CENTENARY UNIVERSITY

Carrier Resource Guide

Welcome

Explore the ways your health plan is designed to help you take better care of yourself

United Healthcare Oxford

Thank you for being a member

We're here to help make each step of your health care experience easier. Take a look at this guide to help you better understand your benefits, find care options, manage costs and get more out of your health plan—and start experiencing all that care can do for you.

Call toll-free

If you don't have computer access, need language assistance or still have questions after reading this, please call the toll-free member phone number on your health plan ID card.

Connect with us

- Facebook.com/UnitedHealthcare
- Twitter.com/UHC
- Instagram.com/UnitedHealthcare
- YouTube.com/UnitedHealthcare

It's easier to connect to your plan

Your benefits include personalized digital tools that help you check in on your plan whenever you want—which helps make it easier to stay on top of your benefit details.

Activate your myuhc.com account

When it comes to managing your health plan, **myuhc.com®** lets you see what's covered, manage costs and so much more. To help everyone get more from their plan, it's important that each member age 18 and over consider creating their own account. Use **myuhc.com** to:

- Find and estimate the cost of care
- See what is covered under your plan
- View claim details
- Check your plan balances
- Find network providers

Get started today:

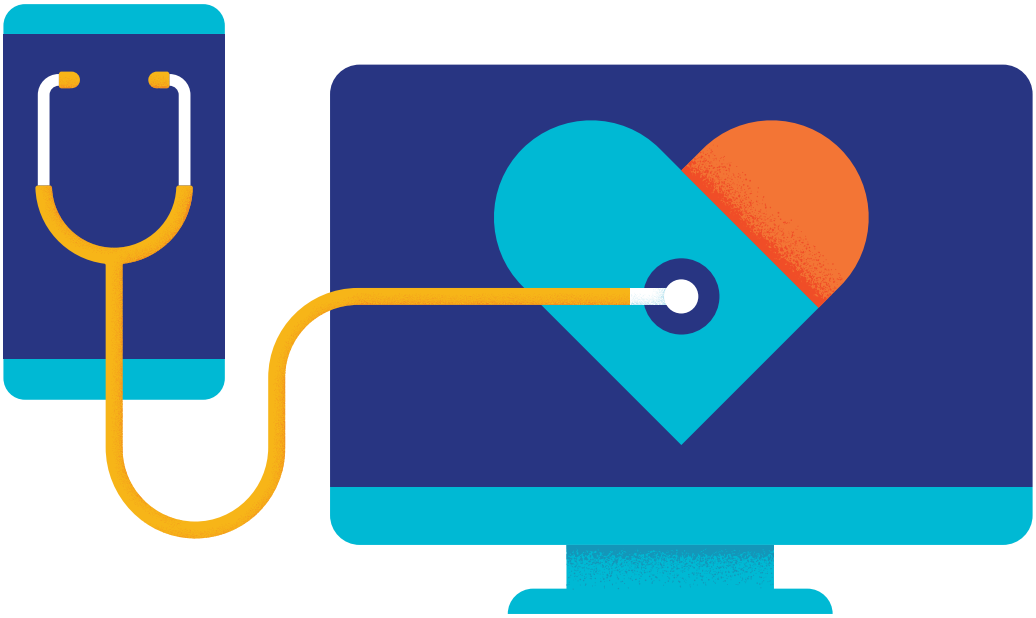
- Go to **myuhc.com > Register Now**
- Have your ID card handy and follow the step-by-step instructions

Download the UnitedHealthcare app

The UnitedHealthcare® app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network
- See your claim details and view progress toward your deductible
- View and share your health plan ID card with your doctor's office
- Video chat with a doctor 24/7

Download on the App Store | GET IT ON Google Play



Simple ways to help you save

Here are a few good-to-know things you can do to help get more out of your health plan.

Stay in the network

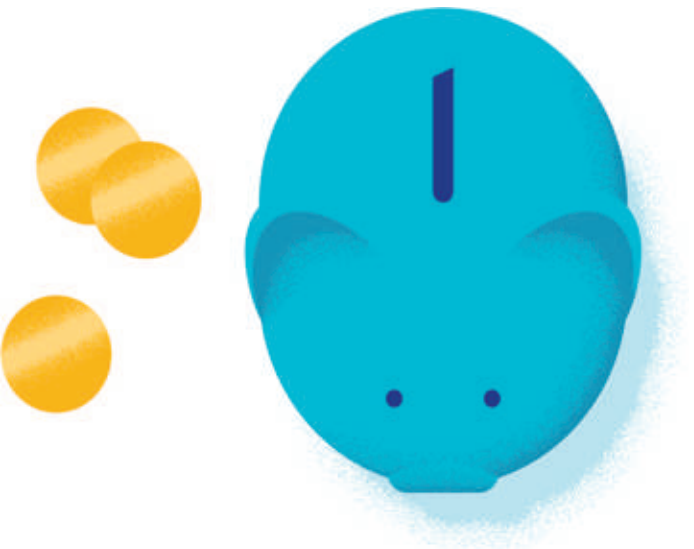
The doctors and facilities in the network may have agreed to provide services at a discount—so visiting an out-of-network provider could end up costing you more for care or may not be covered at all.

Sign in to **myuhc.com > Find Care & Costs** to locate:

- Labs
- Hospitals
- Mental health professionals
- Network providers

Look up the cost of medication

Sign in to **myuhc.com > Pharmacies & Prescriptions** to find information about your medication, pricing and lower-cost options.



Shop around

With such a wide variety of services, from minor procedures to major surgeries, it's a good idea to check approximate pricing first. Visit **myuhc.com > Find Care & Costs** to estimate your costs.

With a PCP, there's a doctor in your corner

A PCP is a primary care provider, sometimes called a primary care physician. They are the doctor who can help connect you to the care you need—and help you avoid cost surprises. A PCP can be a family practitioner, internist, pediatrician or general medicine physician.* Although your plan may not require you and each covered family member to select a network PCP,** it can be a good idea to have one.

Your PCP:

Generally knows your health history and health goals

Provides routine care, which may help identify potential health issues earlier

Advises you when to see a specialist and provides electronic referrals

*Laws in some states allow you to choose a specialist, like an OB/GYN, as your PCP.
**Depending on your health plan, selection of a PCP may be required.

