

Exhibit A

Uniform Health Plan and Benefits Coverage Matrix: **Co-Payments and Deductibles** **“12/24/24” PLAN 3**

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN 3 BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
CO-PAYMENT	\$[] each twelve (12) months
LIFETIME MAXIMUMS	NONE
PROFESSIONAL SERVICES	
Eye Examination (includes refraction)	A member is entitled to one eye examination each twelve (12) months with a follow-up visit at the Member's request, if necessary
OUTPATIENT SERVICES	NOT COVERED
HOSPITALIZATION SERVICES	NOT COVERED
EMERGENCY HEALTH COVERAGE	NOT COVERED
AMBULANCE SERVICES	NOT COVERED
PRESCRIPTION DRUG COVERAGE	NOT COVERED
DURABLE MEDICAL EQUIPMENT	NOT COVERED
MENTAL HEALTH SERVICES	NOT COVERED
CHEMICAL DEPENDENCY SERVICE	NOT COVERED
HOME HEALTH SERVICES	NOT COVERED
OTHER:	
Frames:	Limited to one pair of ophthalmic eyeglass frames each twenty-four (24) months. The Plan will pay up to \$[] toward the Plan Provider's usual and customary retail fee. Any charges over the allowable amount must be paid directly to the provider at the time of service
Frame Repair (when possible) Assisting in the selection of frames Proper fitting and adjustment of frames Subsequent frame adjustments	No Charge
Lenses:	No Charge, subject to the limitations stated below. Limited to one pair of plastic ophthalmic lenses including tint #1, any color each twenty-four (24) months, if the examination indicates the need for visual correction or a prescription change. Prescription change is defined as: (1) a change of 0.5 Diopters or more in one or both eyes. (2) A shift in the axis of astigmatism of 15 degrees, or

PLAN 3 BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	<p>(3) a difference of vertical prism greater than 1 prism diopter.</p> <p>The lens benefit includes:</p> <ul style="list-style-type: none"> (1) Single vision lenses up to ± 6.00 diopters with ± 3.00 cyl. (2) Bifocal Lenses up to +3.00 add and including round top and flat top (25-28mm) (3) Trifocal Lenses flat top (7x25 and 7x28) (4) Lenticular lenses both single lenses and bifocal. <p>-----</p> <p>These benefits are designed to cover visual needs rather than Cosmetic/elective options. The Plan makes available many enhanced lens options at each Plan Provider's office at reduced costs. Progressive lenses are a popular choice as they are line-free, whereas traditional bifocal and trifocal lenses have a line in the middle of the lens. Coatings, thin materials and other specialty items are all available lens option upgrades at reduced costs. All enhanced lens option charges are to be paid directly to the selected Plan Provider at the time of service, by the Member.</p>
<p>Prescribing and ordering proper lenses Verifying accuracy of finished lenses Follow-up care as necessary</p>	<p>No Charge</p>
<p>Contact Lenses (Medically Necessary)</p>	<p>One pair of contact lenses each twenty-four (24) month period when medically necessary and required for anisometropia, keratoconus or following cataract surgery, or when visual acuity cannot be corrected in the better eye to better than 20/70 by standard means (eye glasses) except through the use of contact lenses. ("Anisometropia" means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other. "Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.)</p> <p>The Plan will pay up to \$250 to include the eye examination, fitting, and the medically necessary contact lenses. The balance, if any, in excess of the Plan payment must be paid by the Member to the Plan Provider at the time of service.</p>
<p>Contact Lenses (Cosmetic)</p>	<p>Members may elect contact lenses for Cosmetic usage <u>instead of lenses and frames</u> once every twenty-four (24) months. The Plan will pay \$100 (the allowable amount) toward the Plan Provider's usual and customary contact lens package fee, which includes the eye exam, fitting and contact lenses. The balance, if any, above the allowable amount must be paid directly to the Plan Provider at the time of service or after the fitting and delivery of the contact lenses. If Cosmetic contact lenses are desired, in addition to the basic benefit, there is a fixed additional fitting fee paid directly to the plan provider and a reduced cost for the contact lenses (See Schedule of Extras at Provider's Office). This cost-controlled lens enhancement brings additional options and value to the benefit plan.</p>