

Renaissance Life & Health Insurance Company of America
Summary of Vision Plan Benefits – Choice Plan
For Group # 3605
American Better Health Organization

This Summary of Vision Plan Benefits is part of, and should be read in conjunction with your Group Vision Certificate. Your Group Vision Certificate will provide you with additional information about your RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA (“RLHICA”) coverage, including information about exclusions and limitations.

Benefit Year – January 1 through December 31

Covered Services

RLHICA will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Covered Persons of RLHICA are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Administrative Services for the adjudication of claims and the payment of Benefits under this Plan will be provided by Vision Service Plan Insurance Company (“VSP”), using a VSP network of Providers. VSP is sometimes referred to as the claims administrator for this Plan. If Benefits are available for Out-of-Network Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether an In-Network or Out-of-Network Provider. This Summary forms a part of the Certificate to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network.

When Benefits are received from In-Network Providers, Benefits appearing in the In-Network Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Benefits are received from Out-of-Network Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Covered Person pays the Provider the full fee at the time of service and submits an itemized bill to RLHICA’s claims administrator for reimbursement. Discounts do not apply for Benefits obtained from Out-of-Network Providers.

Copayment

Benefits received from In-Network Providers and Out-of-Network Providers require Copayments.

There shall be a Copayment of \$ 10 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$ 25 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Options, if covered under this Certificate, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to \$ 45.00*	Available once each calendar year**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each calendar year**
Single Vision	Covered in full *	Up to \$ 30.00*	
Lined Bifocal	Covered in full *	Up to \$ 50.00*	
Lined Trifocal	Covered in full *	Up to \$ 65.00*	
Lenticular	Covered in full *	Up to \$ 100.00*	
Benefits for lenses are per complete set, not per lens.			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to \$ 70.00*	Available once every 2 calendar years**
Benefits for lenses and frames include reimbursement for the following necessary professional services:			
<ol style="list-style-type: none"> 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. 			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each calendar year**
Professional Fees/Materials	Covered in full*	Up to \$ 210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once each calendar year**, after a maximum \$60.00 Copayment.		Available once each calendar year**
	Materials Up to \$ 130.00	Professional Fees/Materials Up to \$ 105.00	

*Less any applicable Copayment.

**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Services when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Provider or Out-of-Network Provider. Review and approval by RHLICA's claims administrator is not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Covered in full	Up to \$125.00	*
Supplemental Aids	75% of amount up to \$1000.00*	75% of amount up to \$1000.00*	*

*Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years.

Low Vision benefits secured from Out-of-Network Providers (if covered) are subject to the same time and Copayment provisions described above for In-Network Providers. The Covered Person should pay the Out-of-Network Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what would be paid to an In-Network Provider for the same services and/or materials.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their In-Network Provider or by calling the Member Services Department at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no Benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a $\pm .50$ diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above stated allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.
- Contact lens modification, polishing or cleaning
- Local, state and/or federal taxes, except where RLHICA or its claims administrator is required by law to pay.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

BENEFITS – AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and materials who are not contracted as In-Network Providers but who have agreed to bill RLHICA's claims administrator directly for Covered Services provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Covered Services included in this Schedule. Covered Persons should discuss requested services with their Provider or contact the Member Services Department for details.

COPAYMENT

There shall be a Copayment of \$10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional \$25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

Eye Examination Comprehensive examination of visual functions and prescription of corrective eyewear.	Covered in full *	Available once each calendar year**
Spectacle Lenses Single Vision, Lined Bifocal or Lined Trifocal	Covered in Full*	Available once each calendar year**
Frames	Covered up to the Plan allowance*	Available once every 2 calendar years**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to \$ 130.00	Available once each calendar year**
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The Elective Contact Lens fitting and evaluation services are covered in full once every calendar year, after a maximum \$60.00 Copayment.

Necessary Contact Lenses	Up to \$210.00*	Available once each calendar year**
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Necessary Contact Lenses are a Covered Service when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first date of service.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to \$ 125.00†

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to \$1000.00†

†Maximum benefit for all Low Vision services and materials is \$1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period

Low Vision Services are a Covered Service when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for In-Network Providers shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from an In-Network Provider or an Out-of-Network Provider.
3. RLHICA's claims administrator is unable to require Affiliate Providers to adhere to its quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Benefits.

Eligibility (Certificate Holder and Eligible Dependents) – All due-paying members in good standing and all individuals who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law. ("COBRA")

Also eligible are your Legal Spouse, your dependent Children who have not yet reached the end of the calendar year of their 26th birthday, if the Child is dependent upon you for support.

You pay the full cost of this coverage.

Benefits will cease on the last day of the month in which your employment is terminated, subject to all applicable laws or regulations.