

SUMMARY OF BENEFITS & RATES

Principal Vision Plan

PPO Plan · Network: VSP Choice Network

For demonstration purposes only. This document is a fictitious plan summary created for sales training and product demonstrations. It is not an offer of coverage, not an official carrier document, and does not reflect actual carrier rates or plan designs.

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|--------------------------|-------------------------|---|--------------------------------------|
| PRODUCT Vision | PLAN TYPE PPO | PLAN NAME Principal Vision Plan | NETWORK VSP Choice Network |
|--------------------------|-------------------------|---|--------------------------------------|

BENEFIT FREQUENCIES

| | | | |
|---|--|---------------------------------------|---|
| COMPREHENSIVE EXAM Once every 12 months | EYEGLOSS LENSES Once every 12 months | FRAMES Once every 12 months | CONTACT LENSES Once every 12 months (in lieu of eyeglasses) |
|---|--|---------------------------------------|---|

EXAM, LENSES & FRAMES

| SERVICE | IN-NETWORK (VSP CHOICE NETWORK) | OUT-OF-NETWORK REIMBURSEMENT |
|-----------------------------------|---|------------------------------|
| Comprehensive Eye Exam | \$10 copay | Up to \$40 |
| Eyeglasses — Lenses & Frame Copay | \$10 copay (lenses and frames combined) | Copays do not apply |
| Single Vision Lenses | Covered in full after \$10 materials copay | Up to \$40 |
| Lined Bifocal Lenses | Covered in full after \$10 materials copay | Up to \$60 |
| Lined Trifocal Lenses | Covered in full after \$10 materials copay | Up to \$80 |
| Lenticular Lenses | Covered in full after \$10 materials copay | Up to \$80 |
| Standard Progressive Lenses | Covered in full after \$10 materials copay | Up to \$60 |
| Premium Progressive Lenses | Covered in full after \$10 materials copay | Up to \$60 |
| Included Lens Options | Standard scratch-resistant coating and polycarbonate lenses (for dependent children through age 19) | |
| Frame Allowance | \$100 retail frame allowance (private practice or retail chain) | Up to \$45 |
| Frame Overage Discount | Additional 30% off overage at most participating in-network providers | |

CONTACT LENSES (IN LIEU OF EYEGASSES)

| TYPE | IN-NETWORK | OUT-OF-NETWORK REIMBURSEMENT |
|------------------------------|--|------------------------------|
| Formulary Contacts | Fitting/evaluation fees, contact lenses, and up to two follow-up visits covered in full after \$10 copay | Elective: Up to \$120 |
| Disposable Contacts | Covered in full after copay — up to 4 boxes from an in-network provider | Elective: Up to \$120 |
| Non-Formulary Contacts | \$120 allowance (copay waived) | Elective: Up to \$120 |
| Medically Necessary Contacts | Covered in full after copay (if applicable) | Up to \$210 |

Additional Contact Lens Discount

20% discount on additional contact lens purchases

INCLUDED PROGRAMS & FEATURES**Children's & Maternity Eye Care**

Members age 0–12 and members who are pregnant or breastfeeding are eligible for a 2nd exam per 12 months, and for replacement frames and lenses after a prescription change of 0.5 diopter or more.

Laser Vision Correction (VSP Laser VisionCare)

Average savings of 15% off the regular price or 5% off promotional pricing for laser vision correction (including PRK, LASIK, and Custom LASIK) at VSP Laser VisionCare participating locations.

Additional Materials Discount

20% discount on an additional pair of eyeglasses or contact lenses at a participating in-network provider, after vision benefits have been used.

VSP Exclusive Member Extras

Access to exclusive member-only savings from popular brands (valued at over \$3,000/year) through VSP Exclusive Member Extras, including discounts on eyewear accessories, contacts, and wellness products.

MONTHLY PREMIUM RATES – CURRENT PLAN

| COVERAGE TIER | MONTHLY RATE |
|------------------------------|-----------------------------|
| Employee Only | \$4.81 per month |
| Employee + Spouse | \$9.60 per month |
| Employee + Child(ren) | \$9.71 per month |
| Family | \$15.48 per month |

Rate basis: Rates shown are composite monthly premiums per contract. Contributions between employer and employee are determined at the group level.

GENERAL EXCLUSIONS

- Services and materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated.
- Plano lenses (refractive correction of less than ± 0.50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lost, stolen, or damaged lenses, frames, or contact lenses (except at normal frequency).
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Prescription or non-prescription medications.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial 90-day fitting period.
- Contact lens modification, polishing, or cleaning.
- Missed appointments.
- Any eye examination required as a condition of employment.
- Services obtained outside the United States (except emergency vision care).
- Services for which a charge would not have been made in the absence of insurance.
- Services covered under Workers' Compensation, employer liability, or other employer-provided coverage.

DEMONSTRATION NOTICE

This Plan Summary is provided **solely for demonstration and sales-training purposes**. It is not an offer of coverage, not a binding document, and not an official publication of Principal Financial Group or any affiliated entity. Rates shown are fictitious illustrative examples and do not represent actual carrier pricing.

Notice: This Summary of Benefits is provided for informational purposes and is not an offer of coverage. For a complete listing of coverage, including exclusions and limitations, refer to the Certificate of Coverage. If differences exist between this summary and the Certificate of Coverage, the Certificate of Coverage will govern.

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