

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 12 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	\$44 Allowance
Optometrist (O.D.)	Covered in Full	\$39 Allowance
Materials- Eyeglass Lenses: ³		
Single Vision	Covered in Full	\$34 Allowance
Progressive	Covered to providers retail trifocal amount	\$64 Allowance
Bifocals	Covered in Full	\$48 Allowance
Trifocals	Covered in Full	\$64 Allowance
Lenticular	Covered in Full	\$88 Allowance
Materials – Frames: ³	\$150 Allowance	\$77 Allowance
Materials – Contact Lenses:		
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.