

SCHEDULE OF BENEFITS

Insured Persons have the right to obtain vision care from the Provider of his or her choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	\$10 Co-payment	up to \$35	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$25 Co-payment	up to \$25	
Bifocal	\$25 Co-payment	up to \$40	
Trifocal	\$25 Co-payment	up to \$65	
Frames	\$0 Co-payment, up to \$120 retail allowance	up to \$60	12 months
Contact Lenses (<i>only one option available per Benefit Frequency</i>)			12 months
Conventional	\$0 Co-payment, up to \$135 allowance	up to \$108	
Disposable	\$0 Co-payment, up to \$135 allowance	up to \$108	
Medically Necessary	\$0 Co-payment, Paid in full	up to \$200	