Renaissance
DENTAL • VISION • LIFE • DISABILITY

DENTAL BENEFITS FOR:
The Episcopal Diocese of Fort Worth

EFFECTIVE DATE: November 01, 2025

DENTAL BENEFIT HIGHLIGHTS

Dental PPO

	DENTAL PPO PAYS	
	IN-NETWORK	OUT-OF-NETWORK
Diagnostic & Preventive Services Diagnostic and Preventive Services — includes exams, cleanings, fluoride, and space maintainers Emergency Palliative Treatment — to temporarily relieve pain Brush Biopsy — to detect oral cancer Radiographs — X-rays Sealants — to prevent decay of permanent teeth	100%	100%
Basic Services Other Basic Services — misc. services Periodontic Services — to treat gum disease Minor Restorative Services — fillings Endodontic Services — root canals Oral Surgery Services — extractions and dental surgery	80%	80%
Major Services Major Restorative Services — crowns and veneers Relines and Repairs — to bridges and dentures Prosthodontic Services — bridges, implants, and dentures	50%	50%
Orthodontics Orthodontic Services — braces (no age limit)	50%	50%
ADDITIONAL PLAN INFORMATION		
Allowed Amounts — in-network and out-of-network providers	PPO Fee	90th Percentile
Calendar Year Maximum — per person per Calendar Year Maximum. Applies to all services except orthodontic services.	$2,500	$2,500
Orthodontic Lifetime Maximum	$2,000	
Calendar Year Deductible — per person/per family. Does not apply to any Diagnostic & Preventive Services	$50/$150	

Services are included in our Major Services Guarantee. For more information see next page.

FIND AN IN-NETWORK DENTIST AT:
MYRENPROVIDERS.COM

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ADDITIONAL DENTAL INFORMATION

Waiting Period: None

Maximum Payment: Per person total per Calendar Year on Diagnostic & Preventive, Basic and Major Services. Plan payment will not exceed the higher amount shown in any benefit period or lifetime.

Deductible: Per person total per Calendar Year limited to a maximum family deductible per Calendar Year. Does not apply to any Diagnostic & Preventive Services

Major Services Guarantee: Benefits for Endodontic, Major Restorative, or Prosthodontic services received from an in-network dentist, will be paid up to 100% of the repair or equivalent replacement of the covered services, as deemed reasonable and appropriate at the sole discretion of Renaissance, for as long as you remain insured under the certificate. Replacement solely for cosmetic or aesthetic reasons is not included. To qualify for this guarantee, you must receive at least one Diagnostic & Preventive exam and cleaning each benefit year after the initial benefit was received.]

The Plan Specifications Are Subject To The Following Exclusions And Limitations: No pre-existing condition exclusions or limitations. Oral Exams are payable twice any Benefit Year. Prophylaxes are payable twice any Benefit Year. Fluoride treatments are payable once any Benefit Year up to age 19. People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment. Bitewing Radiographs are payable twice any Benefit Year and Full Mouth Radiographs are payable once any 3 year period. Sealants are payable only for the occlusal surface of first and second permanent molars once any 3 year period up to age 14. The surface must be free from decay and restorations. Space Maintainers are payable once a lifetime up to age 19. Crowns, Inlays, Veneers, Bridgework, Dentures and Implants are payable once any 5 year period.

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vsp vision care

VISION BENEFITS FOR:
THE EPISCOPAL DIOCESE OF FORT WORTH

EFFECTIVE DATE: November 01, 2025
CLASS: 3 All Eligible Employees

VISION BENEFIT HIGHLIGHTS

Vision

IN-NETWORK COVERAGE			
BENEFIT TYPE	**DESCRIPTION**	**COPAY**(1)	**FREQUENCY**
WellVision Exam	• Focuses on your eyes and overall wellness	**$10**	12 months
Prescription Glasses		**$25**	See Frames & Lenses
Frames	• **$150** allowance for a wide selection of frames(4) • 20% savings on the amount over your retail allowance(3)	Copay included in prescription glasses	12 months
Lenses	• Single Vision/Lined Bifocal/Lined Trifocal lenses • Polycarbonate lenses for dependent children	Copay included in prescription glasses	12 months
Lens Enhancements	• Standard/Premium/Custom Progressive Lenses • Savings of 20-25% on other lens enhancements(3)	**STAND. / PREM. / CUST.** $55 / $95 - $105 / $150 - $175	12 months
Contacts	• Contact Lenses coverage instead of Prescription Glasses	See Evaluation & Fitting	12 months
Evaluation & Fitting	• Elective Contact Lenses • Member receives 15% off of contact lens exam services;(3)	Up to $60 (evaluation & fitting)	12 months
Contact Lenses	• **$150** allowance for Elective Contact lenses • Medically Necessary Contact lenses covered in full after $25 copay at VSP doctor locations		12 months

