Schedule of Benefits

PLAN EFFECTIVE DATE: September 1, 2002

EMPLOYEES ELIGIBLE: All employees of a participating Employer.

DEPENDENTS ELIGIBLE: All dependents as defined.

VISION CARE BENEFITS FOR YOU AND YOUR DEPENDENTS:

VSP PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a VSP Panel Provider are provided in accordance with an agreement between Vision Service Plan (VSP) and the panel provider. Under this agreement a provider accepts the VSP payment as payment in full for incurred Covered Charges, after satisfaction of the applicable deductibles. See the "Note" below for reimbursement for frames and cosmetic contact lenses.

Covered Charges for vision care services and materials, other than cosmetic contact lenses, obtained from a VSP Panel Provider are subject to a deductible of $6.50 for each examination and an additional deductible of $18.00 for the combined charges for lenses and frames.

Note: The total maximum benefit payable for each insured person in each plan year for frames is $65.00.

The total maximum benefit payable for each insured person in each plan year for all cosmetic contact lenses and examinations is $90.00. Deductibles do not apply to cosmetic contact lenses and examinations for them.

NON-PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a Non-Panel Provider are subject to the following maximum amount of reimbursement.

Vision Examination	Maximum Amount Performed by an:	
	Optometrist	**Ophthalmologist**
	$28.50	$38.50

Spectacle Lenses (Pair):	**Clear**	**Color Tints/Color Coats**	**Polarized**
Single Vision	$29.00	$33.00	$ 47.00
Bifocal	51.00	61.00	81.00
Trifocal	63.00	75.00	101.00
Lenticular	75.00	89.00	119.00
Frames			$44.00

Contact Lenses (Pair - including the exam)	
Necessary	$175.00
Cosmetic (Elective)	90.00