Meridio

Meridio

Medical Essentials
Value Medical
Dental & Vision
Voluntary Benefits

CONTACT US

Call
1-855-697-0007

New Business Sales
sales@getmeridio.com

Customer Care
hello@getmeridio.com

VE23

Contents

Meridio

Medical Essentials

Affordable health coverage for
Preventive and Wellness care

Plans

MEC ULTIMATE

MEC ULTIMATE HI

Partner

optionsplus
MEC Plans & Discount Benefits

Medical Essentials: Plan Comparison

Compares In-Network Services Only. Review Each Plan For Further Details.

TIERS	MEC ULTIMATE	MEC ULTIMATE HI
Employee Only	$149	$199
Employee +Spouse	$259	$378
Employee + Kids	$254	$361
Family	$373	$531
MEDICAL BENEFITS		
Wellness and Preventive	Covered at 100%	Covered at 100%
Primary Care Visits	$15 Copay	$15 Copay
Specialist Visits	$15 Copay	$15 Copay
Urgent Care Visits	$50 Copay	$50 Copay
Lab Services	$50 Copay	$50 Copay
X-Rays	$50 Copay	$50 Copay
RX BENEFITS		
Generic Rx	Tier 1: $10 Copay Tier 2: $25 Copay	Tier 1: $10 Copay Tier 2: $25 Copay
Brand Rx	Tier 1: $50 Copay Tier 2: $75 Copay	Tier 1: $50 Copay Tier 2: $75 Copay
VIRTUAL HEALTH BENEFITS		
Telemedicine	$0 Copay	$0 Copay
Virtual Behavioral Health	$50 Copay - 3x / year	$50 Copay - 3x / year
MEC COMPANION CARD		
MEC Companion Card	Dental, Vision, Durable Equipment, Fitness Discounts, Hearing Aids, Diabetic Supplies	
HOSPITAL INDEMNITY (HI)		
Admission Benefit	-	$2,500 - 1x year
Confinement Benefit	-	$200/day - 30x year
Inpatient Rehabilitation	-	$100/day - 15x year
Inpatient Surgery Benefit	-	$1,000/day - 1x year
Outpatient Surgery Benefit	-	$750/$1500 - 1x year
Ambulance Benefit	-	$500 air transportation - 2x year $200 Ground Transportation - 2x year
Diagnostic Procedure	-	$250/day - 1x year
Emergency Room	-	$100/day - 2x year
Health Screenings	-	$50/day - 1x year
LIFE INSURANCE		
Life Insurance	-	$10,000

Costs Include Plan Document, Multplan Network, ID Cards, Enrollment Guides, Claims Adjudication, SBCs And COBRA Administration. MEC Preventive Benefits Are Covered 100% For In Network Services. Office Visits, Specialist Visits, Urgent Care, Lab And X-Rays Are All Member Copays. Services Are Repriced Through The Multplan Network.

ULTIMATE MEC EXCLUSIONS & LIMITATIONS

EXCLUSIONS

- Abortion
- Acupuncture/spinal manipulation
- Advanced diagnostic imaging including CT/PET scans and MRIs
- Anesthesia
- Biofeedback
- Biopsies
- Chemical dependency treatment
- Chemotherapy/radiation
- Childbirth/delivery facility services
- Childbirth/delivery professional services
- Chiropractic care
- Cochlear implants
- Cosmetic surgery
- Dental care
- Diabetic supplies including insulin injectors and pumps
- Diagnostic colonoscopies
- Diagnostic mammograms (preventive mammograms are covered)
- Diagnostic testing including non-preventive lab work
- Dialysis
- Durable medical equipment including boots, canes, crutches, splints, prosthetics, orthotics, hospital beds, oxygen equipment, sleep apnea machines, walkers, wheelchairs and scooters
- Electrocardiogram
- Electrocardiography
- Emergency room care
- Emergency transportation including ambulance
- Experimental drugs, procedures or studies
- Eye care
- Foot care
- Genetic testing including breast cancer (BRCA)
- Habilitation services
- Hearing aids
- Home health care
- Hospice Services
- Hospitalization including facility fees and physician/surgeon fees
- Infertility treatment
- Long-term care
- Medical care outside the United States
- Mental health services
- Naturopathic services
- Non-preventive therapy and tests
- Nutritional supplies, vitamins or supplements
- Occupational therapy
- Out-of-network services
- Outpatient laboratory services in hospital setting
- Outpatient surgery including facility fees and physician/surgeon fees
- Pathology
- Physicals

EXCLUSIONS (continued)

- Private duty nursing
- Rehabilitation services including physical therapy or substance abuse
- Services for sexual dysfunction including drugs, supplies and therapy
- Sex change services including drugs, supplies and therapy
- Sleep studies
- Skilled nursing care
- Specialty prescription drugs
- Strength and performance services including devices and drugs
- Surgical procedures including transplants
- TMJ and orthognathic services
- Ultrasounds
- Weight loss drugs, procedures (including gastric bypass surgery and lap banding), programs and supplies

LIMITATIONS

- Behavioral health visits are limited to 3 per plan year at the $50 copay.
- Birth control implants including intrauterine devices (IUD) insertion/removal – 1 per plan year unless due to medical necessity
- Breast Cancer Genetic Testing (BRCA) – counseling only; no testing
- COVID-19 testing is limited to FFCRA[1] and CDC[2] guidelines or due to medical necessity. Testing is also limited to outpatient settings excluding emergency facilities and/or hospitals.
- Prescription drug coverage is limited to the formulary list. For additional information visit https://www.sbmabenefits.com/smithrxformulary
- Preventive breast cancer mammography Screening – 1 per plan year
- Routine preventive/wellness visits (men, women and children) – 1 per plan year
- Timely filing on claims is 12 months from the date of service. Claims not received within the timely filing limit will be denied.

