VISION CARE BENEFIT SUMMARY FOR SALARIED EMPLOYEES

UPDATED JANUARY 1, 2010

RTD VISION CARE PLAN- Questions & Answers

♦ **What are the plan benefits?**

Participation in the vision plan enables you and your eligible dependents to receive high quality vision care services. The Schedule of Benefits is listed below.

SCHEDULE OF BENEFIT	AMOUNT OF BENEFIT
Contact Lens Eye Examination	$50.00 each year
Frames	(Included in the maximum benefit)
Single Vision Lens Exam and Frames included	$300.00 in a 2 year period
Bifocal Lens Exam and Frames included	$325.00 in a 2 year period
Trifocal Lens Exam and Frames included	$375.00 in a 2 year period
Progressive Lens Exam and Frames included	$350.00 in a 2 year period
Contact Lenses (Can be combined with other benefits up to maximum allowable)	$225.00 in a 2-year period
LASIK Surgery (In lieu of other benefits in a 2 year period)	$175.00 lifetime benefit per eye

♦ **Who are acceptable providers?**

The Vision Plan that you are a participant in allows you to choose any licensed ophthalmologist, optician, optometrist, or an optical chain to provide services to you and your eligible dependents. **Note:** If you are covered under either RTD's medical plans you can choose a network provider and pay the applicable co-payment to maximize your total benefit dollars available.

♦ **What is included in the plan design?**

An eye exam as well as your choice of frames and lenses from any assortment available is included and reimbursed at maximum benefit levels.

♦ **Are contact lenses included?**

Contact lenses are available through the plan (Refer to the schedule of benefits listed above for maximum benefit levels available in a 2 year period.); you may select contact lenses, and glasses in your two (2) year eligibility period however your maximum benefit is the greater of either.

♦ **Are there any restrictions?**

Refer to the ***WHAT IS NOT COVERED*** section for restrictions on benefits.

♦ **How do I obtain authorization to use the plan?**

There is no pre-authorization needed. When vision care services are needed you;

- **Contact** a provider of your choice,
- **Receive** the services,
- **Pay** for the services, and
- **Submit** a **Vision Care Reimbursement Claim Form** along with the appropriate documentation to receive reimbursement up to the limits of the plan.

♦ **How is the two year period calculated?**

Your two (2) year eligibility period is calculated from the year you begin using the plan and counting forward 2 consecutive years to determine your eligibility time frame. It does not matter which month the services are received, we only look at the year the services are received. (See sample below)

Joe and Jeannie Clerston have dual coverage, Joe began using his vision benefits on **June 14, 2004**, he had an eye exam and used a medical plan provider therefore the exam cost $20.00. Jeannie had her eye exam at an out of network provider on **July 1, 2004** and she paid $105 for her exam. Joe purchased Bi-focal lenses on **July 8, 2004** for $325.00. Jeannie needed Single vision lenses and purchased a pair for $160.00

Joe completed a Vision Care Reimbursement Claim form on September 22, 2004 the information below shows how the claims were processed.

Name of Participant	Date of Service	Type of Service	Cost of Service	Amount Reimbursed
Joe Clerston	06/14/2004	Eye exam	$20.00	$20.00
Joe Clerston	07/08/2004	Bi-Lens pkg.	$325.00	$305.00 (paid maximum benefit of $325.00 exams, lens, frames included)
Jeannie Clerston	07/01/2004	Eye exam	$105.00	$105.00
Jeannie Clerston	08/20/2004	SV Lens pkg	$160.00	$160.00

Joe has used his maximum vision plan benefit; Jeannie has used $265.00 of her $300.00 and can use the $35.00 anytime within the two year period ending December 31, 2005. Both benefits availabilities will begin again on Jan 1, 2006. **(Calculation is without regard to month of service only year of service is used to calculate the 2 year period)**

♦ **Can I drop the vision plan at anytime?**

Once elected you must remain in the vision plan for three years.

♦ **Who do I call with questions?**

RTD Benefits Technician
Extension 3021 or (303) 299-3021
or
RTD Salaried Benefits Manager
Extension 2361 or (303) 299-2361

RTD VISION CARE PLAN- SUMMARY PLAN DESCRIPTION

SCHEDULE OF BENEFIT	AMOUNT OF BENEFIT
Contact Lens Eye Examination	$50.00 each year
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DEFINITION OF TERMS:

EYE EXAM- A series of tests and procedures to measure case history, visual acuity, eye health, eye muscle, refraction, and disposition.

REFRACTION- The tests performed to determine the refractive status of the eye and the optical correction needed.

OPTOMETRIST- A doctor of optometry providing all ophthalmic services except surgery. In most states they are licensed to treat ocular disease.

