PART I - SCHEDULE OF BENEFITS

Policyholder:	Terrakotta Inc dba Laguna Clay Company
Policy Effective Date:	06/01/2026
Policy Number:	AFCA373718
Policyholder's Address:	14400 Lomitas Ave City of Industry, CA 91746
Associated Companies:	NA
Initial Term:	24 Months
Eligible Classes:	All Actively at Work Eligible Members working at least 30 hours per week and Eligible Dependents completing the Eligibility Period
Eligibility Period:	First of the month following 2 months from the first day of Actively at Work
Mode of Premium Payment:	Monthly
Method of Premium Payment:	Remitted by Policyholder to Us
Premium Due Date:	1st of every month
Plan Year:	Your Plan Year is a Calendar Year Plan

BENEFITS AND ALLOWANCES [1]

	In-Network Provider:			Out-of-Network Provider:
	Visionworks	**Collection**	**Non-Collection**	
Vision Exam:				
Benefit Frequency: Once every 12 Months	$10 Co-Pay	$10 Co-Pay	$10 Co-Pay	Up to $40 allowance
Telemedicine Eye Exam: [2]				
Benefit Frequency: Once every 12 Months	$10 Co-Pay	$10 Co-Pay	$10 Co-Pay	Up to $40 allowance
Fundus Photography (Retinal Imaging) Exam				
Benefit Frequency: Once every 12 Months	$39 Co-Pay	$39 Co-Pay	$39 Co-Pay	Not Available
Contact Lenses Evaluation, Fitting, and Follow-Up Care:				
Benefit Frequency: Once every 12 Months				
Standard	Not Available	Not Available	Not Available	Not Available
Specialty	Not Available	Not Available	Not Available	Not Available
Collection	Not Available	Covered in Full	Not Available	Not Available
Vision Materials [3]				
Eyeglass Lenses – per pair [4] Benefit Frequency: 12 Months	$25 Co-Pay	$25 Co-Pay	$25 Co-Pay	Up to allowance
Single Vision	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Up to $40 allowance
Bifocals	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Up to $60 allowance

Trifocals	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Up to $80 allowance
Lenticular	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Covered in Full After $25 Co-Pay	Up to $100 allowance
Eyeglass Frames [4]				
Benefit Frequency: Once 24 Months				
Collection [3] Fashion Designer Premier	Not Available	 Covered in Full Covered in Full $25 Co-Pay	Not Available	Not Available
Non-Collection	Up to $180 allowance	Not Available	Up to $130 allowance	Up to $50 allowance
Contact Lenses [5]				
Benefit Frequency: Once every 12 Months				
Collection [3 5] Planned Replacement Disposable	Not Available	 2 boxes 4 boxes	Not Available	Not Available
Non-Collection [5]	Up to $130 allowance	Not Available	Up to $130 allowance	Up to $105 allowance
Non-Elective/Visually-Necessary Contact Lenses [5 6 8]	Covered in Full	Not Available	Covered in Full	Up to $225 allowance
Lens Options – per pair [7]				
Benefit Frequency: Once every 12 Months				
Tint [7]	Covered in Full	Covered in Full	Covered in Full	Not Available
Ultraviolet (UV) Coating [7]	$12 Co-Pay	$12 Co-Pay	$12 Co-Pay	Not Available
Scratch Resistant Coating [7]	Covered in Full	Covered in Full	Covered in Full	Not Available
Scratch Protection Plan [7] Single Vision Multifocal	 $20 Co-Pay $40 Co-Pay	 $20 Co-Pay $40 Co-Pay	 $20 Co-Pay $40 Co-Pay	Not Available
Polycarbonate Lenses [7] Age 18 and Under Over Age 18	 Covered in Full $30 Co-Pay	 Covered in Full $30 Co-Pay	 Covered in Full $30 Co-Pay	Not Available
Progressive Lenses [7] Standard Premium Ultra Ultimate	 $50 Co-Pay $90 Co-Pay $140 Co-Pay $175 Co-Pay	 $50 Co-Pay $90 Co-Pay $140 Co-Pay $175 Co-Pay	 $50 Co-Pay $90 Co-Pay $140 Co-Pay $175 Co-Pay	Paid at the lined Bifocal benefit level [9]
Intermediate Digital Lenses [7]	$30 Co-Pay	$30 Co-Pay	$30 Co-Pay	Not Available
Photochromic [7] Plastic Lenses	 $65 Co-Pay	 $65 Co-Pay	 $65 Co-Pay	 Not Available
Polarized Lenses [7]	$75 Co-Pay	$75 Co-Pay	$75 Co-Pay	Not Available
Anti-Reflective (AR) Coating [7] Standard Premium Ultra Ultimate	 $35 Co-Pay $48 Co-Pay $60 Co-Pay $85 Co-Pay	 $35 Co-Pay $48 Co-Pay $60 Co-Pay $85 Co-Pay	 $35 Co-Pay $48 Co-Pay $60 Co-Pay $85 Co-Pay	Not Available
High-Index Lenses [7]	$55 Co-Pay	$55 Co-Pay	$55 Co-Pay	Not Available
Blue Light Filtering [7]	$15 Co-Pay	$15 Co-Pay	$15 Co-Pay	Not Available

[1]Where an “allowance” is shown, You are responsible for paying any charges in excess of the allowance.

[2]The Telemedicine Eye Exam is paid in lieu of the Vision Exam.

[3]Collection Vision Materials are not available from Non-Collection or Out-of-Network Providers.

[4]Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

[5]Contact Lenses are payable in lieu of Eyeglass Lenses and Frames.

[6]Prior Authorization Required.

[7]This Lens Option benefit is in addition to the standard Lens benefit shown above.

[8]If the Non-Elective Contact Lenses are prescribed solely for the purpose of correcting aphakia (after cataract surgery), then a pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective Contact Lenses for this condition.

[9]Under this benefit the Provider will apply the retail charge for standard bifocal lenses against the charge for the style of Progressive lens You have selected. You pay the Provider the difference, if any, between the two.