[1]Families First Coronavirus Response Act
[2]Centers for Disease Control and Prevention

DEFINITIONS

- Counseling – providing patients with advice or education about a condition or disease and the potential treatment options available
- Medical Necessity – determined to be of need as evidenced by documented diagnosis from an individual's attending healthcare provider
- Screening – a method of identifying a medical condition or disease without the existence of any signs or symptoms
- Testing – a process or procedure performed to detect, diagnose or monitor a condition or disease based on a patient's illness, injury or symptoms

THIS LIST IS NOT INTENDED TO BE A COMPLETE LIST OF EXCLUSIONS. ADDITIONAL EXCLUSIONS/LIMITATIONS MAY APPLY. ONLY THE SERVICES LISTED UNDER THE SUMMARY OF BENEFITS ARE COVERED BY THE PLAN. AN OMISSION OF A NON-COVERED SERVICE FROM THE EXCLUSIONS LIST DOES NOT IMPLY THE SERVICE IS COVERED BY THE PLAN. MEMBERS AND PROVIDERS ARE ADVISED TO CONFIRM IF SERVICES ARE COVERED BY THE PLAN PRIOR TO THE SERVICES BEING RENDERED.

Any claims received for excluded services, or outside the coverage limitations listed above, will be denied and members will be responsible for the full out-of-pocket expense of the claim.

Medical Essentials:
How to Use Your Benefits

Access Your Benefits

ID Card: You should receive your cards at the member address on file.
Telemedicine: Call 1.855.373.7450 to activate. Provide your name and DOB and an email will be sent to you to create a login.
MEC Companion: Register at www.WellCardSavings.com with Group ID: MECPLUS.

If you have trouble with your MEC plan, call (888) 505-7724 option 2.

Find Your Provider

To locate providers participating in the MultiPlan® PHCS network ca
www.multiplan.com.

1. Click "Find a Provider" located in the top right-hand corner of the
   steps below.
2. Click on the green "Select Network" button.

- MEC Ultimate - select "Preventive only"
- MEC Ultimat HI - select "Specifics"

FILL A PRESCRIPTION

Review the RX Benefit Summary here

FILE A CLAIM

Submit claims to:
Electronic Claims Payer ID: SBMCO | **Clearing House**: Trizetto (800) 556-2231
SBMA | PO Box 2369 | Montclair, CA. 91763 | (888) 505-7724 option 3 | claims@sbmamec.com

HOW TO USE HOSPITAL INDEMNITY PLAN (FOR ULTIMATE HI MEMBERS)

Hospital Indemnity benefits help pay for out-of-pocket costs associated with being hospitalized in addition to your medical coverage. Payments are made directly to you, even if you did not actually incur any out-of-pocket expenses.

Step 1: Submit a Claim form and Invoice/Bill from your hospital visit
Step 2: A check with the amount listed on your benefit summary will be made out to you.

The hospital bill is the member's responsibility. The check may be used by the member to help pay that bill or other expenses as the member sees fit. Options Plus does not coordinate or submit any payment to the hospital.

optionsplus
MEC Plans & Discount Benefits

Wellness & Preventive Services

1. Abdominal Aortc Aneurysm one-tme screening for men of specifed ages who have ever smoked
2. Alcohol Misuse screening & counseling
3. Aspirin use to prevent cardiovascular disease for men & 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. Hepatts C screening for adults at increased risk, & one tme for everyone born 1945 – 1965
11. HIV screening for everyone ages 15 to 65, & other ages at increased risk
12. Immunizaton vaccines for adults — doses, recommended ages, & recommended populatons vary: Hepatts A, Hepatts B,Herpes Zoster, Human Papillomavirus, Infuenza (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 & counseling for all adults
15. Sexually Transmited Infecton (STI) preventon counseling for adults at higher risk
16. Syphilis screening for all adults at higher risk
17. Tobacco Use screening for all adults & cessaton interventons for tobacco users
18. Sexually Transmited Infectons counseling for sexually actve women
19. Syphilis screening for all pregnant women or others at increased risk
20. Tobacco Use screening & interventons for all women, & exp&ed counseling for pregnant tobacco users
21. Urinary tract or other infecton screening for pregnant women
22. Well-woman visits to get recommended services for women under 65

26 Covered Services for Children

1. Alcohol & Drug Use assessments for adolescents
2. Autsm screening for children at 18 & 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 actve 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 Chemopreventon supplements for children without fuoride in their water source
10. Gonorrhea preventve medicaton for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, Weight & 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. Immunizaton vaccines for children from birth to age 18 — doses, recommended ages, & recommended populatons vary: Diphtheria, Tetanus, Pertussis, Haemophilus infuenzae type b, Hepatts A, Hepatts B, Human Papillomavirus, Inactvated Poliovirus, Infuenza (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 & 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 genetc disorder in newborns
24. Sexually Transmited Infecton (STI) preventon counseling & screening for adolescents at higher risk
25. Tuberculin testng 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.

Telemedicine

Health Care Made Easy

Our telemedicine beneft provides you and your family access to board certfed physicians around the clock (24/7/365) via telephone or secure video. Telemedicine physicians can give advice, diagnose or treat illness, and even prescribe medicaton right over the phone. With healthcare costs rising, an oĸce visit with a PCP or Urgent Care Center can range from $155 to upwards of $300, andan ER visit can average almost $1,000'Y. With this beneft, there is no cost to you or your family for a consultaton.

1 ACTIVATE YOUR ACCOUNT

Actvate online or by calling member services. Once actvated, you will need to setup you member profle and complete your electronic health record.

2 REQUEST A CONSULT

Login to your account online or call member services to request a consult anytme 24/7.

3 RECEIVE CARE

Receive diagnosis and treatment, giving you quality care and piece of mind where ever you are.