Keep up on preventive care

Preventive care—such as routine wellness exams and certain recommended screenings and immunizations—is covered by most of our plans at no additional cost when you see network providers. A preventive care visit may be a good time to help establish your relationship and create a connection for future medical services. Learn more at **uhc.com/health-and-wellness/preventive-care.**

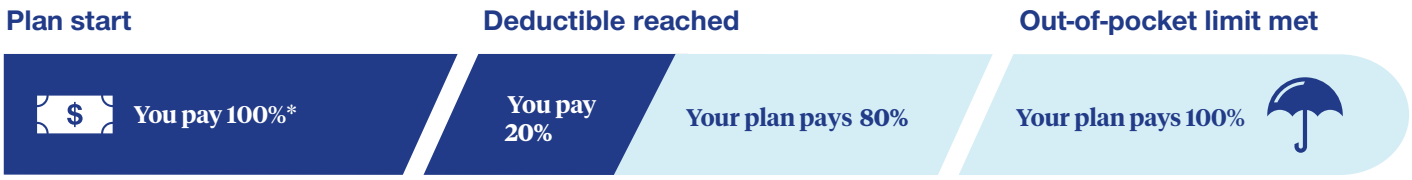
Find a network provider

Sign in to **myuhc.com > Find Care & Costs** to find a network PCP, clinic, hospital or lab based on location, specialty, availability, hours of operation and more. You can even see patient ratings and estimate the cost of care before you choose a provider. If you would like more information about a provider's qualifications, call the member phone number on your ID card.

Care that's centered on you

Here's an example of how a typical health plan works

Let's take a look at an example of how a typical plan works when you receive care from a network provider. Your plan may be different than this example, so to find your specific details go to **myuhc.com > Coverage & Benefits.**



At the start of your plan year, you pay 100% of your covered health services until you meet your **deductible**, which is the amount you pay before your plan starts sharing costs.

Now, your health plan starts to share a percentage of the costs with you—this is your **coinsurance.***

Here, your plan's got you covered at 100%. Your **out-of-pocket limit** is the most you could pay for covered services in a plan year—copays and coinsurance count toward this.

Along the way, you may also be required to pay a fixed amount—or **copay**—each time you see a provider.

*Your deductible and coinsurance may vary by plan or service. This example is for illustrative purposes only. Please refer to your official plan documents for coverage details.

Here's what to do if you need:

Hospital care

Talk to your PCP first to determine which hospital in your network can meet your medical or surgical needs. You or the admitting physician may be required to notify us before you're admitted.

Prior authorization

Your plan may also require prior authorization, sometimes called preauthorization, before you receive certain services. Call the member phone number on your ID card <or sign in at **myuhc.com > Coverage & Benefits**> to check if prior authorization is needed.

Referrals

If your ID card says "Referrals Required," have your PCP send us an electronic referral before you make an appointment with a specialist or other network provider. Without it, your care may not be covered and you may end up paying more. To learn what services require referrals, or to confirm that a referral has been made, sign in at **myuhc.com > Coverage & Benefits.**

Referrals aren't needed to see the following network providers:

- Obstetricians/gynecologists
- Behavioral health or substance use disorder clinicians

Emergencies are covered anywhere in the world—including hospitals out of the network—without a referral.

Get to know your care options and costs

How much you pay for care can depend on where you get it. For serious or life-threatening conditions, call 911 or go to an emergency room. For everything else, it may be best to contact your PCP first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the emergency room.

Care options to consider and approximate costs	START HERE **PCP** Care from the doctor who may know you best	**24/7 Virtual Visits** See a doctor whenever, wherever	**Convenience care** Basic conditions that aren't generally life-threatening	**Urgent care** Serious conditions that aren't generally life-threatening	**Emergency room** Life- and limb-threatening emergencies
Average cost*	**$165**	**Less than $49****	**$100**	**$185**	**$2,500**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location—may be open nights/weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**					
Broken bone				✔	✔
Chest pain					✔
Cough	✔	✔	✔		
Fever	✔	✔	✔		
Muscle strain	✔		✔		
Pinkeye	✔	✔	✔		
Shortness of breath					✔
Sinus problems	✔	✔	✔		
Sore throat	✔	✔	✔		
Sprain	✔		✔	✔	
Urinary tract infection	✔	✔	✔		

Need to find a network provider or PCP?

Visiting an out-of-network provider could end up costing you more for care. To find a PCP, urgent care centers and emergency rooms in your network, go to **myuhc.com**.

Not sure where to go for care? Call the number on your health plan ID card.

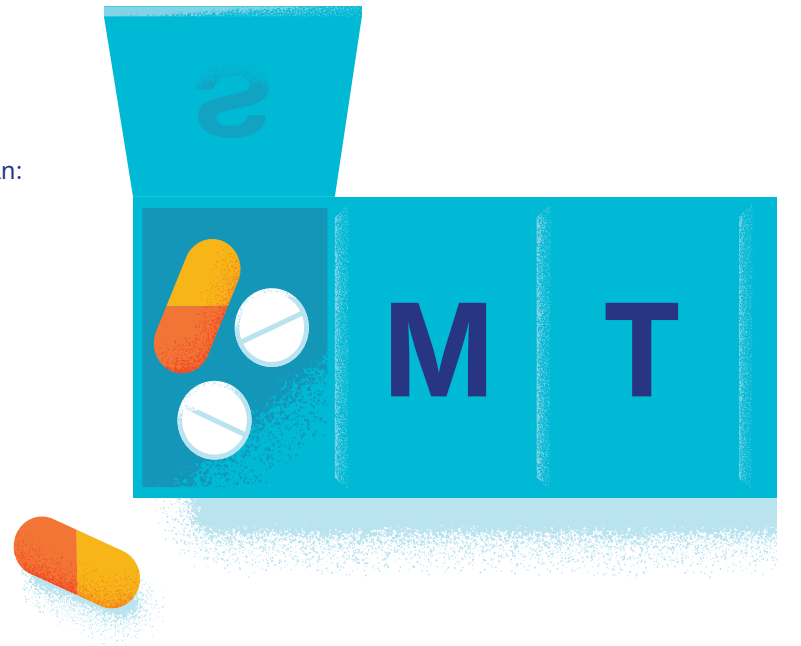
*Source 2020: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,315 difference between the average emergency room visit, $2,500 and the average urgent care visit $185.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your plan.

Say hello to Optum Rx

Optum Rx® pharmacy services help make it easier to save on medications and keep track of them, too—whether you're online or on the go.



Manage your meds

When you go to **myuhc.com** > **Pharmacies & Prescriptions** you can:

- Find and compare medication costs
- Locate a network pharmacy
- See if your medications have any requirements before filling them

Two ways to fill your prescriptions

Use home delivery

Order up to a 3-month supply of medications you take regularly.* Sign up on **myuhc.com,** use the UnitedHealthcare app or call the member phone number on your ID card. Make sure you have at least a 1-month supply to cover you through the transition.

*Not all prescriptions are eligible for home delivery.

Pick up at the pharmacy

Show your ID card at any network pharmacy—which can be found by checking the Pharmacy Locator at **myuhc.com**, on the UnitedHealthcare app or by calling the member phone number on your ID card.

Keep costs in check

Your Prescription Drug List (PDL)—available on **myuhc.com**—lists the most commonly prescribed medications covered by your plan. Choosing medications in the lower tiers may help you save money. And, consider generic medications instead of brand names which may keep costs down.

Health and wellness benefits powered by care

As part of your health plan benefits, you can sign up for wellness programs and health support services at no additional cost to you. Here's what your plan offers.

