SBMA

ENROLL NOW!

Time is limited

You are eligible for benefits under your employer's open enrollment effective August 1st or the first of the month following 30 days from your date of hire.

GET YOUR ID CARD IN DAYS

COVERAGE YOU NEED AT A PRICE YOU CAN AFFORD

BASIC MEDICAL C OVERAGE

Basic MEC: Covers all preventive services 100% and includes prescription discounts

MEC Plus: Covers all preventive services 100%, office visits, urgent care, labs, x-rays, and generic prescription drugs offered at various copays.

MAJOR MEDICAL COVERAGE

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

Anthem Silver: This PPO plan has a $1,850 individual deductible and covers medical services including emergency room and hospitalization at various copay/coinsurance amounts.

Costs of these plans are based on affordability as mandated by the Affordable Care Act (ACA). Employees will not pay more than 9.83% of their salary toward employee coverage.

ANCILLARY COVERAGE

Principal Dental: This PPO plan covers diagnostic and preventive services 100%, basic and restorative services 80% and major services and orthodontia 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, copay or in full depending on medical necessity.

California Dental (Only Available to Employees in California): This HMO plan covers diagnostic and preventive services 100%, and all other covered services at specified copay amounts. You must see a provider in the California Dental Network.

ENROLLMENT APPLICATION

SBMA

EMPLOYEE INFORMATION

Name______________________________ Social Security Number____________________

Employer______________________________ Hire Date______________________________

Date of Birth______________________________ Sex ❑ Male ❑ Female

Address______________________________ Phone Number____________________

City/State/Zip______________________________ Email______________________________

DEPENDENT INFORMATION

Name______________________________ Name______________________________

Social Security Number____________________ Social Security Number____________________

Date of Birth______________________________ Date of Birth______________________________

❑ Male ❑ Female ❑ Spouse ❑ Child ❑ Male ❑ Female ❑ Spouse ❑ Child

Name______________________________ Name______________________________

Social Security Number____________________ Social Security Number____________________

Date of Birth______________________________ Date of Birth______________________________

❑ Male ❑ Female ❑ Spouse ❑ Child ❑ Male ❑ Female ❑ Spouse ❑ Child

COVERAGE ELECTIONS

Medical Election (choose 1)				
Weekly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Employee/Family
Basic MEC	❑ $9.69	❑ $19.38	❑ $19.38	❑ $29.08
MEC Plus	❑ $24.61	❑ $64.31	❑ $48.30	❑ $92.59
Please use the following page for enrollment in Anthem plan options.				

Ancillary Elections				
Weekly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Employee/Family
Principal Dental	❑ $10.51	❑ $20.51	❑ $25.61	❑ $37.41
Principal Vision	❑ $2.22	❑ $3.87	❑ $3.81	❑ $5.49
California Dental CA Employees Only	❑ $2.77	❑ $4.90	❑ $5.48	❑ $7.56

❑ waive coverage

EMPLOYEE ACKNOWLEDGMENT

I hereby acknowledge the offer of health insurance coverage, providing Minimum Essential Coverage (MEC) and Minimum Value plan options, for myself, and my eligible dependents. If electing coverage, I authorize my employer to make salary reductions on a pre-tax basis for my portion of the insurance premiums. I understand that I may not make changes to my coverage elections until my employer's next open enrollment period or due to a qualifying event.

Signature____ Date______________________

ANTHEM ENROLLMENT ADDENDUM

SBMA

COMPLETE ONLY IF ENROLLING IN ANTHEM MEDICAL PLANS

ANTHEM PLAN ELECTION IN FORMAT ION

Name_______________________________ Social Security Number _______________________

Medical Election (choose 1)				
Plan Options	Employee Only	Employee/Spouse	Employee/Child(ren)	Employee/Family
Anthem Bronze	❑	❑	❑	❑
Anthem Silver	❑	❑	❑	❑
Please refer to age-banded rates below. Final rates are subject to change based on affordability.				

Monthly Rates by Age								
Age	Bronze	Silver	Age	Bronze	Silver	Age	Bronze	Silver
0-14	$314.77	$355.41	33	$492.94	$556.58	49	$701.97	$792.59
15	$342.75	$387.00	34	$499.52	$564.01	50	$734.89	$829.76
16	$353.45	$399.08	35	$502.82	$567.73	51	$767.39	$866.46
17	$364.15	$411.16	36	$506.11	$571.45	52	$803.19	$906.88
18	$375.67	$424.17	37	$509.40	$575.16	53	$839.40	$947.76
19	$387.19	$437.18	38	$512.69	$578.88	54	$878.49	$991.90
20	$399.13	$450.65	39	$519.28	$586.31	55	$917.58	$1036.04
21-24	$411.47	$464.59	40	$525.86	$593.75	56	$959.96	$1083.89
25	$413.12	$466.25	41	$535.73	$604.90	57	$1002.75	$1132.21
26	$421.35	$475.74	42	$545.20	$615.58	58	$1048.43	$1183.78
27	$431.22	$486.89	43	$558.36	$630.45	59	$1071.06	$1209.33
28	$447.27	$505.01	44	$574.82	$649.03	60	$1116.73	$1260.90
29	$460.33	$519.88	45	$594.16	$670.87	61	$1156.23	$1305.50
30	$467.02	$527.31	46	$617.21	$696.89	62	$1182.15	$1334.77
31	$476.89	$538.46	47	$643.13	$726.15	63	$1214.66	$1371.47
32	$486.77	$549.61	48	$672.75	$759.60	64-99	$1234.41	$1393.77