Common Conditions Treated

- Allergies
- Arthritc Pain
- Bronchits
- Cold/Flu
- Conjunctvits
- Sprains/Strains
- Respiratory Infectons
- Sinus Infectons
- Upset Stomach
- Urinary Tract Infectons
- Diarrhea
- Ear Infectons
- Gastroenterits
- Headaches
- Insect Bites, etc.

Talk to a Doctor Anytime Day or Night... For Free.

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MEC Plans & Discount Benefits

Therapy & Counseling from Home

Behavioral Health

Getting Help Just Got Easier

Our Behavioral Health Benefit makes it easy to receive therapy and counseling from the comfort and privacy of your own home or office.

It can be difficult to wait days or weeks until your next appointment. Speak with one of our licensed psychiatrists or therapists online or by app.

WHAT WE TREAT

We provide care for many of the most common behavioral health concerns with the added benefits of privacy and convenience.

- Abuse
- Codependency
- Domestic Violence
- OCD
- Addiction
- Conduct Disorder
- Eating Disorders
- Parenting Issues
- ADHD/ADD
- Cognitive Behavioral
- Grief & Loss
- Relationships
- Anger Management Therapy
- LGBT Issues
- Sexuality
- Anxiety & Stress
- Depression & Mood
- Med. Management
- Trauma & PTSD
- Bipolar Disorder
- Divorce
- Men's & Women's Issues
- And more

HOW IT WORKS

1 LOG IN

LOG IN TO YOUR ACCOUNT

2 SCHEDULE AN APPOINTMENT

SCHEDULE AN APPOINTMENT WITH THE BEHAVIORAL HEALTH PROVIDER OF YOUR CHOICE

3 CHAT

VIDEO CHAT WITH YOUR PROVIDER AND RECEIVE A PERSONALIZED TREATMENT PLAN.

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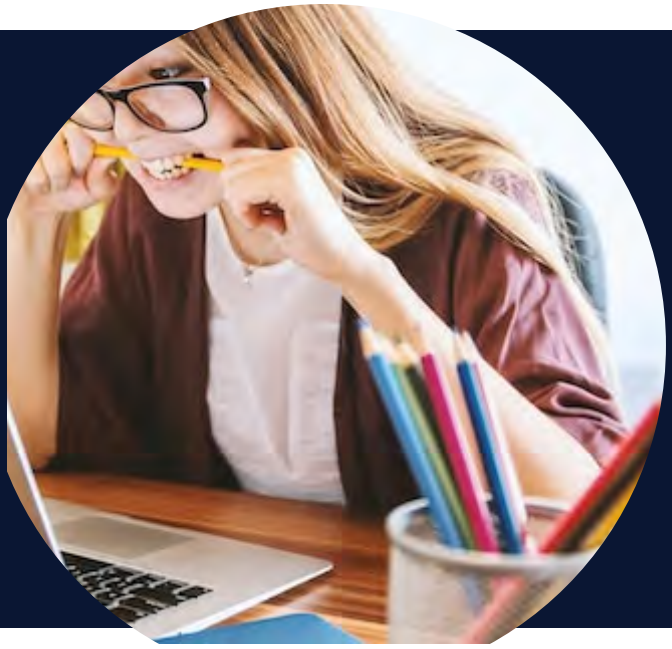
MEC Plans & Discount Benefits

MEC Companion Card

When I show my **MEC Companion Card...**

my card shows me the ***Savings!***



Dental – save up to 50%

Accepted at over 80,000 provider locations nationwide, and covers all dental services and specialties, including orthodontia. Savings can be as high as 50%, and there is no limitation on services or use.

Vision – save up to 50%

Accepted by over 11,000 OUTLOOK vision providers. Cardholders receive up to 50% savings on lenses, frames, and other vision needs.

MRI & Imaging – save up to 75%

Members receive concierge appointment service and enjoy savings up to 75% and more on MRI, PET, and CT scans, as well as other imaging services at over 4,000 locations nationwide.

Lab – save up to 50%

Members save up to 50% using the online search tool to locate a lab and order their test. Actual savings are displayed immediately. Test results are available within 48-96 hours.

Hearing – save up to 70%

Members receive a free hearing test and up to 70% discount on hearing aids at 2,200 providers nationwide.

Diabetic Care Services – save up to 70%

A full line of diabetes testing supplies are delivered directly to the member's home.

Vitamins – save 5%

A wide range of vitamin and mineral supplements are delivered directly to the member's home at discounted rates.

Daily Living Products – save up to 10%

A wide range of medical supplies, safety equipment, and health products are delivered directly to the member's home at discounted rates.

Value
Medical

Comprehensive health benefits with standard rates in all 50 states and no deductibles. Coverage is on average 25-30% less than the Marketplace.

Plans

IHP PLUS

IHP ULTIMATE

Partner

IHP

Value Medical: Plan Comparison

Compares In-Network Services Only. Review Each Plan For Further Details.