Behavioral Support

Tap into behavioral health support

Get connected to self-help digital tools, in-person or virtual behavioral health providers and other resources that may help with a variety of concerns, such as depression and anxiety, relationship difficulties, grief and loss, alcohol and drug use, compulsive habits, eating disorders and more. Call the member phone number on your ID card or visit **myuhc.com.**

Quit For Life

Quit tobacco for good

With a coach on your side, it may be easier to leave tobacco behind. The Quit For Life® program includes online support, a customized action plan and more to help you go tobacco-free. Enroll today at **myuhc.com.**

Rally

Rewards for well-being

Have fun and get healthier with Rally®. Take a health survey to see how you're doing in key areas like nutrition, fitness and stress, get personalized recommendations that fit your lifestyle, track your progress on your dashboard and earn Rally Coins that can be redeemed for rewards. Get started at **myuhc.com.**

Real Appeal

Lose weight, feel great

Connect with a community of support with Real Appeal®, an online weight loss program designed to inspire healthier behaviors. It includes group coaching sessions, 24/7 online resources, a mobile app to set and track goal progress and a Success Kit with scales, exercise tools, food guides and more delivered to your door. Get started at **myuhc.com.**

Access to Real Appeal not available in Hawaii.

Sweat Equity

Get rewarded for exercising

With the Sweat Equity® program, you may earn up to $200 every 6 months for meeting program exercise requirements. To qualify, complete a total of 50 workouts—either gym visits, classes, fitness events or any mix of these options—in a 6-month period, and then send in a reimbursement form. To learn more, call the member phone number on your ID card.

24/7 Virtual Visits

Get care, virtually anywhere

With 24/7 Virtual Visits, you can connect to a care provider by phone or video* through **myuhc.com** or the UnitedHealthcare app. Providers can treat a wide range of nonemergency health conditions—from flu and pinkeye to migraines and more—and may even prescribe medication as needed.** Get started at **myuhc.com/virtualvisits** or via the UnitedHealthcare app.

*Data rates may apply.

**Certain prescriptions may not be available, and other restrictions may apply.

Here's the fine print

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث اللغة العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المدرج على البطاقة الخاصة بعضوية الخطة.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Visit www.uhc.com/legal/required-state-notices to view important state required notices.

Member phone number services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the member phone number services are for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Your health information is kept confidential in accordance with the law. Member phone number services are not an insurance program and may be discontinued at any time.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Evaluation of New Technologies: UnitedHealthcare's Medical Technology Assessment Committee reviews clinical evidence that impacts the determination of whether new technology and health services will be covered. The Medical Technology Assessment Committee is composed of Medical Directors with diverse specialties and subspecialties from throughout UnitedHealthcare and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealthcare. The Committee meets monthly to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements for new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

The information in this guide is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary of Benefits and Coverage and Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official benefits coverage documents prevail.

Twitter is a registered trademark of Twitter, Inc. Facebook is a registered trademark of Facebook, Inc. YouTube is a registered trademark of Google, Inc. Instagram is a registered trademark of Instagram, LLC.

The UnitedHealthcare® app is available for download for iPhone® or Android®.

Android is a registered trademark of Google LLC.

Google Play and the Google Play logo are registered trademarks of Google Inc.

Apple, App Store and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries.

Members can access average cost data online or on the mobile app. None of the average costs are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing average cost data, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

Optum Rx® is an affiliate of UnitedHealthcare Insurance Company.

The Quit For Life® Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

Rally® Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Sweat Equity is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

24/7 Virtual Visits is a service available with a provider via video, or audio-only where permitted under state law. It is not an insurance product or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Telehealth services are available in Connecticut in addition to 24/7 Virtual Visits.

How to search online for Oxford providers

The provider search feature on **myuhc.com®** is a convenient way to find network medical, behavioral health, and other providers near you. The doctors and facilities in the network may have agreed to provide services at a discount — so staying in network makes sense. Depending on your plan, visiting an out-of-network provider could end up costing you a lot more for care or may not be covered at all.

Find a medical provider in your Oxford network

1. Go to **myuhc.com**
2. Select **Find a Provider**
3. Choose **Medical Directory**
4. Choose **Employer and Individual Plans**
5. Scroll down and select **Oxford Health Plans**
6. Choose your Oxford plan and enter your location
7. Finally, select the health care category you'd like to search, or use the search bar if you know the doctor's name, specialty, facility, clinic or medical group name

Find a behavioral health provider in your Oxford network

1. Go to **liveandworkwell.com**
2. Select **Find a provider** under the Explore column
3. Choose **Employer or Individual Plans**
4. Use the search bar to find a provider by name, specialty or location or search using the care categories show

Plans with out-of-area coverage

Follow these steps if your plan has access to the national UnitedHealthcare Choice Plus network or the UnitedHealthcare Core network when traveling outside of the tristate area.[1] Please verify a doctor's participation status by calling the number on your health plan ID card.

1. Go to **myuhc.com**
2. Select **Find a Provider**
3. Choose **Medical Directory**
4. Choose **Employer and Individual Plans**

continued

Look for the hearts

The UnitedHealth Premium® program can help you choose a doctor who meets standards for quality and cost efficiency. When searching for a provider look for the blue hearts.

- Premium Care Physician
- Quality Care Physician
- Quality Not Evaluated
- Does Not Meet Quality

United Healthcare Oxford

5. Scroll down and select **Oxford Health Plans.** Then, select your plan with out-of-network coverage,* either:
   - Freedom with Choice Plus
   - Liberty with Choice Plus
   - Liberty with Core
   - Metro with Core
6. Finally, select the health care category you'd like to search, or use the search bar if you know the doctor's name, specialty, facility, clinic or medical group name

Where to submit claims

If you use a UnitedHealthcare Choice Plus or Core provider, claims submitted on your behalf should be sent directly to the Oxford Claims Department for payment. Claims sent to UnitedHealthcare will not be processed for reimbursement.

Providers submitting a claim on your behalf may do so by:

- U.S. mail: **Oxford Claims Department**
  P.O. Box 31386
  Salt Lake City, UT 84131
- Electronic Data Interchange (EDI) using payer ID **06111**
- Online at **personalhealthmessagecenter.com/public/forms/MedicalClaims**
- By fax: **1-801-994-1416**

Questions?

Call the number on your health plan ID card or **1-800-444-6222,** TTY 711

United Healthcare Oxford

* Effective 9/1/22, Oxford Freedom Network (NY, NJ, CT) includes additional access to out-of-area Choice Plus providers and Oxford Liberty Network (CT) includes additional access to out-of-area Core providers. Effective 1/2/23, some NJ Oxford Metro Network small group (2-50) plans may include out-of-area coverage if the employer has purchased the rider. Out-of-area coverage exclusions; NY Oxford Metro Network; Oxford HMO small group (NY:1-100, NJ:2-25, CT:1-50) plans with effective or renewal dates prior to 2023. To confirm your plan name check your health plan ID card or benefit documents. If you do not have these documents, check with your benefits administrator.

