Dental benefits payable for Treatment or Service received each calendar year will be:

Service	PPO Providers	Non-PPO Providers
Dental Care Type 1		
Preventive Procedures		
Coinsurance	100%	100%
Individual Deductible	None	None
Family Maximum Deductible	None	None

Dental Care Type 2		
Basic Procedures		
Coinsurance	80%	80%
Individual Deductible	$50 per calendar year (Types 2 and 3 combined)	$50 per calendar year (Types 2 and 3 combined)
Family Maximum Deductible	$150 per calendar year (Types 2 and 3 combined)	$150 per calendar year (Types 2 and 3 combined)

Dental Care Type 3		
Major Procedures		
Coinsurance	50%	50%
Individual Deductible	$50 per calendar year (Types 2 and 3 combined)	$50 per calendar year (Types 2 and 3 combined)
Family Maximum Deductible	$150 per calendar year (Types 2 and 3 combined)	$150 per calendar year (Types 2 and 3 combined)

VISION CARE EXPENSE INSURANCE

BENEFITS PAYABLE

Benefits will be payable for Treatment or Service received on a Rolling Benefit Plan basis as shown below.

Visual Service or Vision Materials Per Insured Person	
Benefit Frequency	
Complete Visual Analysis/Vision Exam	Once per 12 consecutive months
Standard Plastic Lenses or Contact Lenses	Once per 12 consecutive months
Frames	Once per 24 consecutive months

Benefits and Discounts	**PPO Providers (Insured Person cost)**	**Non-PPO Providers (*Reimbursement)**
Complete Visual Analysis/Vision Exam with Dilation if necessary	$10 Copay	$30
Retinal Imaging	up to $39 discount	No Benefits Payable
Contact Lens Fitting		
- Standard	up to $40 discount	No Benefits Payable
- Premium	10% discount off retail price	No Benefits Payable
Frames (Any available frame at provider location)	$130 Allowance, then 20% discount off balance over $130	$65
Standard Plastic Lenses		
- Single Vision Lens	$10 Copay	$15
- Bifocal Lens	$10 Copay	$23
- Trifocal Lens	$10 Copay	$40
- Lenticular Lens	$10 Copay	$40
- Standard Progressive Lens	$75 Copay	$23
- Premium Progressive Lens		
Tier 1	$95 Copay	$23

Benefits and Discounts	**PPO Providers (Insured Person cost)**	**Non-PPO Providers (*Reimbursement)**
Tier 2	$105 Copay	$23
Tier 3	$120 Copay	$23
Tier 4	$75 Copay, then 80% of charge less $120 Allowance	$23
Lens Options		
- UV Coating	$15	No Benefits Payable
- Tint (Solid and Gradient)	$15	No Benefits Payable
- Standard Plastic Scratch Coating	$0	$5
- Standard Polycarbonate – Insured Persons age 19 and older	$40	No Benefits Payable
- Standard Polycarbonate - Dependent Children under age 19	$0	$20
- Anti-Reflective Coating - Standard	$45	No Benefits Payable
- Polarized	20% discount off retail price	No Benefits Payable
- Photochromic/Transitions Lens	$75	No Benefits Payable
- Anti-Reflective Coating - Premium		
Tier 1	$57	No Benefits Payable
Tier 2	$68	No Benefits Payable
Tier 3	80% of charge	No Benefits Payable
- Other Add-Ons	20% discount off retail price	No Benefits Payable
Contact Lenses (in lieu of the Standard Plastic Lens benefit) This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.		
- Conventional	$0 Copay, $130 Allowance, then 15% discount off balance over $130	$104

Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
- Disposable	$0 Copay, $130 Allowance, then balance over $130	$104
- Medically Necessary	$0 Copay	$210
** Laser Vision Correction		
- Lasik or PRK from U.S. Laser Network	15% discount off retail price or 5% discount off promotional price	No Benefits Payable
Additional Pairs Benefit	40% discount off the purchase of an additional pair of Standard Plastic Lens and frames and a 15% discount off the purchase of an additional pair of conventional Contact Lenses each 12 consecutive months, once the benefit above has been utilized.	No Benefits Payable

*Reimbursement for a Non-PPO Provider will be the lesser of the amount shown above or the actual cost from Non-PPO Provider.

Discounts are not applicable to Visual Services or Vision Materials provided by Non-Preferred Providers. Discounts described above are not insured benefits. Discounts do not apply to benefits provided by other group benefit plans. Discounts may not be combined with any other discounts or promotional offers, and the discount does not apply to Preferred Provider professional services, disposable Contact Lenses or certain brand name Vision Materials in which the manufacturer imposes a no-discount practice or policy.

**For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

The Contact Lenses benefit will be in lieu of the Standard Plastic Lens and frame benefit. If Contact Lenses are chosen, there will be no benefits payable for the Standard Plastic Lens benefit for a period of 12 consecutive months from the date of service and there will be no benefits payable for the frame benefit for a period of 24 consecutive months from the date of service.

Lens Options or Add-Ons listed above as a Covered Visual Service or Vision Material are paid for in addition to the Standard Plastic Lenses, as indicated above. Lens Options or Add-Ons that are not a Covered Visual Service or Vision Material, or that exceed the stated maximums, are the Insured Person's responsibility to pay to the provider.