TIERS	IHP PLUS	IHP ULTIMATE
Employee Only	$540	$700
Employee + Spouse	$990	$1340
Employee + Kids	$885	$1185
Family	$1195	$1710
MEDICAL BENEFITS		
Deductible	$0	$0
Out of Pocket Max (Ind/Family)	$5,000/$10.000	$2,000/$13,000
Wellness and Preventive	Covered at 100%	Covered at 100%
Primary Care Visits	$15 Copay - 10/year	$20 Copay
Specialist Visits	$25 Copay - 10/year	$40 Copay
Urgent Care Visits	$35 Copay - 3/year	$50 Copay
Lab Services & Radiology	$50 Copay - 3/year	$50 Copay
CT/MRI/MRA/PET Scans	$350 Copay -2/year	$400 Copay
Telemedicine	$0 Copay - Unlimited	$0 Copay - Unlimited
RX BENEFITS		
Generic Rx	$0 Copay Preventive $5 Copay Acute List $10 Copay Other	$0 Copay Preventive $5 Copay Acute List $10 Copay Other
Preferred Brand/Non-Preferred Rx	Tier 1: $40 Copay Tier 2: $80 Copay	Tier 1: $40 Copay Tier 2: $80 Copay
HOSPITAL SERVICES		
Inpatient Hospitalization & Surgery	$350 Copay - 7 days & 3 surgeries/year	$400 Copay
Outpatient Hospitalization & Surgery	$350 Copay - 2/year	$400 Copay
Emergency Room Services	$350 Copay - 1/year	$400 Copay
OTHER SERVICES		
Chiropractic Services	$25 Copay - 10/year	$40 Copay - 10/year
Second Surgical Opinion	$0 Copay	$0 Copay
Home Health Care	$25 Copay - 15/year	$25 Copay - 20/year
Treatment for Chemical Abuse (Inpatient/Outpatient)	$250 Copay - 7 days/year $25 Copay - 10 days/year	$250 Copay $25 Copay
Emergency Medical Transportation	$250 Copay - 1 per year	$400 Copay
Chemotherapy/Radiation	-	$400 Copay
Colonoscopy	-	$400 Copay
Dialysis	-	$400 Copay
Durable Medical Equipment	-	$400 Copay
Transplant Facility	-	$400 Copay
Rehabilitation Services	-	$400 Copay - 20/year
Hospice Care	-	$400 Copay
PREGNANCY SERVICES		
Professional Services	$350/Copay	$50/Copay
Maternity/Childbirth/Delivery	$350 Copay per Admission	$400 Copay per Admission

IHP | Plus

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$0	
Family	$0	

Out of Pocket Information

Out of Pocket Maximum [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$5,000	
Family	$10,000	

Schedule of Benefits

The following table represents the medical services currently covered under the IHP Plus Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions	Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
		Member Pays	
PHYSICIAN SERVICES			
Primary Care OfficeVisit (Limited to 10 visits per plan year)	No	$15 Copay	$15 Copay
Specialist Office Visit (Includes Mental and Behavioral Health. Limited to 10 visits per plan year)	No	$25 Copay	$25 Copay
Other Physicians Services performed in the office[4] (Limited to Primary Care/Specialists visits per plan year)	Yes[5]	$50 Copay per service billed	$50 Copay per service billed
Urgent Care (Limited to 3 visits per plan year)	No	$35 Copay	$35 Copay
Telemedicine Services	No	$0 Copay	Not Applicable

[1] The Deductible and Out of Pocket amounts are combined across In Network and Out of Network Providers.

[2] Out of Network services are covered at 85% of usual and customary charges.

[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.

[4]The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.

[5]Prior authorization is required for any service or procedure over $1,000.

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Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	**No**	$0 Copay	$0 Copay
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to RBP)				
Inpatient Hospitalization (Limited to 7 days per plan year)		**Yes**	$350 Copay per admission (After copay, benefit subject to RBP)	
Inpatient Visits - Physician (Limited to visits up to 7 days per plan year)		**No**	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges (Limited to 3 surgeries per plan year)		**Yes**	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free-Standing Facility Services and Surgery (Limited to 2 visit per plan year)		**Yes**	$350 Copay (After copay, benefit subject to RBP)	
Anesthesia (Limited to 3 inpatient and 2 outpatient anesthetic procedures per plan year)		**No**	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay	
Emergency Room Services (Limited to 1 visit per plan year)		**No**	$350 Copay (After copay, benefit subject to RBP)	
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Radiology)	**No**	$50 Copay	$50 Copay
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Laboratory Services)	**No**	$50 Copay	$50 Copay
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan (Limited to 2 per plan year)	**(Non-Hospital Based)**	**Yes**	$350 Copay (After copay, benefit subject to RBP)	
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member

IHP | Plus

Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREGNANCY BENEFITS				
Professional Services		No	$350 Copay	$350 Copay
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)		Yes	$350 Copay per admission (After copay, benefit subject to RBP)	
OTHER SERVICES				
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)		No	$25 Copay	$25 Copay
Chiropractic Services (Limited to 10 visits per plan year)		No	$25 Copay	$25 Copay
Second Surgical Opinion		No	$0 Copay	Not Covered 100% paid by Member
Home Health Care (Limited to 15 visits per plan year)		Yes	$25 Copay	Not Covered 100% paid by Member
Treatment for Chemical Abuse & Dependency	**(In-Patient)** (Limited to 7 days per plan year)	Yes	$250 Copay per day (After copay, benefit subject to RBP)	
Treatment for Chemical Abuse & Dependency	**(Out-Patient)** (Limited to 10 visits perplan year)	Yes	$25 Copay per day	$25 Copay per day
Emergency Medical Transportation (By land only; Limited to 1 transport per plan year)		No	$250 Copay (After copay, benefit subject to RBP)	

PHARMACY BENEFITS		Participating Pharmacies	Non-Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		APS Acute List - $5 Copay All Other Generic - $10 Copay Preferred Brand - $40 Copay Non-Preferred Brand - $80 Copay	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		APS Chronic List - $15 Copay All Other Generic - $30 Copay Preferred Brand - $120 Copay Non-Preferred Brand - $240 Copay	Not Covered 100% paid by Member
Non-Limited Brand, & Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

IHP | Plus

Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible.
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

Exclusions

27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
46. Radiation and chemotherapy
47. Dialysis
48. Rehabilitative therapies
49. Acupuncture
50. Alternative medicine/homeopathy
51. Children dental and vision
52. Neonatal intensive care (NICU)
53. Routine eye care (Adult)
54. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
55. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded
56. Diagnosis and treatment for sleep apnea
57. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
58. Use of Emergency Room Services for non-emergency care
59. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
60. Gene therapy
61. Private room unless medically necessary or if a semi-private room is not available.
62. Emerging gene and cell therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

