

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

<u>Benefit</u>	<u>Preferred Provider</u>	<u>Non-Preferred Provider</u>	<u>Benefit Period</u>
Vision Examination:	\$10.00	\$35.00	12 Months
Vision Materials:	\$15.00	N/A	
<i>Standard Lenses</i>			12 Months
Single	Paid in full after copayment	\$25.00	
Bifocal	Paid in full after copayment	\$40.00	
Trifocal	Paid in full after copayment	\$50.00	
Lenticular	Paid in full after copayment	\$80.00	
Progressives	20% off retail minus \$50 Allowance	\$40.00	
<i>Frames</i>	\$50.00 wholesale	\$45.00	24 Months
<i>Contact Lenses*</i>			12 Months
Elective	\$130.00	\$130.00	
Medically Necessary	Paid in full	\$250.00	

*Contact Lenses includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Examination is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Vision Examination Benefit - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 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 and safety eyewear, unless specifically covered under the Policy; 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; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; or 8) Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.