[1] Tristate area includes Connecticut, New Jersey and certain New York counties (Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Sullivan, Suffolk, Ulster and Westchester).

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in Oxford online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information.

Data as of January 2022; UnitedHealthcare Networks national network statistics. National network may not be available for all groups. In states where the UnitedHealthcare Core network is not available, Oxford Liberty network members will have access to the full network that mirrors the UnitedHealthcare Choice Plus network. The UnitedHealthcare Core Network is not available for fully insured plans in the following states: AL, AZ, CO, DE, GA, HI, IA, ID, KY, LA, MA, ME, MT, NC, ND, NE, NH, NM, OH, OK, PA, RI, SC, UT, VT, WV, WY. The UnitedHealthcare Core Network is not available for self-funded plans in the following states: AZ, DE, HI, IA, ID, KY, LA, MA, ME, MT, NC, ND, NE, NH, NM, OH, OK, PA, RI, UT, VT, WV, WY.

Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with them for advice on selecting other physicians. You should also discuss designations with a physician before choosing them. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

The UnitedHealthcare Core product is designed to accommodate a limited network of participating physicians, health care professionals, hospitals and facilities ("providers"). Except in emergency situations, members should confirm their provider is participating in this product before receiving services to receive the highest level of benefits. Network status may be determined by calling the number indicated on the health plan ID card or visiting myuhc.com®.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (CT), Inc. and Oxford Health Plans (NJ), Inc. Administrative services provided by Oxford Health Plans LLC.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With an Oxford health plan, your cost for a 24/7 Virtual Visit is usually $0.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$0 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential $2,000[4] cost down to $0.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

continued

United Healthcare Oxford

United Healthcare Oxford

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on the difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $0; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Telehealth services are available in Connecticut in addition to 24/7 Virtual Visits.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Administrative services provided by Oxford Health Plans LLC.

Get rewarded for exercising

With the Oxford® Sweat Equity™ program, you may earn up to $200 in 6 months for meeting the program exercise requirements.

What it is

It's our goal to help people live healthier lives. Making exercise a part of your routine may be one of the most important steps you take toward being the healthiest "you." To help you on your way, we've created the Sweat Equity physical fitness reimbursement program.

The program offers a variety of exercises to choose from and the option to combine your fitness facility visits with your physical fitness classes and events to help you reach the required 50 "workouts" in a 6-month period.

Spouses/domestic partners and dependents, ages 13 and older,[1] covered by the Oxford health plan may participate in the Sweat Equity program and may get rewarded—up to $100 in a 6-month period.[2]

How it works

Eligible Oxford members* may get reimbursed up to $200 in a 6-month period.[1] You can apply for reimbursement under the program as long as you:

- Are an active member of an eligible Oxford plan
- Have gone to the gym and/or exercise classes, as described below, 50 times in 6 months

Your reimbursement period begins on the date of your first fitness facility visit, class or event and ends 6 months later. You can start a new reimbursement period 1 day after your previous reimbursement period ends.

* In this document, the term "member" refers to the Oxford plan subscriber of a fully insured Oxford medical plan or the plan participant of a self-funded plan administered by Oxford, as well as the subscriber's or plan participant's covered spouse or domestic partner and covered dependents ages 13 and older. For the spouse, domestic partner or dependent(s) to be eligible for this benefit, they must also be enrolled in the Oxford product.

continued

United Healthcare Oxford

So many ways to help you get fit and rewarded

Complete 50 visits, 50 classes, 50 fitness events or a mix of these options that add up to 50 in 6 months.

Examples of qualifying fitness facilities and classes:

- Boxing/kickboxing
- CrossFit
- Indoor rock climbing
- Marathons
- Martial arts
- Personal training
- Pilates
- Standard gym, including YMCAs and community centers where fitness services are offered

Examples of cardiovascular equipment:

- Yoga
- Elliptical trainer/cross-trainer
- Rowing machine
- Stair climber
- Stationary bicycle
- Treadmill

How to get started

Decide on a cardio (aerobic) workout that you'll enjoy and find a facility with the equipment or classes that promote cardiovascular wellness.[3] To get reimbursed, the facility, classes or fitness events you choose must be open to the general public. Then, you just need to start moving to start earning.

What we need from you

After you've completed a total of 50 workouts—either gym visits, classes, fitness events or any mix of these options—in a 6-month period, send us:

1. **Your completed Sweat Equity Program Reimbursement form.**
2. **Proof of your payment** (e.g., receipt, automatic bank withdrawal statement) for the gym fee, as well as any money you paid for qualifying fitness classes and organized group fitness events (e.g., marathon), during the 6-month period.
3. **A copy of the brochure or flier or printout of the website page** that describes the cardio (aerobic) machines at the gym you used, the cardio benefits of the class you took or organized group fitness event in which you participated.

Mail these documents to: Oxford Sweat Equity Program, P.O. Box 31386, Salt Lake City, UT 84131

- These documents must be mailed to us (postmarked) no later than 180 days from the end of the 6-month period for which you are asking for reimbursement. Requests postmarked after this date will not be reimbursed.
- We cannot accept requests for reimbursement before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date.

If you are unable to meet the reimbursement requirements of this program, you might be able to earn the same reward in a different way. Call us at the toll-free phone number on your health plan ID card and we will work with you and, if necessary, your doctor, to find another way for you to earn the same reward.

Learn more

Call the phone number on your health plan ID card

United Healthcare Oxford

[1] Eligible covered dependents' participation effective beginning with the 2020 policy renewal date.

[2] Reimbursement is generally limited to the lesser of $200 (subscriber)/$100 (covered spouse/domestic partner and eligible dependents ages 13 and older) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. For the subscriber's spouse/domestic partner and dependents to be eligible for this benefit, they must also be enrolled in an Oxford product. Refer to your Oxford benefits documents or check with your company benefits administrator to confirm eligibility and find out how much you may be reimbursed. You may submit a request for reimbursement under the program once every 6 months. Requests for reimbursement will not be accepted before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date. Rewards may be taxable. Consult with an appropriate tax professional to determine if you have any tax obligations from receiving reimbursement under this program.

[3] To be eligible for reimbursement under the program, the qualifying facility, class or organized group fitness event (e.g., marathon) that you choose must be available to the general public and promote cardiovascular wellness, as determined by us, and have staff supervision. Memberships in tennis clubs, country clubs, social clubs, sports teams, weight loss clinics or spas or any other similar organizations, leagues or facilities will not be reimbursed. You will not be reimbursed for lessons, equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages). Reimbursement is limited to actual workout visits. Physical and rehabilitative therapies do not apply.

Sweat Equity is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program.

The total annual reward amount for your participation in incentive-based programs cannot generally exceed 30% of the cost of coverage.

