SCHEDULE OF VISION BENEFITS

	IN-NETWORK BENEFITS
Deductible	None
Claim Form Required	No
COVERED VISION SERVICES	**YOUR COST**
Examination (Every 12 months)	
Examination (with dilation as necessary)	$0 Copayment
Standard Plastic Lenses (Every 12 months)	
Single	$10 Copayment
Bifocal	$10 Copayment
Trifocal	$10 Copayment
Lenticular	$10 Copayment
Frames (Every 24 months)	
Frames	$0 Copayment, $150 allowance, 20% off balance over $150
Contact Lenses - Materials Only (Every 12 months)	
Medically Necessary	$0 Copayment
Elective - Conventional	$0 Copayment, $130 allowance, 15% off balance over $130
- Disposable	$0 Copayment, $130 allowance, plus balance over $130

Your eyes need a regular checkup to determine their overall health. Your eyes can provide early detection of diabetes, high blood pressure and high cholesterol.