OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Evergreen PPO (HDHP)
Connexus Network
Optional *HSA Allowed*

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	$1,600[2]	$3,200[2]
Maximum deductible per family	$3,200[2]	$6,400[2]
Out-of-pocket (OOP) maximum per person [3]	$6,550[2]	$13,100[2]
Out-of-pocket (OOP) maximum per family [3]	$13,100[2]	$26,200[2]
Maximum cost share per person	N/A	N/A
Maximum cost share per family	N/A	N/A
Preventive Care Services		
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0[1]	50%
Incentive Care Services **(for asthma, heart conditions, cholesterol, high blood pressure, diabetes)**		
Moda Medical Home incentive care	20%	50%
Incentive office visits and home visits	20%	50%
Office Services		
Moda Medical Home primary care services	20%	50%
Primary care office visits	20%	50%
Specialist office visits	20%	50%
Urgent Care	20%	
Mental Health Services		
Mental health office visits	20%	50%
Mental health inpatient and residential services	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	20%	50%
Outpatient Services		
Outpatient surgery/facility care	20%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	20%	50%
Tests (outpatient)		
Preventive tests	$0[1]	50%
Laboratory	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%
CT, MRI, PET scans	20%	50%
Alternative Care Services ($2,000 combined maximum)		
Acupuncture, Chiropractic, and Naturopathic Services, labs, diagnostics, etc. ***Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum***	20%	50%
Maternity Care		
Outpatient Materntity Care	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%
Hospital Services		
Inpatient care/surgery	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%
Additional Cost Tier		
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	20%	50%

OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Evergreen PPO (HDHP)
Connexus Network
Optional *HSA Allowed*

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Member Pays	Out-of-Network Member Pays
Emergency Services		
Emergency room (copay waived if admitted)	20%	
Ambulance	20%	
Other Covered Services		
Hearing Aids $4,000 maximum benefit every 48 months for adults; see handbook for State mandated benefit for children	20%	50%
Durable Medical Equipment (DME)	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered
Pharmacy Services		
Out-of-pocket Maximum	Rx applies toward plan OOP max	
Retail		
Value (Moda Plans Only)	$4 per 31-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	20%	
Preferred Brand	20%	
Non-preferred brand[5]	20%	
Mail		
Value (Moda Plans Only)	$8[1] per 90-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	20%	
Preferred Brand	20%	
Non-preferred brand[5]	20%	
Specialty		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	20%	
Non-preferred brand[5]	20%	

Moda Member Handbooks Available at:
https://www.modahealth.com/oebb/members/handbooks.shtml

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Click on Find Care , then click on Search as a guest

OEBB Moda Health Medical/Vision
Toll-free: 866-923-0409
Local: 503-265-2909
Group ID: 10006726

OEBB Moda Health Pharmacy
Toll-free: 866-923-0411
Local: 503-265-2911

N/A - Not applicable

1 Deductible waived.

2 Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

4 Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

5 A formulary exception must be approved for non-preferred brand prescription medication.

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OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	moda HEALTH Alder CCM** Synergy or Summit Network		moda HEALTH Birch PPO Connexus Network	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	$400	$800	$800	$1,600
Maximum deductible per family	$1,200	$2,400	$2,400	$4,800
Out-of-pocket (OOP) maximum per person [3]	$3,000	$6,000	$4,000	$8,000
Out-of-pocket (OOP) maximum per family [3]	$9,000	$18,000	$12,000	$24,000
Maximum cost share per person	$7,350	N/A	$7,350	N/A
Maximum cost share per family	$14,700	N/A	$14,700	N/A
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	Not covered
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0[1]	50%	$0[1]	50%
Incentive Care Services **(for asthma, heart conditions, cholesterol, high blood pressure, diabetes)**				
Moda Medical Home incentive care	$10 copay[1]	50%	$15 copay[1]	50%
Incentive office visits and home visits	see above	50%	20%[1]	50%
Office Services				
Moda Medical Home primary care services	$20 copay[1]	50%	$30 copay[1]	50%
Primary care office visits	see above	50%	20%	50%
Specialist office visits	20%	50%	20%	50%
Urgent Care	$50[1]		$50[1]	
Mental Health Services				
Mental health office visits	$20 copay[1]	50%	$30 copay[1]	50%
Mental health inpatient and residential services	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	50%
Outpatient Services				
Outpatient surgery/facility care	20%	50%	20%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	20%	50%	20%	50%
Tests (outpatient)				
Preventive tests	$0[1]	50%	$0[1]	50%
Laboratory	20%	50%	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%	20%	50%
CT, MRI, PET scans	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Alternative Care Services ($2,000 combined maximum)				
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	20%	50%	20%	50%
Maternity Care				
Outpatient Materntity Care	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%
Hospital Services				
Inpatient care/surgery	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	50%
Additional Cost Tier				
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%

OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	moda HEALTH Alder CCM** Synergy or Summit Network		moda HEALTH Birch PPO Connexus Network	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Emergency Services				
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%	
Ambulance	20%		20%	
Other Covered Services				
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	50%	10%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered	$500 + 20%	Not covered
Pharmacy Services				
Out-of-pocket Maximum	Rx applies toward plan OOP Max		Rx applies toward Max Cost Share	
Retail				
Value (Moda Plans Only)	$0		$4 per 31-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$8 per 31-day supply		$12 per 31-day supply	
Preferred Brand	25% up to $50 per 31-day supply		25% up to $75 per 31-day supply	
Non-preferred brand[5]	50% up to $150 per 31-day supply		50% up to $175 per 31-day supply	
Mail				
Value (Moda Plans Only)	$0		$8 per 90-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$16 per 90-day supply		$24 per 90-day supply	
Preferred Brand	25% up to $100 per 90-day supply		25% up to $150 per 90-day supply	
Non-preferred brand[5]	50% up to $300 per 90-day supply		50% up to $450 per 90-day supply	
Specialty				
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 31-day supply		25% up to $200 per 31-day supply	
Non-preferred brand[5]	50% up to $300 per 31-day supply		50% up to $500 per 31-day supply	

Moda Member Handbooks Available at:
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Toll-free: 866-923-0409
Local: 503-265-2909
Group ID: 10006726

OEBB Moda Health Pharmacy
Toll-free: 866-923-0411
Local: 503-265-2911

N/A - Not applicable

** If enrolled in a Moda Alder Synergy CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level.

[1] Deductible waived.

[2] Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

[5] A formulary exception must be approved for non-preferred brand prescription medication.

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OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	Med Plan 1 HMO Kaiser Permanente Network		Med Plan 3 HMO (HDHP) Kaiser Permanente Network *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	None	N/A	$1,600[2]	N/A
Maximum deductible per family	None	N/A	$3,200[2]	N/A
Out-of-pocket (OOP) maximum per person [3]	$1,500	N/A	$6,550[2]	N/A
Out-of-pocket (OOP) maximum per family [3]	$3,000	N/A	$13,100[2]	N/A
Maximum cost share per person	N/A	N/A	N/A	N/A
Maximum cost share per family	N/A	N/A	N/A	N/A
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0	N/A	$0[1]	N/A
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0	Not Covered	$0[1]	Not Covered
Incentive Care Services **(for asthma, heart conditions, cholesterol, high blood pressure, diabetes)**				
Moda Medical Home incentive care	N/A	N/A	N/A	N/A
Incentive office visits and home visits	N/A	N/A	N/A	N/A
Office Services				
Moda Medical Home primary care services	N/A	N/A	N/A	N/A
Primary care office visits	$20	Not Covered	20%	Not Covered
Specialist office visits	$30	Not Covered	20%	Not Covered
Urgent Care	$35	See Plan Handbook	20%	See Plan Handbook
Mental Health Services				
Mental health office visits	$20	Not Covered	20%	Not Covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	20%	Not Covered
Outpatient Services				
Outpatient surgery/facility care	$75	Not Covered	20%	Not Covered
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	$30 per visit	Not Covered	20%	Not Covered
Tests (outpatient)				
Preventive tests	$0	Not Covered	$0[1]	Not Covered
Laboratory	$20 per visit	Not Covered	20%	Not Covered
X-ray, imaging, and special diagnostic procedures	$20 per visit	Not Covered	20%	Not Covered
CT, MRI, PET scans	$20 per visit	Not Covered	20%	Not Covered
Alternative Care Services ($2,000 combined maximum)				
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	$20 per service	Not Covered	20%	Not Covered
Maternity Care				
Outpatient Materntity Care	$0	Not Covered	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered
Hospital Services				
Inpatient care/surgery	$100 per day, up to $500 per admission maximum	See Plan Handbook	20%	See Plan Handbook
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	$0	NA	20%	N/A

