Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43216

SCHEDULE OF BENEFITS FOR VISION PLAN

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Nationwide Life Insurance Company at its administrative office and with the Policyholder.

Policyholder:	National Small Business Association
Eligible Classes:	All Association members
Method of Premium Payment:	Remitted by Insured Person to Us or Our Agent
Plan Year:	Service Year

SCHEDULE OF COVERED SERVICES

What is Covered? The following is a complete list of Covered Services and applicable Frequency Limitations. We will not pay benefits for expenses incurred for any Service not listed in this Schedule of Covered Services.

Service or Material	Frequency Limitations	Plan Maximum Covered Expense	
		Participating Provider	Non-Participating Provider*
Eye Examination	Once every 12 months	Covered in full after Copay	Covered up to a maximum of $45
Lenses, Single Vision	Once every 12 months	Covered in full after Copay	Covered up to a maximum of $30
Lenses, Lined Bifocal	Once every 12 months	Covered in full after Copay	Covered up to a maximum of $50
Lenses, Lined Trifocal	Once every 12 months	Covered in full after Copay	Covered up to a maximum of $65
Lenses, Lenticular	Once every 12 months	Covered in full after Copay	Covered up to a maximum of $100
Frames**	Once every 24 months	Covered in full to a maximum of $130*	Covered up to a maximum of $70
Contact Lenses, Elective – Materials only	Once every 12 months	Covered in full to a maximum of $130	Covered up to a maximum of $105***
Contact Lenses, Elective – Fitting and Evaluation	Once every 12 months	Covered in full after $60 Copay	
	Prescription contact lens materials covered-in-full up to the amount listed above in lieu of frame and lenses.		
Contact Lenses, Visually Necessary	Once every 12 months	Covered in full	Covered in Full to a maximum of $210
Maximum benefit for all Low Vision services and materials		$1,000	$1,000
Low Vision – Supplemental Testing	Up to twice every 2 years	Covered in full	Reimbursed up to $125
Low Vision – Supplemental Aids	Once every 2 years	75% of Our Participating Provider fee, up to $1,000	75% of Open Access Provider fee, up to $1,000

Low Vision Services are a Benefit when specific criteria are satisfied and when prescribed by covered Person's Participating Provider.

* Covered Persons may receive additional savings and some services may be covered in full by choosing to visit a Retail Chain Affiliate. Copayment may apply.
**Frame Covered Expense may be applied towards prescription sunglasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.
***Prescription contact lens fitting, evaluation and materials covered-in-full up to the allowance listed (in lieu of frame and lenses).

Copayment: $10 for the examination payable by the Covered Person at the time services are rendered. If materials are provided, there will be an additional $25 copayment payable by the Covered Person at the time the materials are ordered. The Copayment does not apply to Elective Contact Lenses.

Lens Options, if covered under this plan, may have a separate Copayment.

Polycarbonate lenses are covered in full for dependent children up to age 18.