GROUP PPO VISION INSURANCE SCHEDULE

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including the benefits, Copayments, allowances, costs, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

Benefits under the Policy may vary depending on the services or materials received In-Network or Out-of-Network.

All Providers are independent contractors; they are not our employees or agents. We do not supervise, control or guarantee the outcome or results of any services or materials furnished by any Provider. Your relationship with a Provider is that of provider and patient. The Provider is solely responsible for the services and materials provided to you.

POLICY INFORMATION

Policyholder:	Motive Power
Policy Effective Date:	January 1, 2025
Policy Anniversary:	January 1
Policy Number:	GUVC-CMTG
Class(es):	All Eligible Employees
Coverage For:	You and your Dependents

GENERAL PROVISIONS

Work in Progress

Benefits will be provided for Vision Materials delivered after the date an Insured Person's insurance ends if such materials are ordered before coverage ended, and the Covered Services are rendered to the Insured Person within 31 days from the date of such order.

BENEFITS

Benefits are payable for each Insured Person under the Policy for Covered Services described in this section, subject to all terms and conditions of the Policy.

In-Network Benefits

Copayments or any cost above the allowance shown for Covered Services described in this section must be paid in full by the Insured Person to the In-Network Provider at the time a Covered Service is provided. We will pay benefits in excess of the Copayment for Covered Services to the In-Network Provider. The In-Network Provider will submit a claim to us on an Insured Person's behalf.

Out-of-Network Benefits
The Insured Person must pay the Out-of-Network Provider the full cost of services and materials at the time a Covered Service is provided. We will reimburse the Insured Person for benefits up to the Out-of-Network maximum dollar amount shown in this section after the Insured Person submits a claim to us.

Out-of-Area
An Insured Person who does not have access to an In-Network Provider within 20 miles of the Insured Person's residence may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost of services and materials at the time a Covered Service is provided and submit a claim to us. Copayments or any cost above the allowance for In-Network benefits shown in this section must be paid in full by the Insured Person.

COVERED SERVICES

SERVICES	**In-Network**	**Out-of-Network**
Comprehensive Vision Examination	$10 Copayment	Up to $37
MATERIALS	**In-Network**	**Out-of-Network**
Frames	Up to $130 allowance	Up to $58
Standard Plastic Lenses		
• Single Vision	$25 Copayment	Up to $20
• Bifocal	$25 Copayment	Up to $36
• Trifocal	$25 Copayment	Up to $64
• Lenticular	$25 Copayment	Up to $64
Lens Options		
• Progressive Lenses – Standard (add on to Bifocal)	$65 Copayment	Up to $36
• Progressive Lenses – Premium (add on to Bifocal)	Tier 1: $85 Copayment Tier 2: $95 Copayment Tier 3: $110 Copayment Tier 4: $65 Copayment + 80% of charge, less applicable allowance	Up to $36 Up to $36 Up to $36 Up to $36
Contact Lenses (only one option available per Benefit Frequency)		
• Conventional	Up to $130 allowance	Up to $89
• Disposable	Up to $130 allowance	Up to $104
• Medically Necessary	Up to $0 Copayment	Up to $210
BENEFIT FREQUENCY		
• Examination	Once every 12 months	
• Lenses or Contact Lenses	Once every 12 months	
• Frame	Once every 24 months	

LIMITATIONS

Benefit allowances cannot be carried over and provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

We will not pay benefits for any services or materials connected with or charges arising from:

a) orthoptic or vision training, subnormal vision aides and any associated supplemental testing;
b) Aniseikonic lenses;
c) medical or surgical treatment of the eye, eyes or supporting structures;
d) any eye or Vision Examination, or any corrective eyewear required by the Policyholder as a condition of employment;
e) safety eyewear;

f) services or materials provided or paid for in whole or in part by a state or federal government or its agencies;
g) services or materials provided or paid for in whole or in part as a result of any workers' compensation or occupational disease law or as required by any federal or state governmental agency or program;
h) Plano (non-prescription) lenses or contact lenses;
i) non-prescription sunglasses;
j) two pair of glasses in lieu of bifocals;
k) services or materials provided or paid for in whole or in part by any other group benefit plan providing vision benefits;
l) certain name brand Vision Materials for which the manufacturer maintains a no-discount practice;
m) services rendered after the date an Insured Person ceases to be covered under the Policy; or
n) lost, stolen, or broken lenses, frames, glasses, or contact lenses until the next Benefit Frequency when Vision Materials would next become available.