SBMA
Staff Benefits Management and Administrators

2019-2020 HEALTH INSURANCE ENROLLMENT & ACKNOWLEDGEMENT GUIDE

This notification is to inform you that you, and your qualified dependents, are eligible for benefits under your employer's open enrollment effective August 1st or the first of the month following 60 days the date of hire.

Should you choose to decline coverage, please complete the acknowledgement and check the box at the bottom of this page and you may disregard all remaining contents of this guide. If you choose to decline, you will not be able to enroll in benefits until the next open enrollment period or due to a qualifying event.

MINIMUM ESSENTIAL COVERAGE (MEC) BASIC

According to the Affordable Care Act (ACA), more commonly referred to as Obamacare, all individuals must be offered at least Minimum Essential Coverage (MEC). MEC covers 17 preventative services for adults, 22 additional services for women and 26 services for children.

COVERAGE OPTIONS

MEC Basic: Covers ONLY preventive services outlined in ACA 100%. Please note, This plan does NOT cover any additional medical services. MEC Basic includes prescription discounts through SingleCare®.

MEC Plus: Covers preventive services 100% and provides additional medical services such as office visits, urgent care, labs, x-rays and generic prescription drugs offered at various copays. Note: MEC Plus does not cover hospitalization, surgical procedures, emergency room or out-of-network services.

Anthem® Bronze PPO*: This PPO plan has a $5,600 individual deductible and covers medical services at various copay/coinsurance amounts.

Anthem® Silver PPO*: This PPO plan has a $1,750 individual deductible and covers medical services at various copay/coinsurance amounts.

California Dental HMO (ONLY AVAILABLE TO EMPLOYEES IN CALIFORNIA): Coverage includes diagnostic and preventative services at 100%, and all other services at specific copay amounts (see attached benefit summary for more details). Please note, you must see a provider in the California Dental Network.

Principal® PPO Dental: Coverage includes diagnostic and preventative services at 100%, basic and restorative services at 80% and major services and orthodontia at 50%.

Principal® Vision: Coverage includes comprehensive eye exams at a $10 copay, frame allowances, lenses at a $25 copay or contact lenses at an allowance or maximum $25 copay depending on medical necessity.

*Costs of Minimum Value Plans are based on affordability as mandated under ACA. Employees will not pay more than 9.86% of their salary toward employee only coverage.

ACKNOWLEDGEMENT OF RECEIPT

I,______________________________, hereby acknowledge receipt of the offer of health insurance benefits.

I have been provided with the Enrollment Guide and with the information pertaining to the benefit plan offering. I have been offered a plan for myself and my qualified dependents that provides both Minimum Essential Coverage (MEC) and Minimum Value plans. I understand I will not pay more than 9.86% of my pay toward employee only coverage.

I authorize my employer to make salary reductions on a pre-tax basis for my portion of the group insurance premiums. I understand that:

- I cannot change this election during the plan year unless I have a change in status as provided in the Internal Revenue Code and Regulations.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of (1) when I am no longer being paid compensation in an amount at least equal to my total salary reduction or (2) termination of the plan.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I understand if I decline medical coverage I will not be able to enroll in benefits until the next open enrollment period or due to a qualifying event.

Signature ______________________________ Date ____ / ____ / _______

Name ______________________________ Social Security Number _____ - ____ - ______

☐ DECLINE COVERAGE

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ENROLLMENT APPLICATION

EMPLOYEE INFORMATION

Name ____

Social Security Number __ __ __ - __ __ - __ __ __ __

Employer Name _____________________________________

Hire Date __ __ / __ __ / __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __

Sex ☐ M ☐ F

Address ____

City ____________________ State __ __ Zip __ __ __ __ __

DEPENDENT INFORMATION

Name ______________________________________

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __   Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name ______________________________________

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __   Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name______________________________________

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __   Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name______________________________________

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __   Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

MEDICAL

MEC BASIC

☐	**$5.77/week**	**Employee Only**	☐	**$11.54/week**	**Employee + Spouse**
☐	**$11.54/week**	**Employee + Children**	☐	**$17.31/week**	**Employee + Family**

MEC PLUS

☐	**$20.00/week**	**Employee Only**	☐	**$55.03/week**	**Employee + Spouse**
☐	**$39.07/week**	**Employee + Children**	☐	**$78.74/week**	**Employee + Family**

ANTHEM® BRONZE*

*Rates of Anthem® plans are age-based and subject to affordability. Please refer to rate page in this guide and ask your employer for final rates.

☐ **Employee Only**   ☐ **Employee + Spouse**

☐ **Employee + Children**   ☐ **Employee + Family**

ANTHEM® SILVER*

*Rates of Anthem® plans are age-based and subject to affordability. Please refer to rate page in this guide and ask your employer for final rates.

