

**Standard Eyeglass Lenses Benefit.** If You or Your Covered Dependent(s) incurs expenses for Standard Lenses, the Company will pay such expenses up to the Standard Eyeglass Lenses Maximum Benefit at the Benefit Frequency shown in the Benefit Schedule, subject to the Exclusions, provided: 1) such expenses were incurred while You or Your Covered Dependent(s) were covered under the Policy; and 2) You or Your Covered Dependent(s) have paid any applicable Copay, as shown in the Benefit Schedule.

**Eyeglass Frame Benefit.** If You or Your Covered Dependent(s) incurs expenses for eyeglass frames, the Company will pay such expenses up to the applicable Eyeglass Frame Maximum Benefit at the Benefit Frequency shown in the Benefit Schedule, subject to the Exclusions, provided: 1) such expenses were incurred while You or Your Covered Dependent(s) were covered under the Policy; and 2) You or Your Covered Dependent(s) have paid any applicable Copay, as shown in the Benefit Schedule.

**Contact Lenses Benefit.** If You or Your Covered Dependent(s) incurs expenses for contact lenses, the Company will pay such expenses up to the applicable Contact Lenses Maximum Benefit at the Benefit Frequency shown in the Benefit Schedule, subject to the Exclusions, provided: 1) such expenses were incurred while You or Your Covered Dependent(s) were covered for the applicable optical correction type under the Policy; and 2) You or Your Covered Dependent(s) have paid any applicable Copay, as shown in the Benefit Schedule.

In addition to the above, benefits will not be payable for expenses incurred for Sub Normal Optical Correction, unless: the Participating or non-Participating Provider of such services makes a request, in writing, to the Vision Benefit Manager that a special contact lens or lenses is necessary to achieve the best possible correction for You or Your Covered Dependent(s); and 2) the Vision Benefit Manager, upon review of such request, approves the request.

### Limitations

If the Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit, You or Your Covered Dependent(s) shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

### Exclusions

Benefits will not be payable under the Policy for expenses incurred for:

1. professional services and/or materials in connection with:
  - a. blended bifocals, no line, or progressive addition lenses.
  - b. compensated or special multi-focal lenses.
  - c. plain (non-prescription) lenses.
  - d. anti-reflective, scratch, UV400, or any coating of lamination applied to lenses.
  - e. subnormal visual aids.
  - f. tints other than solid.
  - g. orthoptics, vision training and developmental vision procedures.
2. broken, lost or stolen lenses, contact lenses or frames.
3. medical or surgical treatment of the eye, unless such treatment is performed during a Vision Examination, subject to the applicable Vision Examination Maximum Benefit shown in the Benefit Schedule.
4. services or materials which are payable under any Worker's Compensation Act or similar law or any public program other than Medicaid.
5. services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
6. vision examination for vision materials that may be required as a condition of employment, including, but not limited to, industrial or safety glasses.
7. services rendered after the date You or Your Covered Dependent(s) ceases to be covered under this Policy, except when vision materials ordered before coverage ended are delivered and the services are rendered to You or Your Covered Dependent(s) within 31 days from the date of such order.

Regardless of the Optical Necessity, benefits are not available more frequently than that which is specified in the Benefit Schedule.

### Vision Claim Filing and Appeal Instructions

HOW TO FILE A CLAIM: If you or any of your eligible dependents incurs expenses for benefits payable under the vision policy from a participating provider, you or they will pay: (1) the difference in cost (at the time of the purchase) between the maximum allowable benefit and the cost for such purchase; and (2) any applicable Copay, as shown in the vision schedule of benefits. No claim form will need to be filed. If you or any of your eligible dependents incurs expenses for benefits payable under the vision policy from a non-participating provider, you or they will be required to pay the full cost at the time of the purchase. A proof of claim must be submitted, consisting of: (1) an itemized receipt from the non-Participating Provider; (2) the Date of Service; (3) the name of the non-Participating Provider; (4) the charges incurred from such non-Participating Provider; and (5) the name of the Insured Person on whose behalf the charges were incurred, to the Vision Benefit Manager at PO Box 2187, Clifton, NJ 07015 in order to be reimbursed for the amount payable under the Policy. The receipt should also include the Policyholder's name and the Policy Number.

Timely Filing: Timely filing of claims is important. Claims submitted twelve (12) months or more beyond the date of service will not be eligible for payment.

HOW TO HAVE A CLAIM DENIAL REVIEWED: If a claim received for payment is denied in whole or in part based on the criteria set forth in the schedule of benefits for that plan, a notice of denial will be sent by NVA to the member and/or appropriate provider(s) within 30 days of receipt of the claim.