IHP | Ultimate

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$0	$500
Family	$0	$1,000

Out of Pocket Information

Out of Pocket Maximum	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$2,000	Unlimited
Family	$13,200	Unlimited

Schedule of Benefits

The following table represents the medical services currently covered under the IHP Ultimate Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions	Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
		Member Pays	
PHYSICIAN SERVICES			
Primary Care Office Visit	**No**	$20 Copay	After Deductible, 40% Coinsurance
Specialist Office Visit (Includes Mental and Behavioral Health)	**No**	$40 Copay	After Deductible, 40% Coinsurance
Other Physicians Services performed in the office[2]	**Yes[3]**	$40 Copay	After Deductible, 40% Coinsurance
Urgent Care	**No**	$50 Copay	After Deductible, 40% Coinsurance
Telemedicine Services	**No**	$0 Copay	Not Applicable

[1]If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.

[2] Out of Network services are covered at 85% of usual and customary charges.

[3]The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.

[4]Prior authorization is required for any service or procedure over $1,000.

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Plan Provisions		Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers\ (Out of Network)
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	No	$0 Copay	$0 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to RBP)				
Inpatient Hospitalization		Yes	$400 Copay (After copay, benefit subject to RBP)	
Inpatient Visits - Physician		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery – Physician Charges		Yes	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free-Standing Facility Services and Surgery		Yes	$400 Copay (After copay, benefit subject to RBP)	
Anesthesia		No	Included in Inpatient Hospitalization or Outpatient Hospital or Free-Standing Facility Services and Surgery Copay	
Emergency Room Facilities and Covered Services		No	$400 Copay (After copay, benefit subject to RBP)	
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Services	**(Non-Hospital Based)**	No	$50 Copay	After Deductible, 40% Coinsurance
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)**	No	$50 Copay	After Deductible, 40% Coinsurance
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan	**(Non-Hospital Based)**	Yes	$400 Copay (After copay, benefit subject to RBP)	
	(Hospital Based)	Yes		

IHP | Ultimate

Plan Provisions	Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
		Member Pays	
PREGNANCY BENEFITS			
Professional Services	No	$50 Copay	After Deductible, 40% Coinsurance
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	Yes	$400 Copay (After copay, benefit subject to RBP)	
OTHER SERVICES			
Allergy Services (The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	No	$40 Copay	$40 Copay
Chemotherapy/Radiation Therapy (Chemotherapy only includes infusion, not oral)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Chiropractic Services (Limited to 10 visits per plan year)	No	$40 Copay	After Deductible, 40% Coinsurance
Colonoscopy (Diagnostic Purposes)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Dialysis	Yes	$400 Copay (After copay, benefit subject to RBP)	
Durable Medical Equipment (Subject to limitations)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Emergency Medical Transportation (Ground Service Only)	No	$400 Copay (After copay, benefit subject to RBP)	
Home Health Care (Limited to 20 visits per plan year)	Yes	$25 Copay	Not Covered 100% paid by Member
Hospice Care	Yes	$400 Copay (After copay, benefit subject to RBP)	
Rehabilitation/Habilitation Services (Combined limit of 20 visits per plan year with physical, speech, and occupational therapies. Prior authorization is required after 6 visits.)	Yes	$75 Copay	Not Covered 100% paid by Member
Second Surgical Opinion	No	$0 Copay	Not Covered 100% paid by Member
Transplant - Facility	Yes	$400 Copay (After copay, benefit subject to RBP)	
Transplant - Physician and Anesthesiologist Charges during Inpatient Hospitalization	Yes	Benefit subject to RBP	

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Plan Provisions		Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Treatment for Chemical Abuse & Dependency	**(In-Patient)**	**Yes**	$250 Copay per day (After copay, benefit subject to RBP)	
Treatment for Chemical Abuse & Dependency	**(Out-Patient)**	**Yes**	$25 Copay per day	$25 Copay per day

PHARMACY BENEFITS		Participating Pharmacies	Non-Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply (Specialty Drugs and Compounds are not covered)		Generic - $5 Copay Preferred Brand - $40 Copay Non-Preferred Brand - $80 Copay	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		Generic - $15 Copay Preferred Brand - $120 Copay Non-Preferred Brand - $240 Copay	Not Covered 100% paid by Member
Non-Limited Brand, & Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:

a. Sports,
b. Camp,
c. Employment,
d. Travel,
e. Insurance,
f. Marriage,
g. Legal proceedings

2. Routine foot care for treatment of the following:

a. Flat feet,
b. Corns,
c. Bunions,
d. Calluses,
e. Toenails,
f. Fallen arches,
g. Weak feet,
h. Chronic foot strain

3. Dental procedures

4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits

5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service

6. Claims unrelated to treatment of medical care or treatment

7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition

8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document

9. Any claim related to an injury arising out of, or in the course of, any employment for wage or profit that would be covered by other coverage for which the member is eligible

10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed

11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted

12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant

13. Claims due to an act of war, declared or undeclared, not including acts of terrorism

14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy

15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term

16. Travel, unless specifically provided in the schedule of benefits

17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill

18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits

19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials

20. Services or supplies which are primarily educational

21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression

22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion

23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change

IHP | Ultimate

Exclusions

24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant

25. Any claims for fertility or infertility treatment

26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

27. Claims for disability resulting from reversal of sterilization

28. Claims for the completion of forms, or failure to keep scheduled appointments

29. Recreational or diversional therapy

30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider

31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding

32. Claims that arise primarily due to medical tourism

33. Supportive devices of the foot

34. Treatments for sexual dysfunction

35. Aquatic or massage therapy

36. Biofeedback training

37. Skilled nursing facilities

38. Private duty nursing, or long-term care

39. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury

40. Claims for temporomandibular joint syndrome

41. Claims for biotech or specialty prescriptions

42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs

43. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.