☐ **Employee Only**   ☐ **Employee + Spouse**

☐ **Employee + Children**   ☐ **Employee + Family**

Ancillary plan options are available on the following page

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ENROLLMENT APPLICATION

EMPLOYEE INFORMATION

Name ______________________________ Social Security Number __ __ __ - __ __ - __ __ __ __

DENTAL

CALIFORNIA DENTAL HMO
(ONLY AVAILABLE TO EMPLOYEES IN CALIFORNIA)

	Rate	Coverage		Rate	Coverage
☐	**$2.77/week**	**Employee Only**	☐	**$4.90/week**	**Employee + Spouse**
☐	**$5.48/week**	**Employee + Children**	☐	**$7.56/week**	**Employee + Family**

PRINCIPAL® PPO DENTAL

	Rate	Coverage		Rate	Coverage
☐	**$10.64/week**	**Employee Only**	☐	**$20.76/week**	**Employee + Spouse**
☐	**$25.92/week**	**Employee + Children**	☐	**$37.87/week**	**Employee + Family**

VISION

PRINCIPAL® VISION

	Rate	Coverage		Rate	Coverage
☐	**$2.22/week**	**Employee Only**	☐	**$3.87/week**	**Employee + Spouse**
☐	**$3.81/week**	**Employee + Children**	☐	**$5.49/week**	**Employee + Family**

EMPLOYEE DECLARATION

I declare the information provided above is complete and accurate. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from SBMA. **Please review pricing and benefit summaries prior to finalizing your selections.**

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage.)
ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act (“FAA”), including the FAA’s preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

✐Signature ______________________________ **Date __ __ / __ __ / __ __ __ __**

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MEC BASIC
BENEFIT SUMMARY

MEDICAL BENEFITS	MEC BASIC*
Annual Deductible	$0
Preventive / Wellness	Covered 100%
Primary Care / Specialist Office Visits	Preventive / Wellness Only Otherwise Not Covered
Urgent Care / Emergency Room / Hospital	Not Covered
Laboratory Services	Preventive / Wellness Only Otherwise Not Covered
X-Rays / Diagnostic Imaging	Not Covered
Prescription Discount Program**	Included

*MEC Basic excludes out-of-network services and covers ONLY the preventive services listed on the covered services page
**For more information regarding the prescription discount program please contact SingleCare at (866) 978-0843 or visit www.singlecare.com/sbma

To locate providers participating in the MultiPlan PHCS network call (888) 794-7427 or visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner of the page and follow the steps below.

1. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green "Select Network" button.
2. When selecting your network, choose "PHCS," then "Preventive Services Only."
3. Enter one of the search criteria suggested in the search box to begin your search.
4. If your browser settings don't allow your location to be detected, enter a zip code.

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MEC PLUS
BENEFIT SUMMARY

MEDICAL BENEFITS	MEC PLUS*
Annual Deductible	$0
Out-of-Pocket Maximum	$1,850 individual / $3,700 family
Preventive / Wellness	Covered 100%
Primary Care / Specialist Office Visits	$15 copay
Urgent Care	$50 copay
Emergency Room / Hospital	Not Covered
Laboratory Services	$50 copay
X-Rays	$50 copay
Generic Prescription Drugs	$5 copay

*MEC Plus excludes out-of-network services and covers ONLY the medical above services above. This plan does not cover emergency room care, hospitalization, surgical services, advanced imaging or brand name / specialty prescription drugs.

To locate providers participating in the MultiPlan PHCS network call (888) 263-7543 or visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner of the page and follow the steps below.

1. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green "Select Network" button.
2. When selecting your network, choose "PHCS," then "Specific Services."
3. Enter one of the search criteria suggested in the search box to begin your search.
4. If your browser settings don't allow your location to be detected, enter a zip code.

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MEC COVERED PREVENTIVE SERVICES

Covered Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 – 1965
11. HIV screening for everyone ages 15 to 65, and other ages at increased risk
12. Immunization vaccines for adults —doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
13. Lung cancer screening for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
14. Obesity screening and counseling for all adults
15. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
16. Syphilis screening for all adults at higher risk
17. Tobacco Use screening for all adults and cessation interventions for tobacco users

Covered Services for Women

1. Anemia screening on a routine basis for pregnant women
2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
3. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
4. Breast Cancer Chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. Cervical Cancer screening for sexually active women
7. Chlamydia Infection screening for younger women and other women at higher risk
8. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic Acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 months pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women
15. Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older

Covered Services for Women (continued)

16. Osteoporosis screening for women over age 60 depending on risk factors
17. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Sexually Transmitted Infections counseling for sexually active women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
21. Urinary tract or other infection screening for pregnant women
22. Well-woman visits to get recommended services for women under 65

Covered Services for Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. Cervical Dysplasia screening for sexually active females
6. Depression screening for adolescents
7. Developmental screening for children under age 3
8. Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
9. Fluoride Chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
13. Hematocrit or Hemoglobin screening for children
14. Hemoglobinopathies or sickle cell screening for newborns
15. HIV screening for adolescents at higher risk
16. Hypothyroidism screening for newborns
17. Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hemophilus influenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Meningococcal, Pneumococcal, Rotavirus, Varicella
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
21. Obesity screening and counseling
22. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. Vision screening for all children.

