OPEIU – 100/80 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,500 $3,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $5,000 $10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,900 $15,800	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $75 copay	80% after deductible
Telemedicine Services (3)	100% after deductible	Not Covered
Preventive Care (4)		
Routine Adult Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	100% after deductible	100% after in-network deductible for emergencies; 80% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay limit: 20 visits/benefit period	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after $25 copay limit: 20 visits/benefit period	80% after deductible

Benefit	In Network	Out of Network
Occupational Therapy	100% after $25 copay	80% after deductible
	limit: 20 visits/benefit period	
Spinal Manipulations	100% after $25 copay	80% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay	80% after deductible
Outpatient Substance Abuse Services	100% after $25 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design **Specialty Drugs must be purchased at Retail or Mail Order.**	**Retail Drugs (31/60/90-day Supply)** $10 / $20 / $30 Formulary generic copay $10 / $20 / $30 Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $70 / $140 / $210 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 Formulary generic copay $20 Non-Formulary generic copay $50 Formulary brand copay $100 Non-Formulary brand copay	

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(1) Your group's benefit period is based on a Calendar Year which runs from January 1 through December 31
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(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

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U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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បើលោកអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639។

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Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-800-876-7639.

OPEIU 90/70 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $6,000 $12,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $4,400 $8,800	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,900 $15,800	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $30 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $75 copay	70% after deductible
Telemedicine Services (3)	100% after $15 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	90% after deductible	90% after in-network deductible for emergencies; 70% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay limit: 20 visits/benefit period	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy	100% after $30 copay limit: 20 visits/benefit period	70% after deductible
Occupational Therapy	100% after $30 copay limit: 20 visits/benefit period	70% after deductible

Benefit	In Network	Out of Network
Spinal Manipulations	100% after $30 copay	70% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $30 copay	70% after deductible
Outpatient Substance Abuse Services	100% after $30 copay	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (6)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 100 days/benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design **Specialty Drugs must be purchased at Retail or Mail Order.**	**Retail Drugs (31/60/90-day Supply)** $10 / $20 / $30 Formulary generic copay $10 / $20 / $30 Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $70 / $140 / $210 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $30 Formulary generic copay $30 Non-Formulary generic copay $100 Formulary brand copay $175 Non-Formulary brand copay	

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(1) Your group's benefit period is based on a Calendar Year which runs from January 1 through December 31.
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(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
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اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

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OPEIU – 80/60 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $5,000 $10,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $4,400 $8,800	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,900 $15,800	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $40 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $40 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $40 copay	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $100 copay	60% after deductible
Telemedicine Services (3)	100% after $20 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 60% after deductible
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	80% after deductible	80% after in-network deductible for emergencies; 60% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $40 copay limit: 20 visits/benefit period	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Speech Therapy	100% after $40 copay limit: 20 visits/benefit period	60% after deductible
Occupational Therapy	100% after $40 copay limit: 20 visits/benefit period	60% after deductible

Benefit	In Network	Out of Network
Spinal Manipulations	100% after $40 copay	60% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $40 copay	60% after deductible
Outpatient Substance Abuse Services	100% after $40 copay	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	80% after deductible	60% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment (6)	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	limit: 100 days/benefit period	
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design **Specialty Drugs must be purchased at Retail or Mail Order.**	**Retail Drugs (31/60/90-day Supply)** $10 / $20 / $30 Formulary generic copay $10 / $20 / $30 Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $70 / $140 / $210 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $30 Formulary generic copay $30 Non-Formulary generic copay $100 Formulary brand copay $175 Non-Formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1-December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee

made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-800-876-7639 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-800-876-7639 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
. 1-800-876-7639

