Los Angeles Machinist Benefit Trust

3333 Vincent Rd., Suite 203-A • Pleasant Hill, CA 94523 • Phone (800) 499-8121•Fax (925) 405-0659

RE: RETIREE BENEFIT OPTIONS

Dear Retiree

As Retiree under the Los Angeles Machinist Benefit Trust your medical choices are pre-paid (HMO) medical plan coverage through either United Healthcare (UHC) or Kaiser Permanente. You have a choice of the High HMO Option or Low HMO Option plan. The amount you pay monthly is determined by the plan. You may lower your premium rate by opting for Low coverage, or increase your benefits by opting for High coverage.

In addition to the choices listed above, any retiree who resides in the service area of the pre-paid Cigna Dental plan can elect this prepaid dental plan and self-pay for the coverage.

Effective January 1, 2015, retirees are eligible for vision coverage through Vision Service Plan (VSP) in addition to EYEMed by self- paying the full cost. There is a VSP plan with a $5 Copay, and a VSP plan with a $5 Copay and optional lens coverage.

Note: A Comparison of Benefits is also included which will help you make your final decision provides a summary of the benefit options available to eligible retirees.

In order to process your retiree benefits in a timely fashion

- We need a copy of your pension award letter or Social Security award letter
- In addition to the Retiree Enrollment form, we also need you to complete the Class I, II or III enrollment form depending on your designation. Please see pages 3 & 4 of the Summary Plan Description of Benefits dated January 2011 for further information on what class applies to you.
- Medical carrier (UHC or Kaiser) enrollment forms.
  NOTE: If you or your spouse is on Medicare, we'll need you to fill out a separate form; a Senior Advantage form with Kaiser, or a Medicare Advantage form through United Healthcare. Please contact our administrative office to receive these forms.

It is important to return all of the required information within 90 days of your retirement date. Once received, we will contact you and provide the monthly premium amount and any retroactive premiums due from your retirement date.

If you have questions, please contact our office at (800) 499-8121.

Sincerely,

Enrollment Department

Los Angeles Machinist Benefit Trust
3333 Vincent Rd., Suite 203-A • Pleasant Hill, CA 94523 • Phone (800) 499-8121•Fax (925) 405-0659

RETIREE CHECKLIST

- _____Decide on a retirement date final day of work _____
- _____Go over the Retiree Summary Plan Description Booklet.
- _____Determine what Class retiree member you are either I,II,III
- _____Contact pension fund to start the pension process if applicable.
- _____Go over the packet and decide what benefit plans you'll be selecting.
- _____If you would like retiree premium rates contact Monica Abarca at (714) 898-2200

  Monday -Friday 9:00am to 5:00 pm.
- _____Fill out applicable applications for the plans you will be selecting
  .

When you retire and you are eligible for Medicare (member or spouse), The LOS ANGELES MACHINIST BENEFIT TRUST requires you to enroll into Medicare. Please be advised that you must be enrolled in both Parts A and B of Medicare by the end of the month in which you turn 65

- _____Complete the rest of applicable applications (Retiree Class, Retiree Enrollment Form, Vision Form, Medical Forms etc.)
- _____ACH Application (Optional)
- _____Once completed send retiree applications and a copy of pension award letter that states how many years of service to;
  (PO BOX 6149 Garden Grove, CA. 92846)
- _____Once applications are received LAMBT will send a confirmation letter with Effective Date and Premium Rate

If you have questions, please contact our office at (714) 898-2200.

Sincerely,

Monica Abarca
Enrollment Department

Phone (800) 499-8121
Fax (925) 405-0659

Los Angeles Machinists Benefit Trust

PO Box 6149 Garden Grove, CA 92846

RETIREE ENROLLMENT CLASS I

Retired Employee_____ _____
(Last name) (First) (Social Security No.)