This plan provides no coverage for sickness, hospitalization or surgical benefits. Benefits are not limited to the schedule above.
For more information on covered services visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Anthem

Benefit Comparison

Covered Benefits	Bronze	Silver
Deductible	$5,00 individual / $11,200 family	$1,500 individual / $3,500 family
Out-of-pocket maximum	$7,900 individual / $15,800 family	$7,700 individual / $15,400 family
Preventive / Wellness	Covered 100%	Covered 100%
Primary Care Visits	$40/visit for the first 3 visits deductible does not apply, then $40/visit	$55/visit deductible does not apply
Specialist Visits	$80/visit for the first 3 visits deductible does not apply, then $80/visit	$80/visit deductible does not apply
Laboratory Services / X-Rays	Covered 60%	Covered 65%
Advanced Imaging (CT / PET / MRI)	Covered 60%	Covered 65%
Emergency Room Care	$200/visit then covered 60%	$300/visit then covered 65%
Emergency Transportation	Covered 60%	Covered 65%
Urgent Care	Covered 60%	$80/visit deductible does not apply
Hospital Facility/Physician fees	Covered 60%	Covered 65%
Outpatient Hospital / Surgery	Covered 60%	Covered 65%
Mental/Behavioral Health and Substance Abuse Services	Covered 60%	Outpatient - $55/visit then Covered 65% Inpatient - Covered 65%
Home health, Rehabilitation, Habilitation and Skilled Nursing	Covered 60%	Covered 65%
Durable Medical Equipment	Covered 50%	Covered 50%
Hospice services	Covered 100%	Covered 100%
Childbirth / Delivery	Office Visits - No Charge Facility/Physician fees - Covered 60%	Office Visits - No Charge Facility/Physician fees - Covered 65%
Prescription Drug Benefits	**Bronze**	**Silver**
Tier 1a - Lower Cost Generic (deductible does not apply)	$10/retail prescription $25/home delivery	$5/retail prescription $13/home delivery
Tier 1b - Generic	$20/retail prescription $50/home delivery	$20/retail prescription $50/home delivery (deductible does not apply)
Tier 2 - Preferred Brand	$60/retail prescription $180/home delivery	$50/retail prescription $150/home delivery
Tier 3 - Non-Preferred Brand	$100/retail prescription $300/home delivery	$90/retail prescription $270/home delivery
Tier 4 - Specialty	Covered 70% up to $500 max retail and home delivery	Covered 70% up to $250 max retail and home delivery

Age-Banded Weekly Rates

Age	Anthem Blue Cross Bronze PPO 5600	Anthem Blue Cross Silver PPO 1750
0 -14	69.47	78.19
15 -15	75.64	85.14
16 -16	78.00	87.80
17 -17	80.36	90.45
18 -18	82.91	93.32
19 -19	85.45	96.18
20 -20	88.08	99.14
21 -24	90.81	102.21
25 -25	91.17	102.62
26 -26	92.98	104.66
27 -27	95.16	107.11
28 -28	98.70	111.10
29 -29	101.61	114.37
30 -30	103.06	116.01
31 -31	105.24	118.46
32 -32	107.42	120.91
33 -33	108.78	122.44
34 -34	110.24	124.08
35 -35	110.96	124.90
36 -36	111.69	125.72
37 -37	112.42	126.53
38 -38	113.14	127.35
39 -39	114.60	128.99
40 -40	116.05	130.62
41 -41	118.23	133.08
42 -42	120.32	135.42
43 -43	123.22	138.70
44 -44	126.86	142.78
45 -45	131.12	147.59
46 -46	136.21	153.31
47 -47	141.93	159.75
48 -48	148.47	167.11
49 -49	154.91	174.37
50 -50	162.18	182.54
51 -51	169.35	190.62
52 -52	177.25	199.51
53 -53	185.24	208.50
54 -54	193.87	218.21
55 -55	202.50	227.92
56 -56	211.85	238.45
57 -57	221.29	249.08
58 -58	231.37	260.43
59 -59	236.37	266.05
60 -60	246.45	277.39
61 -61	255.16	287.20
62 -62	260.88	293.64
63 -63	268.06	301.72
64 -99	272.42	306.62

