Schedule of Covered Vision Services

The following Vision Services will be covered, subject to a Copayment, when obtained from Network Providers.

When obtaining these Vision Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Vision Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Network Benefit" in the chart below.

When obtaining these Vision Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement for non-Network Providers will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	FREQUENCY OF SERVICE	NETWORK BENEFIT	NON-NETWORK BENEFIT
Routine Vision Examination	Once every 12 months	After a Copayment of $10.00 .	To a maximum of a $40.00 allowance.
Refraction Only in Lieu of Routine Vision Examination	Once every 12 months	$0 allowance	To a maximum of a $40.00 allowance.
Contact Lens Fitting and Evaluation	Once every 12 months	After a Copayment of $25.00 . One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection. To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection.	To a maximum of a $105.00 allowance.
Eyeglass Frames[A]	Once every 24 months	Private Practice Network Provider After a Copayment of $25.00 [B] to a maximum of a $50.00 allowance.	To a maximum of a $45.00 allowance.

		Retail Network Provider After a Copayment of $25.00 [B] to a maximum of a $130.00 allowance.	
Eyeglass Lenses[A]	Once every 12 months		
Single Vision*		After a Copayment of $25.00 .[B]	To a maximum of a $40.00 allowance.
Bifocal-lined		After a Copayment of $25.00 .[B]	To a maximum of a $60.00 allowance.
Trifocal-lined		After a Copayment of $25.00 .[B]	To a maximum of a $80.00 allowance.
Lenticular		After a Copayment of $25.00 .[B]	To a maximum of a $80.00 allowance.
Contact Lenses[A]	Once every 12 months	After a Copayment of $25.00 for up to 4 boxes from the Covered Contact Lens Selection.[C] One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection. To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection.[C]	To a maximum of a $105.00 allowance.
Necessary Contact Lenses[A]	Once every 12 months	After a Copayment of $25.00 .	To a maximum of a $210.00 allowance.

Optional Lens Extras:

Eyeglass Lenses: The following Optional Lens Extras are covered in full:

- Scratch-resistant coating

[A]You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision Services, only one Service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

[B]If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[C]Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for lens not from the Covered Contact Lens Selection will be used.

*Single vision lens are defined as one single power across their entire surface with a single optical center and are made from CR-39 or glass material.