OPTHAMOLOGIST- A doctor of medicine who has completed a residency program in ophthalmology and specializes in treating diseases of the eye and performing ocular surgery.

OPTICIAN- A dispenser of eyeglasses. Some opticians also fit contacts.

SINGLE VISION- A lens with a single refracting power in contrast to the bifocal or trifocal.

BIFOCAL- A lens with 2 refractive powers. The upper part is for distance and the lower part of the lens is for near vision.

TRIFOCAL- A lens with 3 refractive powers. The upper is for distance, the lower is for the near vision and the middle is for intermediate distance.

PROGRESSIVE LENS- A no-line lens with a gradual blend of prescriptions worn instead of Bifocals or Trifocals.

CONTACT LENS- Small plastic discs that float on a layer of tears on the cornea that provides optical effects similar to conventional glasses.

LASIK-refractive surgery to eliminate myopia, myperopia, or astigmatism by changing the curvature of the cornea with a laser

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HOW THE PLAN WORKS:

Vision care reimburses employees for the cost of covered services and the supplies rendered or prescribed by an Ophthalmologist or Optometrist up to the applicable limits. Coverage is also provided for lenses, frames or contact lenses supplies by an Optician. **Enrollment in the Vision Plan is for a three year period.**

WHAT IS COVERED:

The pays 100% of the billed covered charge up to the amounts shown in the Schedule of Benefits for:

1) Contact lens Eye Examination:

- Eye exam performed by an Ophthalmologist or Optometrist, up to $50.00 per eligible person **once in any year** for contact lenses only exam.

2) **Exam Lenses and Frames:**

- Prescription lenses and frames, including the cost of exam, tinting, photograying and hardening of such lenses are covered up to the scheduled amounts stated above per employee and eligible dependent **in any consecutive 2 year period**.

3) **Contact Lenses**

- The maximum payment for contact lenses will be $225.00 and can be used in conjunction with exam, lenses, and frames **in any consecutive 2 year period**.

4) **LASIK Surgery**

- The plan will reimburse up to $175.00 per eye for LASIK surgery.

WHAT IS NOT COVERED

The following are not covered by your Vision Care Plan:

1) A visual analysis or visual aids that are not for Medically Necessary Care; or

2) A visual analysis performed by someone other than a Physician or Optometrist; or

3) Vision aids not prescribed by a Physician or Optometrist; or

4) A visual analysis or vision aids provided by a person in the Member or dependent's immediate family; or

5) Sunglasses, Except prescription; or

6) Frames purchased without prescription lens inserted, or

7) More than one complete Visual Analysis in any year; or

8) A visual analysis or vision aids paid for or furnished by the United States government or one of its agencies (except as required under Medicaid provisions or federal law): or

9) A visual analysis or vision aids provided as the result of a sickness that is covered by a Worker's Compensation Act or similar law; or

10) A visual analysis or vision aids provided as the result of an injury arising out of or in the course of any employment for wage or profit; or

11) A visual analysis or vision aids provided as the result of a sickness or injury due to voluntary participation in criminal activities; or

12) Shipping and Handling charges from mail order purchases; or

13) Claims submitted for services more that 365 days from service date.

14) Claims submitted as a dependent and also as an employee, if both parents are covered dependents may only be covered as dependents of one employee only.

CLAIMS DENIAL

If your claim is partially or fully denied, you may request a review of the decision. Upon denial of a claim, notify RTD's Benefits Department within 15 working days for information on the appropriate procedures to follow to have your claim reviewed.

WHEN COVERAGE ENDS

Your coverage under the Vision Care Plan ends on:

1) The last day of the calendar month in which you are no longer eligible to be a subscriber or enrolled dependent

2) The last day of the calendar month in which the Subscriber retired

3) The last day of the calendar month in which the Plan is discontinued by RTD.

CONTINUATION OF COVERAGE AND CONVERSION

If your coverage ends under the Policy, you may be entitled to elect Continuation Coverage in accordance with federal and state law.

VISION CLAIMS

All claims for vision benefits should be sent to: **Benefits, BLK-33, Attention: Benefits**

1) **DOWNLOAD** Vision Care Reimbursement claim forms from the Intranet Site.
2) **COMPLETE** the **Patient & Employee Information** section.

3) **COMPLETE** the **Examining Physician Section** or attach itemized receipt and verification of payment.

4) **COMPLETE** the **Dispenser Information Section** or attach itemized receipt and verification of payment.

5) **COMPLETE** the **Authorization for Release of Information**.

6) **Provide** verification of payment

7) **CHECKS ARE PROCESSED BI-WEEKLY AND MAILED TO YOUR DEPARTMENT**

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