**AIG LIFE INSURANCE COMPANY**  
600 KING STREET  
WILMINGTON, DELAWARE 19801  
(302) 594-2000  
(Herein called the Company)

### GROUP VISION INSURANCE CERTIFICATE OF COVERAGE

**ABOUT THIS CERTIFICATE:** This Certificate describes vision insurance the Company provides to Insured Employees and to their Covered Dependant(s), if Family Coverage is elected, under the Group Policy (herein called the Policy) issued to the Policyholder.

President

Secretary

### PCI Insurance, Inc. Insured Plan

#### Benefit Schedule

	Participating Provider	Non-Participating Provider
<b>Vision Examination Benefit</b>		
Benefit Copay Amount	\$10	N/A
Maximum Benefit	100%	\$35
Benefit Frequency is <b>once every 12 months</b> from the Date of Service per Plan Year.		
<b>Contact Lens Evaluation and Fitting</b>		
	100%	\$20 daily; \$30 extended
Benefit Frequency is <b>once every 12 months</b> from the Date of Service per Plan Year.		
<b>Standard Eyeglass Lenses Benefit (per pair)</b>		
Maximum Benefit		
Single Vision Standard Lenses	100%	\$35
Bifocal Standard Lenses	100%	\$45
Trifocal Standard Lenses	100%	\$55
Aphalkic/Lenticular Standard Lenses	100%	\$80
Benefit Frequency is <b>once every 12 months</b> from the Date of Service per Plan Year.		
<b>Lens Options</b>		
Solid Tint	\$10	No discount
Gradient Tint	\$12	No discount
Scratch Coating	\$10	No discount
Ultraviolet coating	\$12	No discount
Anti-reflective Coating	\$40	No discount
Glass Phtogray (Single Vision)	\$20	No discount
Glass Photogray (Multi-Focal)	\$30	No discount
Progressive Standard Lenses	\$50	No discount
Transistions Single Vision Standard	\$65	No discount
Transitions Multi-Focal Standard	\$70	No discount
Polycarbonate (Single Vision)	\$25	No discount
Polycarbonate (Multi-Focal)	\$30	No discount
Blended Segment	\$30	No discount
Polaroid	\$75	No discount
Glare Resistant	\$35	No discount
High Index	\$55	No discount

**Lens Options purchased from a participating NVA provider will be provided to the member at the amounts listed above. Lens Options that are purchased from a Non-Participating provider will not be discounted and are the full responsibility of the member.**

## **Eyeglass Frame Benefit**

Maximum Benefit	\$82 retail	\$60
Amounts above maximum benefit are non-covered expenses, Subscriber pays retail less 30% at participating provider locations.		
Benefit Frequency is <b>once every 12 months</b> from the Date of Service per Plan Year.		

## **Contact Lenses**

In lieu of Standard Eyeglass Lenses and Eyeglass Frames Benefit.

Maximum Benefit for Contact Lenses:	\$100	\$75
Medically Necessary (per pair)	100%	\$150
Amounts above maximum benefit and specialty lenses are non-covered expenses, Subscriber pays retail less 25% at participating providers. Contact Lens Evaluation or Fitting Fee are deducted from the Contact Lens Allowance.		
Benefit Frequency is <b>once every 12 months</b> from the Date of Service per Plan Year.		

## **Definitions**

**Covered Dependent(s)** – means Your Eligible Dependent Child(ren): (1) whom You have elected to cover under the Policy; (2) for whom premium has been paid while covered under the policy.

**Date of Service** – means the calendar date on which a specific service was provided or materials were ordered, which are payable under the policy.

**Eligible Person** – shall mean a person that satisfies the eligibility requirements and is therefore eligible to receive Benefits under this Policy as a Subscriber or a Dependent.

**Immediate Family Member** – means a person who is related to You or Your Covered Dependent(s) in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

**Ophthalmologist** – means a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology, who is not: 1) You or Your Covered Dependent(s); 2) an Immediate Family Member; or 3) retained by the Policyholder.

**Optically Necessary/Optical Necessity** – means a prescription or a change of prescription is required to correct visual function.

**Optician** – means a person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an Optometrist or an Ophthalmologist, who is not: 1) You or Your Covered Dependent(s); 2) an Immediate Family Member; or 3) retained by the Policyholder.

**Optometrist** – means a person licensed to practice Optometry as defined by the laws of the state in which his or her services are rendered, who is not: 1) You or Your Covered Dependent(s); 2) an Immediate Family Member; or 3) retained by the Policyholder.