44. Acupuncture

45. Alternative medicine/homeopathy

46. Children dental and vision

47. Routine eye care (Adult)

48. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands

49. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded.

50. Use of Emergency Room Services for non-emergency care

51. Diagnosis and treatment for sleep apnea

52. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).

53. Gene therapy

54. Emerging gene and cell therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

Value Medical

How to Use Your Benefits

ACCESS YOUR BENEFITS

1. You should receive your ID card shortly after your first effective date.
2. Activate Telehealth (See 1800MD page)
3. Download the mobile app (See IHP Mobile app page)

FIND A PROVIDER

To locate providers participating in the MultiPlan® PHCS network call (888) 794-7427 or visit www.multiplan.com.

1. Click “Find a Provider” located in the top right-hand corner of the page and follow the steps below.
2. Click on the green “Select Network” button. Choose “PHCS,” “Practitioner & Ancillary”

To check in a particular providers’ eligibility - call 800.292.0536 or visit HST Connect.

FILL A PRESCRIPTION

When you get your ID, you will be able to log into the MyCigna app or MyCigna.com to search for medications online.

Use this prescription drug guide (follow link) to

- Find detailed instructions on how to use the guide [link to page].
- Review a list of popular medications included in plan
- Search for medications that are not covered and the and alternatives covered by the plan.

PRE-CERTIFY A PROCEDURE / FILE A CLAIM

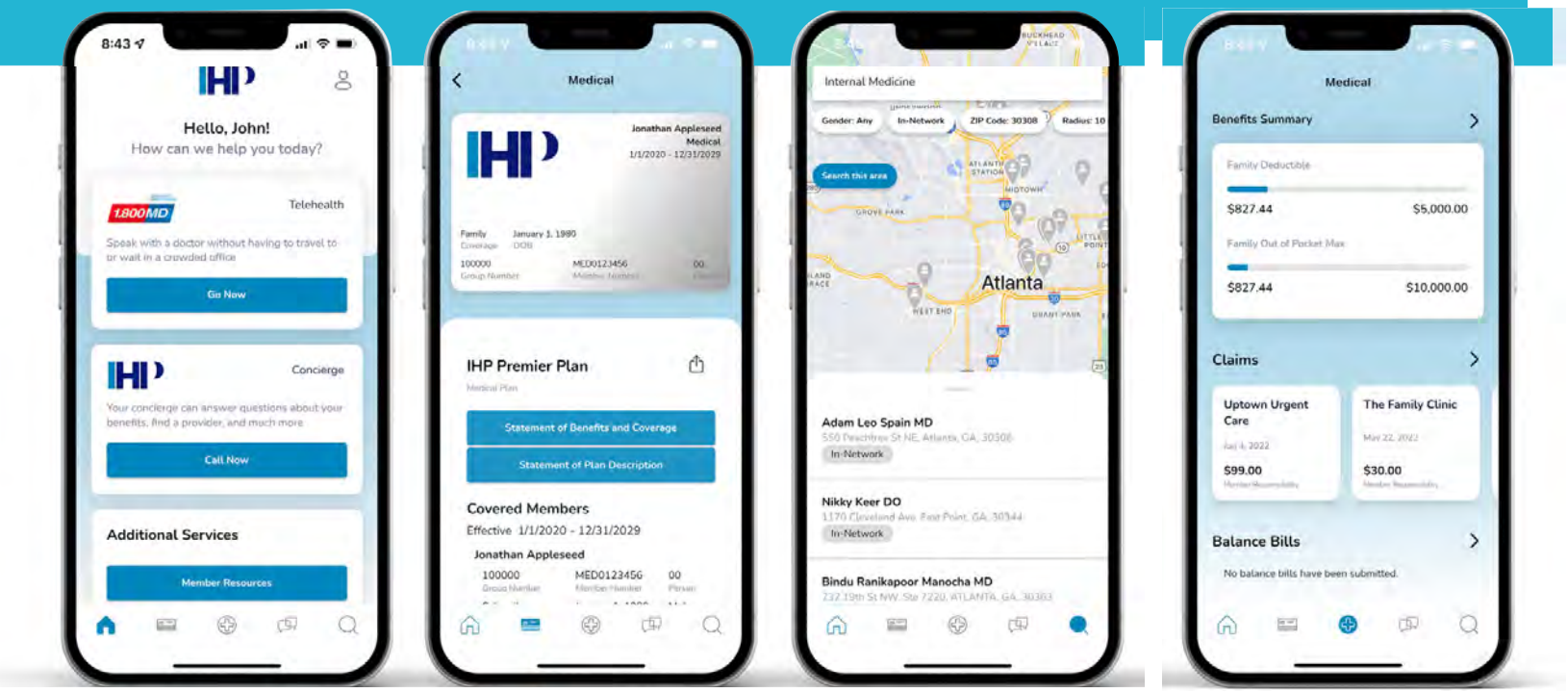
To Get Pre-Certification for a Procedure:
Call MedWatch at 800-432-8421

To File a Claim

1. Contact Customer Service (Number onf the back of your ID Card.
2. Email ValueMedicalClaims@getmeridio.com

How Do I Access The Mobile App?

You're Just A Few Clicks Away From Your New IHP Branded Health Benefits Experience.



Access, Track, and Manage your benefits, online or by mobile, in three easy steps:

STEP 1

Download the app at the Apple App Store or Google Play Store by searching for **"Medxoom"** or **visit member. medxoom.com** for online access.

Download on the App Store | GET IT ON Google Play

STEP 2

Open the app and register by verifying your Social Security Number or Member ID and Date of Birth (don't worry, your information is kept private and secure).

STEP 3

Review dependents and invite adult dependents to register, too.