OEBB Summary of Medical and Pharmacy Benefits
2018-19 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	Med Plan 1 HMO Kaiser Permanente Network		Med Plan 3 HMO (HDHP) Kaiser Permanente Network *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Additional Cost Tier				
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	N/A	N/A	N/A	N/A
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A	N/A	N/A
Emergency Services				
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20%	
Ambulance	$75		20%	
Other Covered Services				
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not Covered	20%	Not Covered
Durable Medical Equipment (DME)	20%	Not Covered	20%	Not Covered
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + Inpatient Care costs	Not Covered	$500 + 20%	Not Covered
Pharmacy Services				
Out-of-pocket Maximum	$1100 Rx max also applies to Medical OOP Max		Rx applies toward plan OOP max	
Retail				
Value (Moda Plans Only)	N/A	N/A	N/A	N/A
Generic (Kaiser plans) / Select generic (Moda Plans)	$5 per 30-day-supply	See Plan Handbook	20%	See Plan Handbook
Preferred Brand	$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand[5]	$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Mail				
Value (Moda Plans Only)	N/A	N/A	N/A	N/A
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand[5]	$90 per 90-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Specialty				
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 30 day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand[5]	25% up to $100 per 30 day supply	See Plan Handbook	20%	See Plan Handbook

Kaiser Member Handbooks available at:
https://my.kp.org/oebb/plan-details/oregon-washington-actives/

Kaiser Contact
866-223-2375

Group ID: 18050

N/A - Not applicable

[1] Deductible waived.

[2] Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

[5] A formulary exception must be approved for non-preferred brand prescription medication.

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OEBB Summary of Dental Benefits
2018-19 Plan Year

Dental	Premier Plan 5♦ Delta Dental Premier Network	Premier Plan 6 Delta Dental Premier Network	Kaiser Dental Plan† Kaiser Permanente Facilities
Dental Office Visit Copayment	N/A	N/A	$20 *
Benefit Maximum	$1,700	$1,200	$4,000 ***
Deductible	$50	$50	N/A
Preventive and Diagnostic Services * - Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans			
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	100%	100% *
Restorative Services *			
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	80% [1]	100% [2]*
Simple Extraction *			
Simple tooth extractions	70% + 10% each Plan Year	80%	100% *
Oral Surgery *			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay *
Periodontics *			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	80%	100% *
Endodontics *			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay *
Major Restorative Services *			
Gold or porcelain crowns and onlays	70%	50%	$250 Copay *
Implants	50%	50%	50% * (limit of 4 per lifetime)
Other covered services*			
Occlusal guards (night guards)	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	90%
Athletic mouth guards	50%	50%	90%
Nitrous Oxide	50%	50%	$25 (Ages 13 & Up)
Fixed and Removable Prosthetic Services *			
Full and partial dentures, relines, rebases	50%	50%	$100 Copay *
Bridge retainers and pontics	50%	50%	$250 Copay *
Orthodontics * (All plans except Delta Dental Plan 6)			
Orthodontic Treatment	80% to $1,800 lifetime max	N/A	$2,500 copay + $20 per visit

N/A - Not applicable

♦ Under Delta Dental Plans 5, benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year. Switching between incentive plan (Plan 5) and other non-incentive plan (Plan 6) will have an effect on benefit level.

† The Kaiser Dental Plan does NOT require enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.

* For Kaiser Permanente Group plan: Office visit copayment applies at each visit, in addition to any plan copayments for services.

** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.

*** Preventive care and orthodontia do not accrue to this maximum.

[1] Posterior fillings paid to composite fee.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser Permanente directly for actual fees.

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Moda Contact: 503-265-2910

Kaiser Contact: 1-866-223-2375

OEBB Summary of Vision Benefits
2018-19 Plan Year

You will <u>not</u> receive an ID card from VSP. No ID card needed at your appointment, simply tell them you have VSP. To find out more, go to vsp.com or call 800-877-7195. Your group ID is 30076188 .

	
Vision	**VSP Choice Plus Plan** VSP Choice Network
Plan Year Maximum	N/A
Routine Eye Exam:	
Benefit:	Plan pays 100% after $10 copay
Frequency:	Every 12 months
Lenses:	
Basic lens benefit:	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Polycarbonate lenses, scratch resistant, and UV coatings covered in full**
Lens enhancements	**$0 copay for standard progressive lenses** **$15 copay for** **anti-reflective coating, or progressive lenses**
Frequency:	Once every 12 months
Frames / Contacts:	
Benefit:	Covered in full up to retail allowance of **$300**; 20% off amount over retail allowance for frames
Frequency:	Once every 12 months

vsp.com
800-877-7195
Group ID: 30076188

For coverage with Out-of-Network Providers, the plan pays up to the amounts below. Please contact VSP for additional information.
Exam $45
Single Vision Lenses $30
Lined Bifocal Lenses $50
Lined Trifocal Lenses $65
Frame $70
Contacts $105

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