**Participating Ophthalmologist** – means an Ophthalmologist who is a Participating Provider.

**Participating Optometrist** – means an Optometrist who is a Participating Provider.

**Participating Provider** – means an Ophthalmologist, Optician or Optometrist who has elected to enter into a contract with the Vision Benefit Manager and who is listed in the Participating Provider Directory.

**Standard Lenses** – means any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

**Sub-Normal Optical Correction** – means vision is not correctable to better than 20/70 in the better eye by use of conventional lenses.

**Vision Benefit Manager** – Means the organization contracted to administer the vision benefit plan in effect for the Policyholder. The Vision Benefit Manager for this plan is National Vision Administrators, LLC.

**Vision Examination** – means an examination of principal vision functions. A Vision Examination includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the provider practice is located.

**Subscriber** – Shall mean a person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for coverage under the Policy, who enrolled under this Policy by submitting an Enrollment Application to the appropriate entities that administer your plan .

**Vision Examination** – means an examination of principal vision functions. A Vision Examination includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the provider practice is located.

**You or Your** – means the Eligible Employee who: (1) has been issued a program identification card; (2) has enrolled for coverage under the Policy; and (3) for whom premium is paid while covered under the Policy.

**Ward** – Shall mean children for whom the subscriber or Subscriber's spouse has been granted legal custody by a court of competent jurisdiction.

## **Eligible Members**

1. Employee/Subscriber
2. Employee's Spouse
3. Dependent children to age 19 (to age 23 of unmarried, full-time student)
4. Dependent children physically or mentally unable to be self-supporting regardless of age.

**To be eligible to be enrolled under this Policy as a Dependent, an individual must be:**

1. the lawful spouse of the Subscriber;
2. unmarried child(ren) under age nineteen (19) who are: (i) the birth children of the Subscriber or the Subscriber's spouse; or (ii) legally adopted by or placed for adoption with the Subscriber or the Subscriber's spouse; or (iii) Wards;
3. unmarried child(ren) under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order;
4. unmarried child(ren) nineteen (19) or older who: (i) are either the birth or adopted children or Ward of the Subscriber or the Subscriber's spouse, (ii) are mentally or physically incapable of earning a living, and (iii) are chiefly dependent upon the Subscriber or Subscriber's spouse for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19),
5. unmarried children over age nineteen (19) until the age of twenty-three (23) who: (i) are either the birth or adopted children or Ward of the Subscriber or the Subscriber's spouse, and (ii) are attending and are enrolled full-time in an accredited educational institution, defined as an accredited university or college, or in a technical or specialized school. An unmarried child over age nineteen (19) enrolled in a correspondence school is not a Dependent for purposes of this Policy.

## **Premium**

**Premiums.** The Company provides insurance in return for premium payments. The Company may change the required premiums due by giving the Policyholder at least 31 days in advance written notice. The Company may also change the required premiums at any time when any coverage change affecting premiums is made in the Policy.

**Grace Period.** A Grace Period of 31 days will be provided for the payment of any premium due after the first. Your coverage will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. Your coverage will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period. No grace period will be provided if the Company receives notice to terminate the Policy prior to a premium due date.

## **Vision Benefits**

The amount of Vision Benefits payable under the Policy and the manner of payment is determined by whether You or Your Covered Dependent(s) utilizes the services of a Participating Provider or a non-Participating Provider. You will receive a program identification card or cards for use while covered under the Policy.

### **Participating Provider**

When You or Your Covered Dependent incur the services of a Participating Provider, You or Your Covered Dependent(s) may be required to present the program identification card to the Participating Provider. The Participating Provider may:

- (1) verify eligibility; and (2) notify You of any out-of-pocket expenses.

### **Non-Participating Provider**

If You or Your Covered Dependent(s) incur services of a non-Participating Provider, the Insured Person will be required to pay the full cost of such services at the time of purchase.

If You or Your Covered Dependent(s) incur charges under the Contact Lenses Benefit for Sub-Normal Optical Correction from a non-Participating Provider, You may be required to present the program identification card so that the non-Participating Provider may contact the Vision Benefit Manager for pre-approval.

**Vision Examination Benefit.** If You or Your Covered Dependent(s) incurs expenses for a Vision Examination, the Company will pay such expenses up to the applicable Vision Examination Maximum Benefit at the Benefit Frequency shown in the Benefit Schedule, subject to the Exclusions, provided: 1) such expenses were incurred while You or Your Covered Dependent(s) were covered under the Policy; and 2) You or Your Covered Dependent(s) have paid any applicable Copay, as shown in the Benefit Schedule.