Oxford does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability in health programs and activities. We provide free services to help you communicate with us. Such as, letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your Oxford health plan ID card, Monday through Friday, 8 a.m. to 6 p.m., ET. TTY users dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

B2C EI1954903.3 7/21 11594 R6

If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. In New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Reimbursement form

Please print

Member[1] information			
Member first name:	Member last name:	Date of birth (month/day/year):	
Are you the plan subscriber? (yes/no):	If no, what is your relationship to the plan subscriber? (e.g., spouse, domestic partner):		
Employer/company name:		Group number:	Member ID number:
Member street address:			
City:		State:	ZIP code:

Sweat Equity program 6-month period	
Start date:	End date:

Completing and submitting this form

1. **To be completed by, and remittance to be provided to, parental/legal guardian for eligible dependent minors participating in the program.**
2. **Use 1 form per member. Record the 50 fitness facility visits and/or classes that you completed in a 6-month period on the chart shown below. Record only 1 session per day.**
   - The first date you put on the chart is the beginning of your 6-month program
   - Your program will end 6 months from this date. Do not make entries for activity after your program end date.
   - If you complete 50 qualifying workouts in less than 6 months, please do not submit your reimbursement request early. We cannot accept reimbursement requests before 6 months have passed.
   - Instead of filling in the dates of your 50 workouts, you can attach 1 of the following documents to this form:
     - A computer printout of your visits to the fitness facility and/or classes completed, including dates and the name of the place
     - Receipts that show the dates of your fitness facility visits and/or classes, with the name of the place

   Your documentation must include signatures from a facility representative, class administrator or event coordinator, as appropriate, to prove participation.
3. **Attach proof of payment** (e.g., receipt, payroll deduction, automatic bank withdrawal statement) for the fitness facility fee, as well as any money you paid for fitness classes and events, during the 6-month period.*
4. **Enclose a copy of the brochure, flier or downloaded website content** that describes the cardio equipment at the facility you used or the cardio benefits of the class or organized group fitness event in which you participated.
5. **Mail documentation to:**
   Oxford Sweat Equity Program
   P.O. Box 31386, Salt Lake City, UT 84131

   These documents must be mailed to us (postmarked) no later than 180 days from your program end date. **Requests postmarked after this date won't be reimbursed.**

Electronic reimbursement request

You have the option to make your Sweat Equity reimbursement request online if you do not wish to make the request by mail. To make the request online:

- Sign in to **myuhc.com®**
- Click **Claims & Accounts**
- Click **Submit a Claim**
- On the **Medical** tile, click **Start a claim** and fill in the required information

*On your proof of payment, please be sure to cross out any personal account ID information that's not needed so it isn't readable.

continued

Fitness events, facility visits and classes (record only 1 session per day)

Date (mm/dd/yyyy)	Session type*	Date (mm/dd/yyyy)	Session type*
1.		26.	
2.		27.	
3.		28.	
4.		29.	
5.		30.	
6.		31.	
7.		32.	
8.		33.	
9.		34.	
10.		35.	
11.		36.	
12.		37.	
13.		38.	
14.		39.	
15.		40.	
16.		41.	
17.		42.	
18.		43.	
19.		44.	
20.		45.	
21.		46.	
22.		47.	
23.		48.	
24.		49.	
25.		50.	

* Indicate “F” for facility/gym; “C” for class including organized group events (e.g., marathon).

continued

Fitness event, class, session, facility information	
Organization name:	Organization name (If second one was used):
Organization type:	Organization type:
Address:	Address:
City, State, ZIP code:	City, State, ZIP code:
Telephone number:	Telephone number:
Name of events, classes, sessions you participated in:	

Fitness facility/instructor information	
Facility employee/class instructor name:	Organization name (If second one was used):
Signature:	Date:
Instructor or other facility employee's signature above constitutes agreement that the instructor/facility promotes cardio wellness for members.	

Member verification	
If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. In New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.	
Signature:	Date:

Exclusions and limitations

- Sweat Equity is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.
- For this program, the use of "you" and "member" in communications refers to the Oxford plan subscriber, the subscriber's covered spouse or domestic partner, the subscriber's eligible dependents ages 13 or older, the plan participant of a self-funded plan administered by Oxford or the plan participant's covered spouse/domestic partner and dependents, if eligible. For the subscriber's or plan participant's spouse/domestic partner and dependents to be eligible for this benefit, they must also be enrolled in the Oxford product. The program may not be available to all Oxford plan subscribers, plan participants and their spouses/domestic partners and dependents. Reimbursement is generally limited to the lesser of $200 (subscriber/plan participant)/$100 (covered spouse/partner/eligible dependent ages 13 and older) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your Certificate of Coverage, Summary Plan Description or other governing member document to determine eligibility, including your plan's benefit and application deadlines.

continued

- To be eligible for reimbursement under the program, the qualifying facility, class or organized group physical fitness event (e.g., marathon) that you choose must be available to the general public and promote cardiovascular wellness, as determined by us, and have staff supervision.
- You must be an active employee at the time of your application for reimbursement. You may submit an application for reimbursement under the program once every 6 months. We will reimburse only those qualified visits, sessions or events that were completed while you were an Oxford member or participant of a self-funded plan administered by Oxford. We will not reimburse visits, sessions or events that occurred before your coverage became effective or after your coverage terminates. Partial reimbursements will not be given for fewer than 50 workouts in a 6-month period.
- You must hold an active fitness facility or class membership for the facility/class named in the request at the time of your application for reimbursement.
- Memberships in tennis clubs, country clubs, social clubs, sports teams, weight-loss clinics or spas or any other similar organizations, leagues or facilities will not be reimbursed. We will not reimburse you for the purchase of lessons, equipment, clothing, vitamins or other items or services that may be offered by the facility. Reimbursement is limited to actual workout visits. Physical and rehabilitative therapies do not apply.
- Lifetime memberships are not eligible for reimbursement.
- If you paid for a full-year's facility membership or class enrollment in advance, at the end of the first 6-month period for which you are applying for reimbursement, submit the receipt along with the required documentation noted above for reimbursement against half of the annual fee that you paid. Repeat this process at the end of your second 6-month period for which you made a full-year's payment, providing you have met the requirements for another, consecutive reimbursement.
- Complete 1 form per member for each 6-month period for which you are applying for reimbursement.
- We cannot accept requests for reimbursement before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date.
- If any information is missing from this form, incorrect or cannot be substantiated, the application for reimbursement will be delayed or denied.
- If you are unable to meet the reimbursement requirements of this program, you might be able to earn the same reward a different way. Call us at the toll-free phone number on your health plan ID card and we will work with you and, if necessary, your doctor to find another way for you to earn the same reward.
- Any information we collect in conjunction with this program is kept confidential according to HIPAA requirements and is separate from and has no effect on a member's medical benefits or premium.

Learn more

Call the phone number on your health plan ID card

United Healthcare Oxford

[1]On this form, the term "member" refers to the Oxford plan subscriber of a fully insured Oxford medical plan or the plan participant of a self-funded plan administered by Oxford, as well as the subscriber's or plan participant's covered spouse or domestic partner and covered dependents ages 13 and older. For the spouse, domestic partner or dependent(s) to be eligible for this benefit, they must also be enrolled in the Oxford product.