ADDITIONAL SAVINGS	
Primary EyeCare Plan℠ (1)	$10 copy per visit at VSP doctors. Provides covered in full retinal screening for members with diabetes who do not have diabetic eye disease. (Additional exams and service for members with diabetes, glaucoma, or age-related macular degeneration. Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members.)(8)
Low Vision	Supplemental testing covered every two years. 75% coverage for approved low vision aids, up to $1,000 (less any amount paid for supplemental testing) every two years at VSP doctors
Glasses/ Sunglasses(7)	Members receive an extra $20 to spend on Featured Frame Brands including bebe, Calvin Klein, Cole Haan, Dragon®, Flexon®, Lacoste, Nike, and more. Go to vsp.com/specialoffers for details.(5)
Contacts	Get exclusive offer(s) on eligible elective contacts at VSP network doctors. Visit vsp.com/offers for more information.(6)
Retinal Screening	No more than $39 copay on routine retinal screening as an enhancement to a WellVision Exam
Laser Vision Correction	Average 15% off regular price or 5% off the promo price; discounts only available from contracted facilities(9)
Additional Offers	VSP's offers a variety of additional savings . Go to **vsp.com/offers** for details

OUT-OF-NETWORK COVERAGE:(11) Exam: Up to $45.00 | Frame: Up to $70.00 | Contacts: Up to $105 ($210 if medically necessary)(10)

LENSES: Single: Up to $30.00 | Lined Bifocal: Up to $50.00 | Lined Trifocal: Up to $65.00 | Progressive: Up to $50.00 | Lenticular: Up to $100.00

REAL PROVIDER CHOICES(1)

Your employees can choose their provider from more than 112,000 access points, including the largest national network of independent doctors and nearly 26,200 participating retail chain access points.** Find an eye doctor at **MyRenProviders.com.**

VSP Doctors: 80% offer early morning, evening and weekend hours. 24-hour access to emergency care.

Participating Retail Chains(1,10)**:** Your employees get the convenience of popular retail chains like these and more.

Walmart · sam's club · COSTCO OPTICAL · Visionworks · COHEN'S Fashion Optical · PEARLE VISION

ADDITIONAL VISION INFORMATION

In addition to the exclusions and limitations set forth in the Vision Benefit Highlight sheets, the following additional proposal information applies to all Vision plans. 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.(12)

(1) When covered-in-full services are obtained from a VSP network provider, the patient will have no out-of-pocket expense other than any applicable copays. Services and eye-wear obtained through out-of- network providers are subject to product availability and the same copays and limitations.

(2) Based on applicable laws, benefits may vary by location.

(3) Walmart and Costco published prices already include discounts instead of those noted.

(4) Retail frame allowance will vary at participating retail locations.

(5) Reflects current promotion, evaluated annually. Promotion/featured frame brands are subject to change and the promotional allowance does not apply at Walmart and Costco. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

(6) Offer(s) subject to change.

(7) 20% off applies to unlimited additional pairs of glasses valid through any VSP network provider within 12 months of the last covered eye exam.

(8) The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.

(9) Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Laser VisionCare discounts are only available from VSP-contracted facilities.

(10) Participating retail chains upon request. Benefits may vary at participating retail chain locations.

(11) Services and eyewear obtained through out-of-network providers are subject to product availability and the same copay and frequency limitations as services and eyeware obtained in-network.

(12) Coverage shall be governed solely by the terms of your Renaissance contract.

EXCLUSIONS AND LIMITATIONS:
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. (E1) Optional cosmetic processes (E2) Anti-reflective coating (E3) Color coating (E4) Mirror coating. (E5) Scratch coating (E6) Blended lenses (E7) Cosmetic lenses (E8) Laminated lenses (E9) Oversize lenses (E10) Polycarbonate lenses (E11) Photochromic lenses, tinted lenses except Pink #1 and Pink #2, may or may not be included. Please refer to your certificate. (E12) Progressive multifocal lenses (E13) UV (ultraviolet) protected lenses (E14) Certain limitations on low vision care.
NOT COVERED: There are no Benefits for professional services or materials connected with: (N1) Orthoptics or vision training and any associated supplemental testing. (N2) Plano lenses (less than a ± .50 diopter power). (N3) Two pair of glasses in lieu of bifocals. (N4) Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available. (N5) Medical or surgical treatment of the eyes. (N6) Corrective vision treatment of an Experimental Nature. (N7) Costs for services and/or materials above stated allowances. (N8) Services and/or materials not indicated on this Schedule as covered Plan Benefits. (N9) Contact lens modification, polishing or cleaning (N10) Local, state and/or federal taxes, except where RLHICA or its claims administrator is required by law to pay. (N11) Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.