Address: _____ _____
(Street/P.O. Box) (City) (Date of Birth)

_____ _____ _____ _____
(State) (Zip Code) (Home Phone) (Pension Effective Date)

Name of Employer at time of Retirement_____

Date of hire _____ Last day of work: _____

Are you currently eligible for Medicare A&B: Yes___No___ Effective Date: _____

Are you eligible for medical benefits from any other group plan: Yes___ No ___

If yes, name of Group Plan_____

Are you married: Yes___ No___ If yes, _____ _____
(Spouse's Name) (Date of Birth)

Spouse's Social Security No: _____

Is Spouse eligible for Medicare A&B: Yes___ No___ Medicare Effective Date: _____

Is Spouse eligible for benefits from other Group Plan: Yes ___ No___

If yes, name of Group Plan_____

__Retiree elects to decline coverage Explanation: _____
_____
_____

==========

All Retiree members MUST RETURN THIS FORM. (Include a check for first payment)
Make check payable to: Los Angeles Machinist Benefit Trust. Your employer's last month of contribution determines retiree effective date**. Official pension award letter from pension office is required at time of retirement**.
After retiree setup has been processed and initial payment deposited you will be sent monthly payment slips. Failure to pay contributions when they are due will lead to the termination of benefits.

_____ _____ _____
(Date Signed) (Retiree's Signature) (Spouse's Signature)

Los Angeles Machinist Benefit Trust

3333 Vincent Rd., Suite 203-A • Pleasant Hill, CA 94523 • Phone (800) 499-8121 • Fax (925) 405-0659

TO: **LOS ANGELES MACHINIST BENEFIT TRUST**
RETIREES AND COBRA PARTICIPANTS

FROM: **BOARD OF TRUSTEES**

RE: **DIRECT PAY PLAN**

The Board of Trustees of the Los Angeles Machinist Benefit Trust offers a direct payment plan for your monthly health insurance payment.

If you wish to participate, **your monthly payment will be automatically deducted from the account you list on the enclosed "Direct Debit Authorization Form" on the third of each month** (or the first working day following the third day if the third of the month occurs on a weekend or holiday).

Direct payment will eliminate the need for you to write a check and mail it to the Trust Office each month; you need only make an entry of the deduction each month in your check register.

If you are interested in participating in the direct payment plan you will need to do the following.

If the monthly payment is to be deducted from ***your checking account****:*

> Read, complete, sign, date and return the Direct Debit Authorization Form; ***attach a voided check from your checking account***.

If the monthly payment is to be deducted from ***your savings account***:

> Read, complete, sign, date and return the Direct Debit Authorization Form; ***attach a voided deposit slip from your savings account.***

If there are not sufficient funds in your account to cover your payment on the third of the month (or the first working day following the third day if the third of the month occurs on a weekend or holiday) the automatic debit will be processed again on the 15th of the month (or the first working day following the 15th day if the 15th of the month occurs on a weekend or holiday). The Fund will handle this as it would a "returned check" and there will be an additional $10.00 fee for processing. If there are two experiences of insufficient funds in a row you will be removed from the program.

(over)

If you wish to take advantage of this payment option, return your completed form (*along with a voided check if you are using a checking account, or a voided deposit slip if you are using* a *savings account*) to:

LAMBT
PO BOX 6149
Garden Grove, CA 92846

Please see the examples below to determine when your automatic payments will begin, based on the date your form is received by the Trust Office. **Payments will be automatically deducted from your account on the third of each month** (or the first working day following the third day if the third of the month occurs on a weekend or holiday).

Form Received by Administration Office	First Payment Debit
Before July 20	August 3
Before August 20	September 3
Before September 20	October 3
After July 20	September 3
After August 20	October 3
After September 20	November 3

NOTE: You will need to continue making payments for your coverage by check or money order through the last month before your automatic payments begin, as shown above.

If you have any questions, please call our office and speak with Brianda. The phone number is 714 898-2200. Office hours are Monday through Friday, 9:00 am to 5:00 pm, closed for lunch noon to 1:00 pm.

Enclosure (Authorization Form)

LOS ANGELES MACHINIST BENEFIT TRUST

DIRECT DEBIT AUTHORIZATION FORM

If you would like to participate in the direct debit program, please do one of the following:

1) If the direct debit will be drawn upon your *checking account*, please sign below and ***attach a voided check***. The voided check is for informational purposes only.