The total annual reward amount for your participation in incentive-based programs cannot exceed 30% of the cost of coverage.

Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving reimbursement under this program.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.

UnitedHealthcare
Oxford

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health insurance coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must, however, request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. You must, however, request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please call Customer Service at the telephone number on the back of your Oxford member ID card, or at 1-800-444-6222.

MS-09-385
10221

OPTUMRx®

UnitedHealthcare®
Oxford

NEW PRESCRIPTION MAIL-IN ORDER FORM

1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number		
(Additional coverage, if applicable) Secondary Member ID Number		
Last Name	First Name	MI
Delivery Address		Apt. #
City	State	ZIP
Phone Number with Area Code		
Date of Birth (mm/dd/yyyy)	Gender ○ M ○ F	Email
Physician Name		
Physician Phone Number with Area Code		

2 Health history

Medication Allergies:	○ Aspirin	○ Erythromycin	○ Quinolones	○ Others: _____
○ None known	○ Cephalosporins	○ NSAIDs	○ Sulfa	_____
○ Amoxil/Ampicillin	○ Codeine	○ Penicillin	○ Tetracyclines	_____
Health Conditions:	○ Asthma	○ Glaucoma	○ High cholesterol	○ Others: _____
○ None known	○ Cancer	○ Heart condition	○ Osteoporosis	_____
○ Arthritis	○ Diabetes	○ High blood pressure	○ Thyroid Disease	_____

Over-the-counter/herbal medications taken regularly:

3 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to **oxfordhealth.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

○ **Ship overnight.** Add $12.50 to order amount (subject to change).

○ **Check enclosed.** All checks must be signed and made payable to: OptumRx.

○ **Charge to my credit card on file.**

○ **Charge to my NEW credit card.**

New Credit Card Number

Expiration Date (Month/Year) ___/___

Visa, MasterCard, AMEX and Discover are accepted.

Signature: _____ **Date:** _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

4 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Centenary University
Group # 07656
Delta Dental PPO Plus Premier™

Preventive & Diagnostic	100%
* Exams, Cleanings (each twice in a calendar year)	
* Bitewing X-rays (twice per calendar year for persons 18 and younger, once per calendar year for persons age 19 and over)	
* Full mouth x-rays and panoramic x-rays (once per five years)	
* Fluoride Treatment (twice in a calendar year, children to age 19)	
* Sealants	
Remaining Basic	80%
* Fillings (including composite restorations on back teeth)	
* Extractions	
* Endodontics (root canal)	
* Periodontics, Oral Surgery	
* Repair of Dentures	
* Space Maintainers	
Crowns & Prosthodontics	50%
* Crowns, Gold Restorations (over natural teeth)	
* Bridgework	
* Full & Partial Dentures	
Calendar Year Maximum (per patient)	$2,000
Calendar Year Deductible (waived on Preventive & Diagnostic)	
* Per Person	$50
* Family Aggregate Deductible	$150
Orthodontic Benefits, full comprehensive treatment (Adult & Child)	50%
* Lifetime Maximum (per patient)	$1,000

Delta Dental's *Oral Health Enhancement Option* enables you to receive up to four dental cleanings and/or periodontal maintenance procedures in any combination per benefit period if you have been treated for periodontal (gum) disease in the past. For the additional dental cleaning and/or periodontal maintenance procedures to be covered, you must have had periodontal surgery or periodontal scaling and planing in the past. Details on how to qualify can be found in your benefit booklet.

Over 301,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. **Maximum benefit may be derived by utilizing the services of a participating dentist.**

Where the eligible patient is treated by a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier® dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee.

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call **1-800-DELTA-OK** and a list of participating dentists located in your area will be mailed directly to your home, or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Member ID number.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

2021

FDP
Flagship Dental Plans

1-800-722-3524 New Jersey
1-800-848-3524 Out of State

Plan NJ6

PRIMARY SERVICES

PRIMARY SERVICES are covered if necessary and performed by your attending Plan Dentist subject to the Limitations, Exclusions and Governing Administrative Policies of the Program.

PROCEDURE CODES		ENROLLEE PAYS
DIAGNOSTIC		
D0120	Periodic oral evaluation est. patient	No Cost
D0140	Limited oral evaluation	No Cost
D0145	Oral evaluation for a pat. Under 3yrs of	No Cost
D0150	Comprehensive oral evaluation	No Cost
D0160	Detailed and extensive oral exam	No Cost
D0170	Re-eval., limited (est. patient)	No Cost
D0180	Comprehensive periodontal evaluation	No Cost
D0210	Intraoral radiographs	No Cost
D0220/0230	Intraoral periapical film-each add. film	No Cost
D0240	Intraoral occlusal film	No Cost
D0260	Extraoral -each additional film	No Cost
D0270/0272	Bitewing single/two films	No Cost
D0273/0274	Bitewings-three/four films	No Cost
D0330	Panoramic film	No Cost
D0415	Bacteriologic studies	No Cost
D0460/0470	Pulp Vitality Tests/Diagnostic casts	No Cost
	Initial exam by Specialist	$ 25.00
PREVENTIVE		
D1110/1120	Prophylaxis-adult/child –two treatments per any 12 month period	No Cost
D1208	Topical application of fluoride	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant – per tooth	$ 20.00
D1510/1515/75	Space maintainer-fixed uni./bilateral	No Cost
D1520/1525	Space maintainer-remov. uni./bialateral	No Cost
D1550/1555	Recementation/Removal of space maint.	No Cost
RESTORATIVE (FILLINGS) **Includes indirect pulp capping, bases, liners and acid Etch procedures**		
Silver (Amalgam) Restorations- Primary/Permanent Teeth:		
D2140	Amalgam-one surface prim./perm.	No Cost
D2150	Amalgam-two surfaces prim./perm.	No Cost
D2160	Amalgam-three surfaces prim./perm.	No Cost
D2161	Amalgam-four or more prim./perm.	No Cost
Resin (White) Restoration, Anterior/Posterior Teeth:		
D2330	Resin, one surface, anterior	No Cost
D2331	Resin, two surfaces, anterior	No Cost
D2332	Resin, three surfaces, anterior	No Cost
D2335	Resin, involving incisal angle anterior	No Cost
D2390	Resin based composite crown, anterior	$ 75.00
D2391	Resin based composite one surf. post.	$ 20.00
D2392	Resin based composite two surf. post.	$ 25.00
D2393	Resin based composite three surf. post.	$ 35.00
D2394	Resin based composite four + surf. post	$ 50.00
D2542/43/44	Onlay-metallic-two/three/four + surf.	$270.00

Crowns:

Limitations may apply, refer to your Benefit Plan Summary booklet.