NOW YOU CAN

- View your Digital ID Card and details about your medical plan
- View detailed information about your Claims
- Get real-time updates on progress towards meeting your deductible and Out-of-Pocket maximums
- Review your treatment history
- Initiate a Telehealth visit
- View and pay medical bills
- Search for doctors and procedures
- See important messages from IHP
- and much more! Start maximizing your health benefits today!

Have questions? Call your Concierge Team at 866-862-6935 for help.

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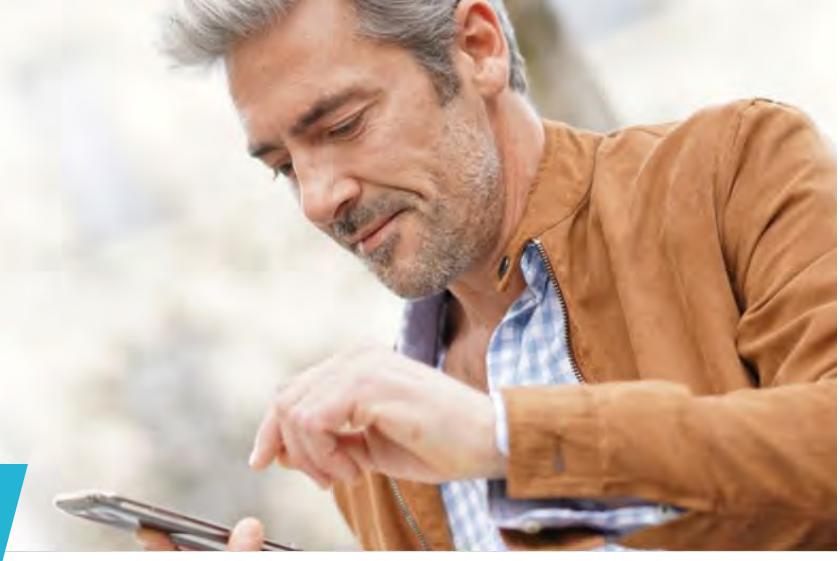
1.800 MD™



Healthcare Made Easy

ACTIVATE

Activate your account

online or by calling member services. Once activated, you will need to setup you member profile and complete your electronic health record.

REQUEST A CONSULT

Login to your account

online or call member services at 1.800.530.8666 to request a consult anytime 24/7.

RECIEVE CARE

Receive diagnosis

and treatment, giving you quality care and piece of mind where ever you are.

COMMONLY TREATED CONDITIONS

- *Allergies*
- *Arthritic Pain*
- *Bronchitis*
- *Cold/Flu*
- *Conjunctivitis*
- *Diarrhea*
- *Ear Infections*
- *Gastroenteritis*
- *Headaches*
- *Insect Bites*
- *Sprains/Strains*
- *Respiratory Infections*
- *Sinus Infections*
- *Upset Stomach*
- *Urinary Tract Infections*

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Partner

DELTA DENTAL

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optionsplus
MEC Plans & Discount Benefits

Dental & Vision Plan Options

MONTHLY	PREVENTIVE DENTAL + VISION	COMPREHENSIVE DENTAL + VISION
• Employee Only	$30	$50
• Employee + Spouse	$55	$98
• Employee + Child(ren)	$60	$92
• Family	$98	$156

DENTAL BENEFITS	In-Network	Out-Of-Network	In-Network	Out-Of-Network
• **Preventive & Diagnostic** Exams; Cleanings; Bitewing X-Rays; Full Mouth X-Rays; Fluoride Treatments (Frequency limitations apply); Space Maintainers	100%	100%	100%	80%
• **Basic** Fillings; Simple Extractions; Oral Surgery; Periodontics; Root Canals (Endodontics); Sealants	-	-	80%	50%
• **Major** Crowns & Gold Restorations; Bridgework; Full & Partial Dentures; Repair of Dentures; Implants	-	-	50%	50%
• **Annual Maximum** (per person)	$1 000	$1 000	$1 500	$1 500
• **Annual Deductible**				
Per person	None	None	$50	$100
Family Maximum	None	None	$150	$300
• **Waived For**		Preventive & Diagnostic		

DENTAL PROVIDER LOOKUP

Visit: **https://www.deltadental.com/us/en/member/fnd-a-dentst.html**
Specialty: Choose one or Choose Any | Your Plan: Delta Dental PPO
Search by Current Locaton: No, Enter Zip Code | Find Dentsts

DELTA DENTAL®

DENTAL PLAN NOTES

Carryover MaxSM from Delta Dental allows you to increase your benefits.

This feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future- such as bridges, crowns, and root canals.

The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provisions, including limitations and exclusions, are provided in the group contract.

Meridio

optionsplus
MEC Plans & Discount Benefits

VSP VISION
Benefit Summary

BENEFITS	
• Network/Plan	VSP Choice
• Copay (Exams/Materials)	$10/$25

SERVICE FREQUENCIES	
• Eye Exams	Once Every 12 months
• Lenses Benefit	Once Every 12 months
• Contact Lenses	Once Every 12 months
• Frames	Once Every 24 months

REIMBURSEMENT	In-Network (Copay)	Out-Of-Network (Before Copay)
• Eye Exams	$10	$45 max
• Contact lens fit/evaluation	$60	--
• **Lenses Benefit**		
Single Vision	$25	$30 max
Bifocal	$25	$50 max
Trifocal	$25	$65 max
Lenticular	$25	$100 max
• **Contact Lenses Benefit**		
Medically Necessary	Covered (Copay Waived)	$210 max
Elective Materials	$130 max	$105 max
• **Frames Benefit**	$130 max | $70 Walmart/Sam's Club/Costco	$70 max

VISION PROVIDER LOOKUP

Visit: https://www.vsp.com/eye-doctor
Search by Location, Office Name, or Doctor Name

vsp VISION

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Access Your Dental Benefits

Connect With Your Benefits On MySmile®

MySmile offers free, easy-to-use tools that make navigating your Delta Dental benefits a whole lot simpler.