2) If the direct debit will be drawn upon your *savings account*, please sign and fill in the information below and ***attach a voided deposit slip.*** The voided deposit slip is for informational purposes only.

NAME:_____

BANK NAME:_____

ACCOUNT NUMBER:_____

SIGNATURE:_____ DATE:_____

Send this form to: LAMBT
PO BOX 6149
Garden Grove, CA 92846

Los Angeles Machinist Benefit Trust
Health & Welfare

Send to: PO BOX 6149 Garden Grove, CA 92846

Phone: (800) 499-8121
FAX: (925) 405-0659

Website
www.lambt.org

RETIREE ENROLLMENT FORM

PLEASE INDICATE YOUR SELECTION

This form does NOT need to be completed if you make no change to your benefits.
If you do make changes, please select only the change you want to make.

Health Coverage (Choose One):

- ☐ Kaiser Permanente - High Option
- ☐ Kaiser Permanente - Low Option
- ☐ United HealthCare - High Option
- ☐ United HealthCare - Low Option

Optional Vision Plans (Choose One):

- ☐ Vision - EYEMed
- ☐ Vision - Vision Services Plan $5 Copay
- ☐ Vision - Vision Services Plan $5 Copay with Lens Option

Optional Dental Plan - ☐ CIGNA (DHMO) ☐ CIGNA (DPPO)

RETIRED EMPLOYEE

Last Name _____ First Name _____ MI _____

Birth Date (mm/dd/yyyy) _____ Social Security Number _____ Email Address _____

Mailing Address (Street/PO Box) _____ City _____ State _____ ZipCode _____

Name of Employer at Time of Retirement _____ Hire Date _____ Last Day of Work _____

Are you currently eligible for Medicare A and B? ☐ No ☐ Yes

If yes, Medicare effective date: _____

Medicare HICN: _____

Are you eligible for medical benefits from any other group plan? ☐ No ☐ Yes

If yes, name of the group plan: _____

SPOUSE (only complete if adding spouse to the health plan)

Last Name _____ First Name _____ MI _____

Birth Date (mm/dd/yyyy) _____ Social Security Number _____

Is your spouse currently eligible for Medicare A and B? ☐ No ☐ Yes

If yes, Medicare effective date: _____

Medicare HICN: _____

Is your spouse eligible for medical benefits from any other group plan? ☐ No ☐ Yes

If yes, name of the group plan: _____

If you wish to enroll, you must return this form. Failure to pay contributions when they are due will lead to termination of benefits.

☐ I decline coverage in ALL coverage options.
Explanation:

SIGNATURE(S)

Retiree Signature _____ Date _____

Spouse Signature _____ Date _____

2024 RETIREE SCHEDULE OF BENEFITS						
	Class I Retiree*		Class II Retiree		Class III Retiree	
Benefit Plan Option	**High**	**Low**	**High**	**Low**	**High**	**Low**
Medical Plan Option - **Doctor Visit Copays -**						
Kaiser (California only)	$15 copay	$25 copay[1]	$15 copay	$25 copay[1]	$15 copay	$25 copay[1]
UnitedHealthcare (California only)	$15 copay[2]	$25 copay[1]	$15 copay[2]	$25 copay[1]	$15 copay[2]	$25 copay[1]
Prescription Drugs HMO Plans	Refer to Medical Comparison		Refer to Medical Comparison		Refer to Medical Comparison	
Dental Plans (Self-Pay)						
Prepaid	CIGNA		CIGNA		CIGNA	
Indemnity	CIGNA		CIGNA		CIGNA	
Vision (Self-Pay)						
Prepaid (Optional)	Medical Eye Services (MES)		Medical Eye Services (MES)		Medical Eye Services (MES)	
	Vision Service Plan (VSP)		Vision Service Plan (VSP)		Vision Service Plan (VSP)	

