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| **SCHEDULE OF BENEFITS** | **SUGGESTED** | | **PROPOSED** | |
| **Network** | **NVA** | |  | |
|  | **In Network** | **Out of Network** | **In Network** | **Out of Network** |
| Eye Exam | $10 Copay | $40 Allowance |  |  |
| Contact Lens Exam (Fit and Follow-up) | Covered 100% | Up to $50 Allowance |  |  |
| **Frequency of Services** |  |  |  |  |
| Examination | Once Every Calendar Year | |  | |
| Lenses | Once Every Calendar Year | |  | |
| Frames | Once Every Calendar Year | |  | |
| Contact Lenses | Once Every Calendar Year | |  | |
| **Lenses** | *Copay* | *Reimbursement* |  |  |
| Single | $20 | Up to $40 |  |  |
| Bifocal | $20 | Up to $60 |  |  |
| Trifocal | $20 | Up to $80 |  |  |
| Progressive | $20 | Up to $90 or N/A |  |  |
| Lenticular | $20 | Up to $100 |  |  |
| **Frames** |  |  |  |  |
| Retail | $225 Retail (then 20% disc.) | Up to $50 |  |  |
| **Contact Lenses** |  |  |  |  |
| Contact Lenses (Elective)  *In lieu of lenses* | $225  (then 15% disc.) | Up to $105 |  |  |
| Contact Lenses (Medically Necessary) | Covered 100% | Up to $225 |  |  |

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| **Premium (Fully-Insured)** | **Current Monthly Rates** | **Proposed Monthly Rates** |
| Employee Only |  |  |
| Employee + Spouse |  |  |
| Employee + Children |  |  |
| Employee + Family |  |  |
| Rate Guarantee |  |  |
| Participation Requirements | N/A |  |