	Up to \$40
Progressive – Premium Tier IV	\$85 copay, 20% off retail price less \$120 allowance	Up to \$40

LENS OPTIONS

Polycarbonate – Standard < 19 years of age	\$0 copay	Up to \$5
Scratch Coating – Standard Plastic	\$0 copay	Up to \$5

CONTACT LENSES in lieu of lenses once every calendar year

Contacts – Conventional	\$0 copay; 15% off balance over \$150 allowance	Up to \$150
Contacts – Disposable	\$0 copay; 100% of balance over \$150 allowance	Up to \$150
Contacts – Medically Necessary	\$0 copay; paid-in-full	Up to \$210

All plans are based on a 45 month contract and 45 month rate guarantee. Monthly Rate 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. The Plan reserves the right to make changes to the products available on each tier.

LSC Communications LLC

BENEFITS

- Base
- Exam & Materials
- Custom network
- Fully Insured
- Employee Paid

MONTHLY RATES

- Subscriber \$5.61
- Subscriber + Spouse \$10.25
- Subscriber + Child(ren) \$9.98
- Subscriber + Family \$13.80

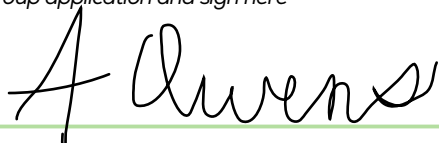
Plan Details

Quote for group situated in the State of IL and will be valid until the 04/01/2026 implementation date. Date Quoted 04/21/2026. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Exclusions/Limitations

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 associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision 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; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If LSC Communications LLC has chosen this benefit design, attach this document to the group application and sign here


SIGNATURE

4.1.26

DATE



*We're committed to keeping
money in our members' pockets*

That's why we offer our members additional
discounts above the proposed plan benefits

VISION CARE SERVICES

IN-NETWORK MEMBER COST

CONTACT LENS FIT AND FOLLOW-UP

Fit and Follow-Up – Standard	Up to \$40
Fit and Follow-Up – Premium	10% off retail price

LENS OPTIONS

Anti Reflective Coating – Standard	\$45
Anti Reflective Coating – Prem Tier 1	\$57
Anti Reflective Coating – Prem Tier 2	\$68
Anti Reflective Coating – Prem Tier 3	20% off retail price
Photochromic – Non-Glass	\$75
Polycarbonate – Standard	\$40
Tint – Solid or Gradient	\$15
UV Treatment	\$15
All Other Lens Options	20% off retail price

40%OFF



additional pairs of glasses

20%OFF



any item not covered by the plan,
including non-prescription sunglasses

15%OFF



retail price or 5% off promotional price
for Lasik or PRK from US Laser Network

UP
TO **66%OFF**



hearing aids, with an extended
warranty and free batteries through
Amplifon Hearing Health Care Network



Members can get exclusive additional
discounts and deals that are often
stackable with their vision benefits
at eyemed.com/member⁴

DISCOUNT DETAILS

Discounts are not insured benefits. Member receives a 20% discount on items not covered by the insurance plan at EyeMed In-Network locations. 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 EyeMed's 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 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. Service and amounts listed above are subject to change at any time.

LSC Communications LLC

BENEFITS

- Buyup
- Exam & Materials
- Custom network
- Fully Insured
- Employee Paid

MONTHLY RATES

- Subscriber \$16.81
- Subscriber + Spouse \$30.69
- Subscriber + Child(ren) \$29.89
- Subscriber + Family \$41.34

SUMMARY OF BENEFITS

Vision Care Services

In-Network Member Cost

Out-of-Network
Member Reimbursement

EXAM SERVICES once every calendar year, twice every calendar year kids <19

Exam	\$0 copay	Up to \$35
Retinal Imaging	\$0 copay	Up to \$20

CONTACT LENS FIT AND FOLLOW-UP

Fit and Follow-Up – Standard	\$0 copay; contact lens fit and two follow-up visits	Up to \$40
Fit and Follow-Up – Premium	\$0 copay; 10% off retail price, then apply \$40 allowance	Up to \$40

FRAME once every calendar year

Frame	\$0 copay; 20% off balance over \$170 allowance	Up to \$85
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STANDARD PLASTIC LENSES *in lieu of contacts* once every calendar year

Single Vision	\$10 copay	Up to \$25
Bifocal	\$10 copay	Up to \$40
Trifocal/Lenticular	\$10 copay	Up to \$55/\$80
Progressive – Standard	\$10 copay	Up to \$55
Progressive – Premium Tier I, II, or III	\$30, \$40, \$55 copay	Up to \$55
Progressive – Premium Tier IV	\$10 copay, 20% off retail price less \$120 allowance	Up to \$55

LENS OPTIONS

Polycarbonate – Standard	\$0 copay	Up to \$5
Scratch Coating – Standard Plastic	\$0 copay	Up to \$5
Tint – Solid or Gradient	\$0 copay	Up to \$5
UV Treatment	\$0 copay	Up to \$5
Anti Reflective Coating – Standard	\$0 copay	Up to \$5
Anti Reflective Coating – Prem Tier 1	\$12 copay	Up to \$5
Anti Reflective Coating – Prem Tier 2	\$23 copay	Up to \$5

CONTACT LENSES *in lieu of lenses* once every calendar year

Contacts – Conventional	\$0 copay; 15% off balance over \$170 allowance	Up to \$150
Contacts – Disposable	\$0 copay; 100% of balance over \$170 allowance	Up to \$150
Contacts – Medically Necessary	\$0 copay; paid-in-full	Up to \$210

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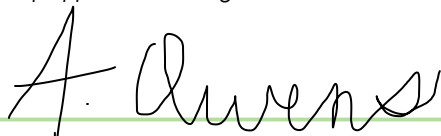
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VISION CARE SERVICES

IN-NETWORK MEMBER COST

LENS OPTIONS

Anti Reflective Coating - Prem Tier 3 20% off retail price

Photochromic - Non-Glass \$75

All Other Lens Options 20% off retail price

40%OFF



additional pairs of glasses

20%OFF



any item not covered by the plan,
including non-prescription sunglasses

15%OFF



retail price or 5% off promotional price
for Lasik or PRK from US Laser Network

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hearing aids, with an extended
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