1 Non-Medicare Retirees - $25 copay

2 Non-Medicare Retirees - $15 copay

2024 MEDICAL PLANS COMPARISON				
Benefit	**UnitedHealthcare (UHC) High Option**	**UnitedHealthcare (BSC) Low Option**	**Kaiser Permanente High Option**	**Kaiser Permanente Low Option**
Deductible	None	None	None	None
Ambulance	No charge	No charge	No charge	No charge
Durable Medical Equipment	No charge	No charge	No charge	No charge
Emergency Services	$100/visit; waived if admitted	$100 copay; waived if admitted	$100 copay; waived if admitted	$100 copay; waived if admitted
Home Health Care	No charge	No charge	No charge; 100 2-hr visits/CY	No charge; 100 2-hr visits/CY
Hospital				
Inpatient	$100 per admit	$100 per admit	$100 per admit	$100 per admit
Outpatient	$50 copay	Facility - $50/surgery; no charge treatment	$15 copay	$25 copay
Maximums (lifetime and annual)	Unlimited	Unlimited	Unlimited	Unlimited
Mental Health*				
Inpatient*	$100 copay per admit. Alternative levels of treatment covered - $50 copay.	Provided by MHN; $100 copay per admit. Alternate levels of treatment - $50 copay.	$100 copay/admit; up to 45 days/CY no limit on mental health parity	$100 copay per admit
Outpatient	Provided by MHN: $15 copay individual; $7.50 copay group	Provided by MHN: $25 copay individual; $17.50 copay group	$15 copay/individual;$7 copay group; 20 visits/CY; no day limit mental health parity	$25 individual; $12 group
Outpatient Diagnostic-X-ray and Laboratory	No charge	No charge	No charge	No charge
Preventive Health Benefits	$15 copay	$25 copay - routine physical; well women care - no charge; well-baby - no charge to age 2 year	$15 copay	$25 copay
Physician Services -				
Office/Home visit	$15 copay; Access+specialist - $20	$25 copay; Access+specialist - $30	$15 copay	$25 copay
Rehabilitative	$15 copay	$25 copay/visit	$15 copay	$25 copay
Prescription Drugs	Retail: $10 copay/Generic; $30 copay/ Brand; Mail - 2 x retail	Retail: $10 copay/Generic; $30 copay/ Brand; Mail - 2 x retail	Retail (100 day supply): $10 copay Generic; $30 copay Brand	Retail (100 day supply): $10 copay - Generic; $30 copay Brand;
Skilled Nursing Facility	No charge; 100 days/CY	No charge; 100 days/CY	No charge; 100 days/benefit period	No charge; 100 days/benefit period
Substance Use*				
Inpatient	Provided by MHN; PPO - $100 copay per admit. Alternate levels of treatment covered - $50 copay.	Provided by MHN; PPO - $100 copay per admit. Alternate levels of treatment covered - $50 copay.	$100 copay per admit; Detox only	$100 copay per admit
Outpatient	MHN: $15 copay/visit;	Provided by MHN: $25 copay individual; $17.50 copay group	$15 copay individual; $5 copay group	$25 individual; $5 group

Note: This is only a summary of your benefits; Refer to the EOC or disclosure forms for HMO benefit details, and exclusions and limitations

Los Angeles Machinist Benefit

Save even more with PLUS Providers

$50 Additional frame allowance from PLUS Providers*

*Compared to $130 frame allowance at other EyeMed in-network providers

Find an eye doctor (Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Provider	$0 copay	Up to $40
Exam	$0 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame at PLUS Provider	$0 copay; 20% off balance over $180 allowance	Up to $91
Frame - Retail	$0 copay; 20% off balance over $130 allowance	Up to $91
Frame - Wholesale*	$0 copay; balance over $91 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $30
Bifocal	$0 copay	Up to $50
Trifocal	$0 copay	Up to $70
Lenticular	$0 copay	Up to $70
Progressive - Standard	$0 copay	Up to $50
Progressive - Premium Tier 1 - 4	$85 - 175 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68 copay	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $20
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $105 allowance	Up to $74
Contacts - Disposable	$0 copay; 100% of balance over $105 allowance	Up to $74
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Lenses	Once every 12 months	Once every 12 months
Contacts Lenses	Once every 12 months	Once every 12 months