D2710/12	Resin / ¾ Resin (indirect)	$100.00/$270.00
D2720	Resin with high noble metal*	$290.00
D2721	Resin with predominately base metal	$290.00
D2722	Resin with noble metal*	$290.00
D2740	Porcelain/ceramic substrate*	$290.00
D2750	Porcelain fused to high noble metal*	$290.00
D2751	Porcelain fused to predom. base metal	$290.00
D2752	Porcelain fused to noble metal*	$290.00
D2780/81/82	¾ cast high noble/base./noble metal*	$270.00
D2783	¾ porcelain / ceramic	$270.00
D2790	Full cast high noble metal*	$290.00
D2791	Full cast predominately base metal	$290.00
D2792	Full cast noble metal*	$290.00
D2910/15/20/21	Recement inlay/post & core/crown/reat	No Cost
D2930/31	Prefab. stainless steel (prim/perm)	$ 75.00
D2932	Prefabricated resin	$100.00
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention-per tooth, + restoration	$ 25.00
D2952/53	Cast post and core + crown/+ add. post	$175.00
D2954	Prefabricated post and core + crown	$225.00
D2957	Each additional prefabricated post	$175.00

ENDODONTICS		
D3110/3120	Pulp capping (direct/indirect)	No Cost
D3220/3221	Therapeutic pulpotomy/Pulpal debrib.	No Cost
D3230/40	Pulpal therapy (anterior/posterior)	No Cost
D3310	Anterior root canal	No Cost
D3320	Bicuspid root canal	No Cost
D3330	Molar root canal	No Cost
D3346	Retreatment previous root canal (ant.)	No Cost
D3347	Retreatment previous root canal (post.)	No Cost
D3348	Retreatment previous root canal (molar)	No Cost
D3410	Apicoectomy-anterior	No Cost
D3421/25/26/27	Apico.-bicuspid/molar/ and each add. rt.	No Cost
D3430	Retrograde filling – per root	No Cost
D3450	Root Amputation – per root	No Cost
D3920	Hemisection (include root removal)	No Cost

SPECIALTY SERVICES--Are covered if necessary by a Plan Dental Specialist with a referral from your primary care dentist. Services are subject to the Limitations, Exclusions and Governing Administrative Policies of the Program

PERIODONTICS		
D4210	Gingivectomy or Gingivoplasty, Qd.	No Cost
D4211	Gingivectomy or gingivoplasty, per tooth (if fewer than four teeth)	No Cost
D4230/4231	Anatomical crown ex. 4+/1-3 per qd.	No Cost
D4240	Gingival flap procedures Qd.	No Cost
D4241	Gingival flap proc. including root plan.	No Cost
D4249	Clinical crown length.-hard tissue	No Cost
D4260	Osseous surgery Qd. (Incl. flap entry	No Cost

D4261	Osseous surgery 1 to 3 teeth per Qd.	No Cost
D4263	Bone replacement graft (first site in Qd.	No Cost
D4264	Bone replacement graft (each add. site)	No Cost
D4270	Pedicle soft tissue graft procedure	No Cost
D4271/73	Free soft tissue graft(include.donor site)	No Cost
D4341	Periodontal root planing 4 more Qd.	No Cost
D4342	Periodontal root planing, 1-3 teeth Qd.	No Cost
D4355	Full mouth debridement to enable com.	No Cost
D4910	Periodontal maintenance	No Cost

PROSTHETICS (Removable and Fixed bridges & dentures)

D5110	Complete upper denture	$300.00
D5120	Complete lower denture	$300.00
D5211/12	Partial resin denture, upper/lower	$320.00
D5213	Partial denture, upper	$340.00
D5214	Partial denture, lower	$340.00
D5281	Removable partial denture	$300.00
D5410/5411	Denture Adjustments-max./mand.	No Cost
D5421/5422	Partial Adjustments-max./mand.	No Cost
D5511/5512	Repair broken complete dent max/mand	$ 50.00
D5520	Replace missing/broken teeth(per tooth)	$ 60.00
D5611/12/21/22	Repair resin/cast framework part. dent.	$ 60.00
D5630	Repair / replace broken clasp	$ 60.00
D5640	Replace broken teeth per tooth	$ 60.00
D5650	Add tooth to existing. partial	$ 70.00
D5660	Add clasp to existing partial	$ 70.00
D5670/71	Replace all teeth&acrylic (max./mand.)	$225.00
D5730/5731	Reline full dent. max./mand. (chairside)	$ 75.00
D5740/41	Reline max/mand. part. dent.(chairside)	$ 75.00
D5750/5751	Reline full max./mand. denture (lab.)	$110.00
D5760/61	Reline max./mand. partial dent. (lab.)	$110.00
D6210	Pontic cast high noble metal*	$290.00
D6211	Pontic cast predominantly base metal	$290.00
D6212	Pontic cast noble metal*	$290.00
D6240	Pontic porcelain fused to high noble*	$290.00
D6241	Pontic porcelain fused to base metal	$290.00
D6242	Pontic porcelain fused to noble metal*	$290.00
D6245	Pontic porcelain / ceramic	$200.00
D6250	Pontic resin w/high noble metal*	$290.00
D6251	Pontic resin w/predom. base metal	$290.00
D6252	Pontic resin with noble metal*	$290.00
D6545	Retainer cast metal for resin bond fix	$290.00
D6610	Onlay cast high noble metal, two surf.*	$270.00
D6611	Onlay cast high noble metal, 3+ surf *	$270.00
D6612	Onlay cast predominately base metal 2	$270.00
D6613	Onlay cast pred. base metal 3+ surf.	$270.00
D6614	Onlay cast noble metal, two surfaces	$270.00
D6615	Onlay cast noble metal, three + surf.	$270.00
D6710	Crown indirect resin based composite	$100.00
D6720/21/22	Crown resin w/high noble/base/noble*	$290.00
D6740	Crown porcelain / ceramic	$290.00
D6750	Crown porcelain fused to high noble*	$290.00
D6751	Crown porcelain fused to base metal	$290.00
D6752	Crown porcelain fused to noble metal*	$290.00
D6780	Crown ¾ cast high noble metal*	$270.00
D6781	Crown-¾ cast pred. base metal	$270.00
D6782	Crown-¾ cast noble metal*	$270.00
D6790	Crown full cast high noble metal*	$290.00
D6791	Crown full cast predominantly base	$290.00
D6792	Crown full cast noble metal*	$290.00
D6930	Recement bridge	No Cost
D6970	Post and core+ fixed part. denture, ind.	$225.00
D6972	Prefabricated post and core +fixed part.	$225.00
D6973	Core build up for retainer,+ any pins	No Cost
D6976/77	Each add.cast/add. prefab.post same tth	$175.00

*Note: Base metal is the benefit. Noble and High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast post and cores, inlays and onlays. Porcelain on molars is considered optional treatment.