REQUIREMENT FOR BINDING ARBITRATION

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 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 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 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 ______________________

SBMA

Medical Benefits	Basic MEC
Preventive / Wellness	Covered 100%
Rx Discount Program	Included

[1]The Basic MEC plan excludes out-of-network services and covers only the services listed above and on the covered services page.
[2]Rx program offers discounts up to 80% on all FDA-approved prescription medications.

Highlights of Your Plan:

21 preventive services for adults
24 additional services for women
31 services for children

Affordable Coverage

Preventive Services covered 100%

Rx Discount Program

Locating a participating provider in the PHCS network all begins with the specific network logo on the front of your medical ID card. Please locate the PHCS logo on your card and follow the instructions below.

By phone: call **1.888.794.7427**
Online: visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner 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

Save up to 80% on all FDA-approved prescription medications at the largest pharmacy chains in the United States. Simply provide your ID card at the pharmacy and save.

- **No claim forms**
- **No deductibles**
- **No limitations or maximums**
- **No preexisting condition exclusions**

www.singlecare.com/sbma | **1.866.978.0843**

MEC PLUS

SBMA

Covered Medical Benefits	MEC Plus
Annual Deductible	$0
Out-of-Pocket Maximum (for covered services)	$1,850 Individual / $3,700 family
Preventive / Wellness	Covered 100%
Primary Care / Specialist Visits	$15 Copay
Urgent Care	$50 Copay
Laboratory Services	$50 Copay
X-Rays	$50 Copay
Generic Prescription Drugs	$15 Copay

[1]The MEC Plus plan excludes out-of-network services and covers ONLY the medical services listed above and on the covered services page.

Preventive Services covered 100%

All other Services covered at a copay

Additional pharmacy discounts through SmithRx

Locating a participating provider in the PHCS network all begins with the specific network logo on the front of your medical ID card. Please locate the PHCS logo on your card and follow the instructions below.

By phone: call **1.888.263.7543**
Online: visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner 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

Using Your Prescription Drug Card at Retail Pharmacies SmithRx

Present your medical card with your prescription to any of our 67,000+ retail pharmacies every time you fill your prescription. You can access a participating pharmacy list at www.mysmithrx.com. For additional support, call **1.844.454.5201**

PREVENTIVE SERVICES

SBMA

Covered Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over
- Hepatitis B screening for people at higher risk
- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 –1965
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- Immunization vaccines for adults — doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma virus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis and Varicella
- 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
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 years at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults with symptoms at higher risk

Covered Services for Women

- Anemia screening on a routine basis for pregnant women
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer (counseling only; not testing)
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening
- Chlamydia Infection screening for younger women and other women at higher risk
- 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."
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Human Papilloma virus (HPV) DNA Test every 5 years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors

Covered Services for Women (continued)

- Preeclampsia prevention and screening for pregnant women and follow-up testing for women at higher risk
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Urinary tract or other infection screening, including urinary incontinence
- Well-woman visits to get recommended services for women under 65

Covered Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- 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.
- Bilirubin concentration screening for newborns
- 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
- Blood screening for newborns
- Cervical Dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- 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.
- Fluoride Chemo prevention supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
- 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.
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents ages 11 to 17 years at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Meningococcal, Pneumococcal, Rotavirus and Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- 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.
- Obesity screening and counseling
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- 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.
- Vision screening for all children.

For more information on covered preventive services visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Anthem Benefit Comparison