California Dental Network
A DentaQuest company

Dental Insurance

The No Problem Plan

- **No deductibles**
- **No claim forms**
- **No Annual Maximums**
- **No Limitations on Most Pre-Existing Conditions**
- **No Waiting Periods to See a Dentist**

- ❖ **The procedures below are covered benefits only when provided by a participating general dentist and are subject to plan limitations, exclusions and guidelines.**
- ❖ **Members must select, and be assigned to, a California Dental Network (CDN) plan contracted dental office to utilize covered benefits.**
- ❖ **Member Co-payments are payable to the dental office at the time of services.**
- ❖ **This schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.**
- ❖ **Dental procedures not listed are available at the dentist office's usual and customary fee. (Please note, this is not a complete list of covered services)**

Plan Features	In-Network
Annual Deductible	$0
Annual Maximum Benefit	N/A
Diagnostic and Preventive Services (cleanings, x-rays, exams)	Covered 100%
Restorative Services	$0-$150 depending on type and number of surfaces
Inlays/Onlays (Fillings)	$90-$250 depending on type and number of surfaces
Crowns	$150-$300 depending on type of fusion
Premium Alternative Crowns	$645-$900 depending on materials used
Endodontics (Root Canals)	$100-$235 depending on type of tooth
Dentures	$15-$225 depending on type and location
Implants	$450-$1,500 depending on type

For more information, including a complete schedule of benefits and information on how to locate a CDN provider, visit www.caldental.net or call (877) 4DENTAL

Principal

Dental Insurance

Dental Insurance can help you maximize your oral health and minimize out-of-pocket costs for routine dental check-ups, expensive procedures and most things in between. This PPO plan offers the flexibility to visit any licensed dentist, so you're sure to find a provider who meets your needs.

- **Large network of dentists, and the freedom to visit any dentist in or out-of-network.**
- **Additional savings when you visit a participating dentist. Participating dentists have agreed to accept negotiated fees for covered services, which are typically 30-45% less than the average fees charged by dentists in the same community.**
- **No paperwork in or out-of-network, if your dentist submits your claims for you.**

Plan Features	In-Network	Out-of-Network
Annual Deductible	$50 individual / $150 family	$50 individual / $150 family
Annual Maximum Benefit	$1,500	$1,500
Diagnostic and Preventive Services (cleanings, x-rays, exams)	Covered 100% (deductible waived)	Covered 100% (subject to deductible)
Basic and Restorative Services (fillings, extractions, root canals)	Covered 80%	Covered 80%
Major Services (crowns, bridges, dentures)	Covered 50%	Covered 50%
Orthodontia (dependent children only)	Covered 50% Lifetime Maximum: $1,000	Covered 50% Lifetime Maximum: $1,000

How to find a participating provider

Use the Provider Directory on www.principal.com/dentist to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist
2	Begin your search by picking the state where you would like to find a provider. Next, specify a network Depending on the network chosen, you may be transferred to a partner site.
3	Enter the name of the provider you are looking for (if known). If you are looking for a nearby dentist, enter the city and state and/or zip code. Be sure to indicate how far you are willing to travel.
4	Select the desired specialty or use the No Specialty Preference default. Click Continue.
5	Select a language if your preference is other than English. Click Continue.

Principal

Vision Insurance

Vision Insurance helps protect your eyesight and health, with lower out-of-pocket expenses for you.

- **Save on a wide range of services that are standard benefits under this plan, including routine eye exams, glasses, contact fittings and lenses. Plus, additional savings on non-prescription sunglasses and laser vision correction.**
- **Convenience of visiting any licensed eye care professional. Or choose from the thousands of participating ophthalmologists, optometrists and opticians in the VSP Network**

Plan Features	In-Network	Out-of-Network
Routine / Comprehensive Exam (one exam every 12 months)	$10 copay	Plan reimburses up to $45
Frames (once every 24 months)	Covered up to $130 allowance (20% discount on amounts greater than allowance)	Plan reimburses up to $70
Lenses (once every 12 months)		Plan reimburses:
Single vision	$25 copay	up to $30
Lined bifocal		up to $50
Lined trifocal		up to $65
Lenticular		up to $100
Elective Contact Lenses	up to $60 copay then $130 allowance	up to $105
Medically Necessary Contacts	$25 copay	up to $210

Additional Savings	
Glasses and Sunglasses	Members save an average of 20-25% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last covered vision exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

To locate providers in the VSP Network call (800) 877-7195 or visit www.vsp.com