PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Rolling Benefit Plan Basis	
Vision Exam:	Once every 12 Months
Eyeglass Lenses:	Once every 12 Months
Frames:	Once every 24 Months
Contact Lenses:	Once every 12 Months
Contact Lens Fit:	Once every 12 Months

CO-PAY (PER INSURED)		
	In-Network Providers:	Out-of-Network Provider:
Vision Exam:	$10	$10
Eyeglass Lenses/Frames:	$10	$10
Contact Lens Fit:	$25	Not Covered

BENEFITS AND ALLOWANCES [1]		
	In-Network Providers: [2]	Out-of-Network Provider:
Vision Exam:		
Ophthalmologist (M.D.)	Covered in Full	$34 Allowance
Optometrist (O.D.)	Covered in Full	$26 Allowance
Materials-Eyeglass Lenses: [3]		
Single Vision	Covered in Full	$29 Allowance
Standard Progressive	Covered in Full	$43 Allowance
Bifocals	Covered in Full	$43 Allowance
Trifocals	Covered in Full	$53 Allowance
Lenticular	Covered in Full	$84 Allowance
Polycarbonate – for dependent children only	Covered in Full	Not Covered
Materials – Frames: [3]	$150 Allowance	$74 Allowance
Materials – Contact Lenses: [4]		
Non-Elective	Covered in Full	$210 Allowance
Elective	$150 Allowance	$100 Allowance
Contact Lens Fit:		
Standard	Covered in Full	Not Covered
Specialty	$50 Allowance	Not Covered

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

[2] If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network allowance.

[3] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

[4] The contact Lenses Benefit is paid in lieu of Eyeglass Lenses and Frames.