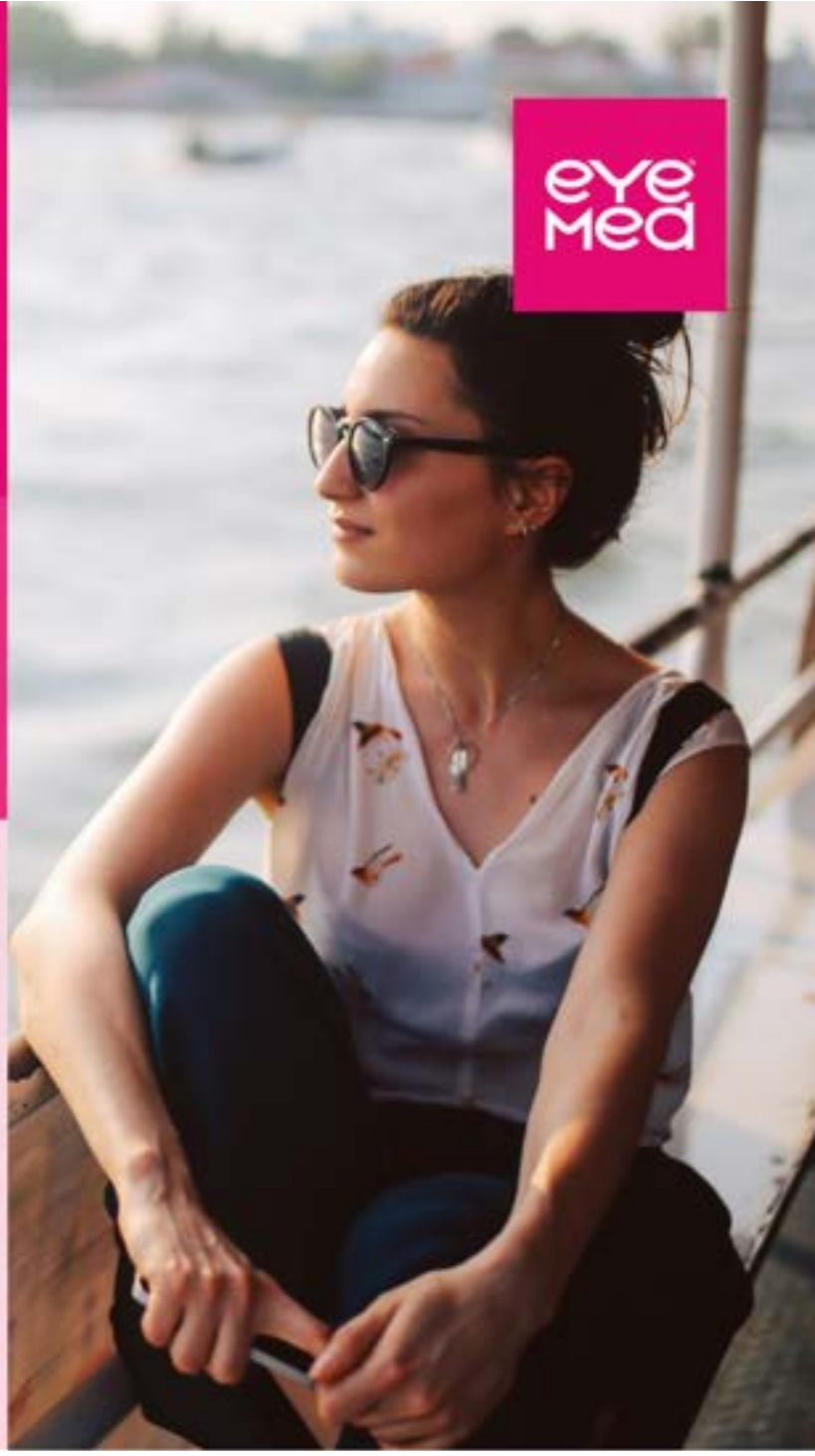
(Plan allows member to receive either contacts and frame, or frame and lens services)

QL-0000078147

*Available at wholesale providers, such as Costco Optical; discounts do not apply. View the provider locator to find wholesale providers.

