

MEREDITH CORP. CONSOLIDATED HEALTH AND WELFARE PLAN

SUMMARY OF COVERED SERVICES AND BENEFITS

\$20 LENS COPAY \$130 FRAME ALLOWANCE – Insight Network

Benefit Frequency			
Contact Lenses or Lens	Once every calendar year.		
Exam	Once every calendar year.		
Frame	Once every calendar year.		
Vision Care Services		In-Network Member Cost	Out-of-Network Reimbursement
Exam			
Exam		\$20 Copay	\$35
Fundus Photograph Benefit		Up to \$39	
Eye Exam Refraction		\$0	
Lens			
Single Vision		\$20 Copay	\$25
Bi-focal		\$20 Copay	\$40
Tri-focal		\$20 Copay	\$55
Standard Progressive Lens		\$85 Copay	\$40
Premium Progressive Lens		Premium Progressive as follows:	\$40
Tier 1		\$95	
Tier 2		\$105	
Tier 3		\$120	
Tier 4		80% of Charge less \$120, plus \$85 Copay	
Lenticular		\$20 Copay	\$55
Other Lens Type		80% of Charge	
Frame			
Frame		80% of Balance over \$130	\$70
Lens Options			
Standard Polycarbonate - <i>Adults</i>		\$40 Copay	
Standard Polycarbonate - <i>Minors under 19</i>		\$0 Copay	\$5
Standard Plastic Scratch Coating		\$15 Copay	
Tint		\$15 Copay	
UV Treatment		\$15 Copay	
Standard Anti-reflective (a/r) Coating		\$45 Copay	
Premium Anti-reflective (a/r) Coating		Premium Anti-reflective Coating as follows:	
Tier 1		\$57	
Tier 2		\$68	
Tier 3		80% of Charge	
Photochromatic/Transitions		\$75	
Other Lens Options		80% of Charge	
Contact Lenses			
Contact Lens — Conventional		85% of Balance over \$130	\$96
Contact Lens — Disposable		Balance over \$130	\$96
Standard Fit And Follow Up Exam		\$0 Copay, paid in full fit and 2 follow up visits	\$40
Premium Fit And Follow Up Exam		\$0 Copay, 10% off retail price then apply \$40 allowance	\$40
Medically Necessary Contacts		\$0	\$210

Non-Scheduled Items Doctor Misc. Materials	80% of Charge	
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	
Second Pair Discount	40% discount off complete pair of eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	

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 an employer 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 or materials provided by any other group benefit plan providing vision care; 9) Services rendered after the date a member ceases to be covered under the Benefit Certificate, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order. 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. 11) 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.

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network. The information on this page summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of your Certificate.