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Access MySmile from your computer or mobile device to securely:

- View your coverage
- Check on your dental claims
- View and print your ID card
- Review your treatment history
- Find a dentist
- Get cost estimates
- And more

Visit our Website or Download our App

How to Register:

1. Visit DeltaDentalNJ.com; click "Sign In or Register" on the top right corner of the homepage.
2. Click "Register Now" and enter your contact information.
3. Create a username and password when prompted.
4. Read and check the box to "agree to Terms of Use" for our website.
5. Click "Register"; you will be emailed a code within 24 hours to the email address you used when registering.
6. Enter the code when prompted.
7. Once you enter the code, you will be able to access your account using your newly created username and password!

Download on the App Store

GET IT ON Google Play

The subscriber and any adult dependents on the plan can create their account with or without an ID number.

(800) 452-9310 www.deltadentalnj.com

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August 2020

Voluntary Benefits

Voluntary Benefits complement health coverage, helping you save money when it matters most.

Plans

ACCIDENT

CRITICAL ILLNESS

DISABILITY

HOSPITAL CONFINEMENT

TERM LIFE INSURANCE

Partner

Colonial Life

Colonial Life

Accident Insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Accidents can happen to anyone

You never know when you or someone you love could get hurt in an accident. And accidents come with costs, such as emergency room fees, doctor's bills and lost income from missing work. Even if you have good health insurance, deductibles and co-pays can really add up.

With accident insurance from Colonial Life, you can receive benefits to help with the expenses of a covered accident. This financial protection can help you focus on what really matters: healing.

With this coverage:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Unlike workers' compensation, which only covers on-the-job injuries, accident insurance covers injuries that happen on-the-job or off-the-job.
- Coverage is available for you, your spouse and eligible dependent children.

If guaranteed-issue coverage is available, you won't have to answer health questions. For more details, talk with your Colonial Life benefits counselor.

ACCIDENT POLICIES PROVIDE LIMITED BENEFITS.

The policies or their provisions may vary or be unavailable in all states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life representative for specific provisions and details of availability.

Colonial Life insurance products are underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

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Colonial Life

Critical illness insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

You can't predict an illness, but you can be prepared

No matter where you are in life, you never know when you or a loved one could experience a critical illness, such as a heart attack or stroke. Medical advancements and early detection are helping many people survive critical illnesses. However, preventive tests and treatment can lead to increased medical expenses, and your health insurance may not cover these costs.

Critical illness insurance helps supplement your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness.

With this coverage:

- Benefits are paid directly to you, unless you specify otherwise.
- You may receive additional benefits if you're diagnosed with more than one critical illness.
- Coverage options are available for you, your spouse and eligible dependent children.

If guaranteed-issue coverage is available, you won't have to answer health questions. For more details, talk with your Colonial Life benefits counselor.

CRITICAL ILLNESS POLICIES PROVIDE LIMITED BENEFITS.
The policies or their provisions may vary or be unavailable in all states. The policies have exclusions and limitations which may affect any benefits payable. See the individual policy or the group certificate, as applicable, or your Colonial Life representative for specific provisions and details of availability.

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Colonial Life

Disability insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Help protect your income

You never know when a disability could impact your way of life. Fortunately, there's a way to help protect your income. If a covered accident or sickness prevents you from earning a paycheck, disability insurance from Colonial Life can provide a monthly benefit to help you cover your ongoing expenses.

Disability insurance from Colonial Life helps protect your income, so you can have help paying the bills while you recover from a covered accident or sickness.

With this coverage:

- You can choose the amount of your disability benefits, subject to income.
- You're paid regardless of any insurance you may have with other companies.
- Benefits are paid directly to you, and you can use these benefits however you choose.

If guaranteed-issue coverage is available, you won't have to answer health questions. For more details, talk with your Colonial Life benefits counselor.

The policies or their provisions may vary or be unavailable in all states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life representative for specific provisions and details of availability.

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Colonial Life®

Hospital Confinement Indemnity Insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Get help with rising health care costs

If you're admitted to the hospital because of an accident or sickness, it's important to focus on your recovery – not your finances. That's easier said than done if you have costly co-payments, deductibles and other expenses coming your way.

Hospital confinement indemnity insurance from Colonial Life can help you pay for medical expenses that your health insurance may not cover.

With this coverage:

- Benefits are paid directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You're paid regardless of any other insurance you may have with other companies.

If guaranteed-issue coverage is available, you won't have to answer health questions. For more details, talk with your Colonial Life benefits counselor.

HOSPITAL CONFINEMENT INDEMNITY POLICIES PROVIDE LIMITED BENEFITS.

The policies or their provisions may vary or be unavailable in all states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life representative for specific provisions and details of availability.

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Colonial Life

Term Life Insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Life insurance protection when you need it most

Life insurance needs change as life circumstances change. You may need more coverage if you're getting married, buying a home or having a child.

Term life insurance from Colonial Life provides protection for a specified period of time, typically offering the greatest amount of coverage for the lowest initial premium. This fact makes term life insurance a good choice for supplementing cash value coverage during life stages when obligations are higher, such as while children are young. It's also a good option for families on a tight budget – especially since you can convert it to a permanent cash value plan later.

With this coverage:

- A beneficiary can receive a benefit that is typically free from income tax.
- The policy's accelerated death benefit can pay a percentage of the death benefit if the covered person is diagnosed with a terminal illness.
- You can convert it to a Colonial Life cash value insurance plan, with no proof of good health, to age 75.

For more details, talk with your Colonial Life benefits counselor.

The policies or their provisions may vary or be unavailable in all states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life representative for specific provisions and details of availability.

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Making Health Affordable

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