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Expect more from your benefits



EyeMed vision benefits include access to PLUS Providers to help you save even more

You save more at an in-network provider – an average of 71% more off the retail price of eye exams and glasses.* Choosing a PLUS Provider can boost those savings.

Since PLUS Providers are already in our network, the extra perks are built right into your vision benefits. No promo codes, no coupons, no paperwork, no claims. The same vision care, plus a little more savings.

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator.

Just look for the PLUS.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS® PEARLE VISION OPTICAL

PDF-1902-M-046

*Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/ $10 materials copay/ $120 frame or contact lens allowance.

VSP
Vision care for life

Your Vision Benefits Summary

Get the best in eyecare and eyewear with LOS ANGELES MACHINISTS BENEFITS TRUST and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  The decision is yours to make—choose a VSP provider or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best EyeCare

You'll get the highest level of care, including a WellVision Exam® the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$5 for exam and glasses
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Combined with exam
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $ 0 - $90 $120 - $1 0
Contacts (instead of glasses)	• $105 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Primary Eyecare	
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam.....up to $50
Frame.....up to $70
Single Vision Lenses.....up to $50
Lined Bifocal Lenses.....up to $75
Lined Trifocal Lenses.....up to $100
Progressive Lenses.....up to $75
Contacts.....up to $105

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change.

VSP
Vision care for life

Your Vision Benefits Summary

Get the best in eyecare and eyewear with LOS ANGELES MACHINISTS BENEFITS TRUST - BUY UP and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  The decision is yours to make—choose a VSP provider or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$5 for exam and glasses
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Every 12 months	Combined with exam
Lens Enhancements	• Progressive lenses • Anti-reflective coating • Tints/Photochromic adaptive lenses • Polycarbonate lenses • Scratch-resistant coating • Average savings of 35-40% on other lens enhancements • Every 12 months	$0 $0 $0 $0 $0
Contacts (instead of glasses)	• $105 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Primary Eyecare	
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam.....up to $50
Frame.....up to $70
Single Vision Lenses.....up to $50
Lined Bifocal Lenses.....up to $75
Lined Trifocal Lenses.....up to $100
Progressive Lenses.....up to $75
Contacts.....up to $105

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

[1]Brands/Promotion subject to change.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

2024 DENTAL BENEFIT COMPARISON LOW		
Procedure	**Indemnity Plan 6[1]**	**CIGNA[2]**
Annual Maximum	$ 1,500	None
Dental Preferred Provider	80%	Not applicable
Preventative & Diagnostic -		
X-rays, Complete	$ 45.00[3]	No charge
X-rays, First Periapical	14.00	No charge
X-rays, Next Periapical	5.00	No charge
X-rays, 2 Bitewings	15.00[3]	No charge
X-rays, 4 Bitewings	20.00[3]	No charge
Prophylaxis, Adult	30.00	No charge
Prophylaxis, Child	30.00	No charge
Restorative -		
Amalgam, 1 Surface (Permanent)	$ 30.00	No charge
Amalgam, 2 Surfaces (Permanent)	40.00	No charge
Composite Resin, 1 Surface	40.00	No charge
Crown, Porcelain with Metal	300.00	$60.00[4]
Other -		
Perio Scale	$ 40.00	No charge
Simple Extraction	30.00	No charge
Orthodontia for Dependent Children and Adults	See your Schedule of Benefits	$1,500[5] or $2,000[6]; 2-year maximum length of treatment; additional usual and customary charges thereafter

1 The benefits listed are amounts payable by the Plan if a non-contracting provider is used; use of a contracting provider will limit your co-payment.
2 Sample co-payments only, refer to CIGNA brochure for other co-payments.
3 Includes exam. The Plan does NOT pay for routine exams when routine x-rays are taken.
4 Plus cost of metal.
5 Children, plus start up fees.
6 Adults adult children, plus start up fees.

Note: This is only a summary of your benefits. You should refer to the Administrative Office or CIGNA's Evidence of Coverage for a binding and detailed description of benefits.