SCHEDULE OF BENEFITS
00044
Platinum 100-MO

The following is your plan coverage:

Deductible:	N/A
Vision Examination:	Not a covered benefit.
Frame:	Once each 12 months: Paid in full up to $100 retail value if received from a participating provider OR reimbursed up to $50 retail value if received from a non-participating provider.
Spectacle Lenses:	Once each 12 months: A pair of clear glass or plastic standard Single Vision, Bifocal, Trifocal or Lenticular (post-cataract) lenses paid in full with a prescription if received from a participating provider. Members who elect to purchase lens types other than those listed above receive an allowance toward the specialty lens purchase equal to the participating provider's usual and customary charge for standard lenses of similar type (Single Vision, Bifocal or Trifocal; for Progressive lenses, the participating provider's usual and customary fee for standard Trifocals is applied). The Member is financially responsible for the additional cost associated with the specialty lens or lens add-on. If spectacle lenses are received from a non-participating provider, Member reimbursement is as follows: Single Vision (pair) $25 Trifocal (pair) $45 Bifocal (pair) $40 Lenticular (pair) $80
Contact Lenses and Related Diagnostic Fitting & Evaluation Services:	Once each 12 months: Paid in full up to $125 retail value *in lieu of* frame and spectacle lens benefit above if received from a participating provider OR reimbursed up to $100 if received from a non-participating provider. Medically necessary contact lenses paid in full with VIPA prior approval or reimbursed up to $150 if received from a non-participating provider.