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

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Dental Plan

Benefit Provision	Plan B
Diagnostic Services (Not subject to Annual Maximum) ➢ Routine oral examinations ➢ Dental X-rays - Full mouth X-rays - Bitewing X-rays	**100%**
Preventive Services (Not subject to Annual Maximum) ➢ Routine cleanings ➢ Topical fluoride application for dependent children under age 19 ➢ Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under 19 years of age ➢ Sealants when provided to children. Coverage is limited to one sealant per tooth in any three-year period	**100%**
Basic Restorative ➢ Fillings ➢ Simple extractions ➢ Endodontics, including pulpotomy and root canal treatment	**100%**
Periodontal Services ➢ Diagnosis and treatment planning including periodontal examination ➢ Non-surgical periodontal therapy including periodontal scaling and root planing ➢ Surgical periodontal therapy ➢ Maintenance – post treatment preventive periodontal procedures (periodontal cleanings)	**100%**
Oral Surgery ➢ Surgical removal of teeth	**100%**
Prosthetics ➢ Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays) ➢ Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion) ➢ Replacement of an existing partial or full denture or bridge by a new denture or bridge	**50%**
Crown, Inlay and Onlay Restorations ➢ Single unconnected crowns, inlays and onlays ➢ Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing crown, inlay or onlay, and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable	**50%**
Orthodontics (Not subject to Annual Maximum) ➢ Diagnosis, including radiographs ➢ Active treatment, including necessary appliances ➢ Retention treatment following active treatment ➢ Lifetime maximum $1,500	**50%**
Annual Maximum	**$1,500**
Annual Deductible (*Excludes* Diagnostic, Preventive and Orthodontic Services)	**NONE**

NOTE: UCCI Participating Dentists will accept the Maximum Allowable Charge (MAC) reimbursement as payment in full.
This summary is intended as a general description of coverage. Specific limitations and exclusions may apply to some services.

VSP® Vision Care Plan Options

COVERAGE WITH A VSP PROVIDER	Vision Plan Design
	Advantage Premium Plus
Frequency	**All Members**
WellVision Exam®	Every calendar year
Lenses	Every calendar year
Frame	Every calendar year
Contact Lenses (instead of glasses)	Every calendar year
Copays	
Eye health examination	Covered
Essential Medical Eye Care[1]	$20 per exam
Contact lens evaluation and fitting	15% savings
Prescription Glasses – Frame	
Frame allowance (retail):	Up to $130 OR Up to $180 Featured Frame Brands[2] or any frame at Visionworks 20% savings on the amount over your allowance
Prescription Glasses – Lenses	
Clear plastic single vision, lined bifocal, trifocal, or lenticular lenses (any size or prescription)	Covered
Tints	Covered
Scratch-resistant coating	Covered
Impact-resistant lenses (children/adults)	$0 / $30
UV protection	$10
Anti-reflective (AR) coating (standard/premium/custom)	$41 / $69 / $85
Progressive lenses (standard/premium/custom)	$0 / $105 / $175
High-index lenses	80% of U&C[3]
Polarized lenses	80% of U&C
Light-reactive lenses (glass/plastic)	$75
Blended lenses	80% of U&C
Contacts (instead of glasses)	
Contact Lens: materials allowance	Up to $130 plus 15% savings on any overage
Medically Necessary Contact Lenses (with doctor approval) Materials, evaluation, fitting & follow-up care	Covered
Additional Savings	
Routine retinal screening	Up to $39 Fully covered for members with diabetes
Unlimited additional pairs of prescription or non-prescription eyewear	20% savings
Laser Vision Correction	Average of 15% off the regular price; discounts available at contracted facilities.
TruHearing	Save up to 60% on digital hearing aids with TruHearing[4]. Visit **vsp.com/offers/special-offers/hearing-aids** for details.

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR		
Exam: up to $40	Lined Bifocal Lenses: up to $60	Lenticular Lenses: up to $100
Frame: up to $50	Lined Trifocal Lenses: up to $80	Elective Contact Lenses: up to $105
Single Vision Lenses: up to $40	Progressive Lenses: up to $50	Medically Necessary Contact Lenses: up to $225

The **VSP Premier Edge™ Promise** is a worry-free eyewear guarantee that protects you from the unexpected—whether it's accidentally broken or damaged glasses, a prescription change, or a style change if you don't love the glasses you chose.[5]

Questions? Visit **vsp.com** or call **800.877.7195 (TTY: 711)**.

1. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.
2. Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.
3. Usual and Customary Fees
4. VSP is providing information to its members but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit **vsp.com/offers/special-offers/hearing-aids/truhearing.** For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.
5. Premier Edge Promise covers broken/damaged glasses or a prescription change within 12 months, or a style change within 100 days. Restrictions may apply; visit **vsp.com/offers/premier-edge-offers/glasses-and-sunglasses/Premier-Edge-Promise** for terms and conditions.

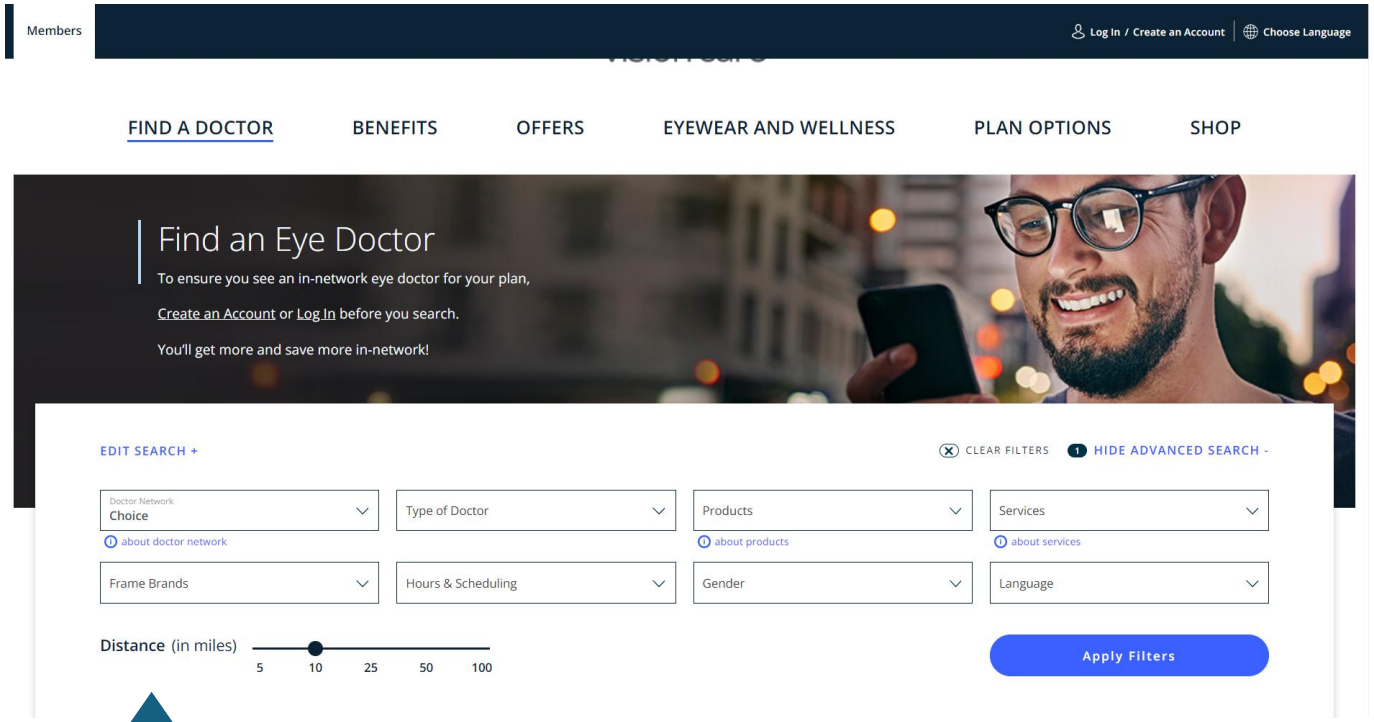
The Right Doctor for You

Using the Find a Doctor tool on **vsp.com** is easy

Visit **vsp.com/eye-doctor**
(or navigate from **vsp.com** home page)

Enter the preferences that are meaningful to you like:

- Location
- Gender
- Language
- Frame brands
- Specialty
- Services
- Hours & Scheduling



A sliding distance bar makes finding a match nearby easy. You can even opt to view locations on a map.