Benefit Category	Bronze	Silver
Deductible	$5,600 individual / $11,200 family	$1,850 individual / $3,700 family
Out-of-Pocket Maximum	$8,400 individual / $16,800 family	$8,500 individual / $17,000 family
Preventive / Wellness	Covered 100%	Covered 100%
Primary Care Visits	$40 / visit	$55 / visit
Specialist Visits	$80 / visit	$85 / visit
Diagnostic Test (Labs / X-Rays)	Covered 60% after deductible	$20 / service
Imaging (CT, PET, MRI)	$100 / service, then covered 60% after deductible	$100 / service, Then covered 65% after deductible
Emergency Room Care	$250 / visit, then covered 60% after deductible	$350 / visit, then covered 65% after deductible
Emergency Transportation	Covered 60% after deductible	Covered 65% after deductible
Urgent Care	Covered 60% after deductible	$85 / visit
Outpatient Surgery (Facility fee / Physician fee)	Covered 60% after deductible	Covered 65% after deductible
Inpatient Hospitalization / Surgery (Facility fee / Physician fee)	Covered 60% after deductible	Covered 65% after deductible
Outpatient Mental Health, Behavioral Health or Substance Abuse Services	Office visit fee, Covered 60% after deductible	$55 / visit, then covered 65% after deductible
Inpatient Mental Health, Behavioral Health or Substance Abuse Services	Covered 60% after deductible	Covered 65% after deductible
Home Health / Skilled Nursing Care	Covered 60% after deductible	Covered 65% after deductible
Maternity	No charge for office visits, facility / physician fees covered 60% after deductible	No charge for office visits, facility / physician fees covered 65% after deductible
Prescription Drug Coverage	**Bronze**	**Silver**
Prescription Drug Deductible	$0	$300 individual / $600 family
Tier 1 – Typically Generic	$20 / prescription	$25 / prescription
Tier 2 – Typically Preferred Brand	$60 / prescription	$95 / prescription (subject to deductible)
Tier 3 – Typically Non-Preferred Brand	$100 / prescription	$140 / prescription (subject to deductible)
Tier 4 – Typically Preferred Specialty	Covered 70% up to $500 / prescription	Covered 60% up to $250 / prescription (subject to deductible)

This is not a complete list of covered services, exclusions or limitations. A full Summary of Benefits and Coverage (SBC) is available upon request.

DENTAL INSURANCE

Principal

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.

Dental Benefits	In Network	Out of Network
Annual Deductible	$50 individual / $150 family	$50 individual / $150 family
Annual Benefit Maximum	$1,500 per insured person	$1,500 per insured person
Diagnostic & Preventive		
Exams / Cleanings (2 per year) Bitewing X-Rays (1 per 12 months) Full Mouth X-Rays (1 per 60 months)	Covered 100% (deductible waived)	Covered 100% (subject to deductible)
Basic Services		
Fillings and stainless-steel Crowns Simple Extractions / Oral Surgery Root Canals	Covered 80%	Covered 80%
Major Services		
Crowns (each 60 months per tooth) Inlays / Onlays (each 60 months per tooth) Bridges (once per 60 months) General Anesthesia (if necessary) Implants (each 60 months) Dentures (each 60 months)	Covered 50%	Covered 50%
Orthodontic Procedures (children only)	$1,000 lifetime max benefit	$1,000 lifetime max benefit

This is not a full list of covered services. To request a full list of covered services, exclusions and limitations, please contact the phone number below.

Locating Participating Providers

1. Visit www.principal.com/dentist
2. Under Find a dentist, click Search for a dentist.
3. 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.
4. 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.
5. Select the desired specialty or use the No Specialty Preference default.
6. Select a language of your preference is other than English. Click Continue.

For additional assistance please call (800) 247-4695

CaliforniaDENTAL (CALIFORNIA EMPLOYEES ONLY)

Advantage 150 Plus

- The procedures below are covered benefits only when provided by a participating General Dentist, and they 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	Benefit Information / Your Cost for Services
Annual Deductible	$0
Annual Maximum Benefit	N/A
Diagnostic and Preventive Services (oral evaluations/cleanings – 1 per 6 months, bitewing radiographs)	Covered 100%
Additional evaluations/cleanings	$45 adult / $35 child
Sealants	$5 per tooth
Spacers	$35-$55 depending on type and location
Restorative Services	$0-$150 depending on type and number of surfaces
Inlays/Onlays	$90-$250 depending on type and number of surfaces
Crowns	$150-$300 depending on type
Alternative Premium Crowns	$645-$900 depending on material
Endodontics (Root Canals)	$100-$235/tooth depending on tooth
Dentures	$600-$650 for upper/lower $1,200-$1,300 for full mouth
Bridges	$645-$900 depending on type
Orthodontics (covered for up to 24 months of active treatment)	$1,000-$1,975 depending on treatment type

This is not a full list of covered services. To see a full list of covered services, exclusions and limitations, please refer to the information below.

For more information regarding the California Dental Advantage 150 Plus Plan, including a complete schedule of benefits and information on how to locate a CDN provider, visit www.caldental.net or call (877) 433-6825.

VISION INSURANCE

Principal

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

Vision Benefits	In Network	Out of Network	Frequency
Comprehensive eye exam	$10 copay	$45 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance (20% discount beyond allowance)	$70 allowance	Once every 12 months
Eyeglass Lenses (instead of contacts)			
Single	$25 copay	$30 allowance	Once every 12 months
Bifocal	$25 copay	$50 allowance	Once every 12 months
Trifocal	$25 copay	$65 allowance	Once every 12 months
Contact Lenses (instead of glasses)			
Contact Fitting & Evaluation	Maximum $60 copay	Applied to contact lens allowance	Once every 12 months
Elective disposable	$130 allowance	$105 allowance	Once every 12 months
Non-elective (medically necessary)	Covered 100% after copay	$210 allowance	Once every 12 months

This is not a full list of covered services. To request a full list of covered services, exclusions and limitations, please contact the phone number below.

Locating Participating Providers

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network.

For additional assistance please call (800) 877-7195