ORAL SURGERY

D7111	Coronal remnants-deciduous teeth	No Cost
D7140	Ext. erupted tooth or exposed root	No Cost
D7210	Ext erupted tooth req. removal of	No Cost
D7220	Removal of impacted tooth/soft tissue	No Cost
D7230	Removal of impacted tooth/par. bony	No Cost
D7240/41	Removal of impacted tooth/com. bony	No Cost
D7250	Surgical removal of residual roots	No Cost
D7260	Oroantral fistula closure	No Cost
D7280/83	Surg. exp.of unerupt tth/dev. aid erupt.	No Cost
D7285/86	Biopsy of oral tissue (hard/ soft)	No Cost
D7310/11/20/21	Alveoloplasty in conj.w/wo extraction	No Cost
D7340/50	Vestibuloplasty-sec. Epit/Soft tissue grf	No Cost
D7410	Excision of benign lesion (up 1.25 cm)	No Cost
D7411	Excision of benign lesion (+1.25 cm)	No Cost
D7440/41	Excision of mal. up to 1.25/+1.25 cm	No Cost
D7450	Removal of cyst or tumor (up 1.25 cm)	No Cost
D7451	Removal of cyst or tumor (+1.25 cm)	No Cost
D7460	Removal of cyst/tumor nonodon.(↑1.25)	No Cost
D7461	Removal of cyst/tumor nonodon.(+1.25)	No Cost
D7465	Destruction of lesions (s), by report	No Cost
D7471	Removal of lateral exost. (maxi./mand.)	No Cost
D7472/73	Removal of torus palantinus/mandibula	No Cost
D7485	Surgical reduction of mand. oss. Tuber.	No Cost
D7510/11	Incision & drainage of abscess intraoral	No Cost
D7520/21	Incision & drainage of abscess extraoral	No Cost
D7530/40	Removal of foreign/reaction bodies	No Cost
D7550	Removal of non-vital bone (part.ostect)	No Cost
D7960	Frenulectomy, frenectomy or frenotomy	No Cost
D7963	Frenuloplasty	No Cost
D7970	Excision of hyperplastic tissue-per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

ORTHODONTICS

Includes initial exam, diagnosis, consultation, initial banding, 24 months of active comprehensive treatment and retention phase of treatment of up to 24 months. This includes construction, placement and adjustment to retainers and office visits for a maximum of 24 months.

Full orthodontic case depending on group contract.

ADJUNCTIVE SERVICES

D9110	Palliative (emergency) treatment (pain)	No Cost
D9210	Local anesthesia not in conj.w/oper./surg.	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9222/23	Deep sedation/general anes1st 15/15min.	No Cost
D9239/43	Intravenous moderate sedation 1st 15/15	No Cost
D9310	Consultation	No Cost
D9430	Office visit observation (regular hours)	No Cost
D9440	Office visit after regular hours	No Cost
D9450	Case presentation, detailed & exten. trea.	No Cost
D0125	Failed appt. without 24 hours	$10.00 per 15 min.

OUT - OF - AREA EMERGENCY CARE

DeltaCare will reimburse the enrollee for actual charges less any applicable copayment, up to $100.00 per enrollee when receiving emergency care while temporarily more than 35 miles from the attending primary care dental office.

Services that are more expensive than the treatment usually provided under accepted dental practice standards are considered optional treatment. The patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional or more expensive treatment plus any applicable copayment.

All services are subject to the limitations and exclusions outlined in your Dental Benefit Plan summary booklet.

FDP

Flagship Dental Plans

FLAGSHIP DENTAL PLANS – A WHOLLY OWNED SUBSIDIARY OF DELTA DENTAL OF NEW JERSEY, INC.

The following is important information about how to use this dental plan

DENTAL CARE - SIMPLIFIED

In this age of rising health care costs, Flagship Dental Plans offers the **DeltaCare®** program - an economical and convenient way to obtain dental care for you and your family. Flagship was founded on the principle of delivering quality dental care and preventing dental problems before they start.

Flagship has contracted with a network of private dental offices, a listing of which is enclosed. This network of dental offices is composed of established dental practices, which meet or exceed nationally recognized standards of care. When you enroll in the DeltaCare program, you select one office from any of these dental offices for you and your family's needs.. Your primary dentist also coordinates referrals to specialists when necessary.

DELTACARE® MEANS

No Claim Forms

The dental location you choose provides all primary dental services. There are no claim forms to complete.

No Deductibles

In the DeltaCare program there are no required deductibles to pay so your benefits begin immediately.

No Dollar Limit of Dental Benefits

No annual maximum.

No Pre-Existing Conditions Restrictions

These conditions are not excluded in a DeltaCare program, except for dental treatment started before coverage begins.

Prepaid Plan Saves on Dental Costs

Your out-of-pocket savings are substantial. You know the cost prior to treatment, and this aids in better financial planning for you and your family.

Quality Review of Dental Providers

On-site audit of participating dental locations confirms that established standards of quality are maintained.

Specialty Services

The DeltaCare program offers services in dental specialty areas. These include periodontics (treatment of diseased gums and bone), endodontics (root canal therapy), oral surgery procedures, and orthodontics

Emergency Services

You are also covered for out-of-area dental emergencies. This program will pay dental expenses incurred up to a maximum of $100.00. "Out-Of-Area" means 35 miles or more from your Flagship participating dentist's office

Dedicated Customer Service

Flagship Customer Service Representatives are available to DeltaCare enrollees ***only.*** This focus, along with prior dental practice experience, makes our reps second to none in the industry.

HOW IT WORKS…

1. If you meet your employer's eligibility requirement, you can enroll in DeltaCare. You can also enroll your eligible dependents, which include your lawful spouse and unmarried children, including step-children, legally adopted and foster children to the limiting age as specified by your employer.

2. When you enroll in DeltaCare, select a panel dental office from the list attached to this brochure. This location is now the center for all of your dental needs.

3. We ask you to select 3 panel dentists from 3 different offices. Your first choice takes priority. If for some reason that dentist is not available, we will automatically choose your second and/or third choice dentist and you will be notified of this change.

4. After you have enrolled, you will receive an Evidence of Coverage booklet that fully describes the benefits of your dental plan. To receive all necessary dental care covered by the plan, simply call your selected panel dentist to make an appointment.

5. Remember to always contact your selected panel dentist. ***Dental services which are not performed by your panel dentist or not authorized by Flagship will not be covered by the DeltaCare program***.

SUMMARY OF BENEFITS

The DeltaCare program provides coverage for dental services listed on the Schedule of Services and Patient Copayments as long as care is rendered by your primary care dentist or you are referred to a participating dental specialist. The following section illustrates the exclusions and limitations under the DeltaCare program. It does not constitute a contract. Coverage can only commence with execution of a group contract issue by Flagship Dental Plans.

A. The following are specifically excluded as services or benefits to be provided or covered by the Flagship Group Contract:

General Exclusions

1. Dental procedures performed for cosmetic purposes;
2. Dental conditions arising out of and due to Covered Person's employment for which Worker's Compensation is payable. Services, which are provided to the Covered Person by state government or agency thereof, or are provided without cost to the Covered Person by any municipality, county or other subdivision;
3. Treatment required by reason of war, declared or undeclared;
4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities;
6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to Covered Person's eligibility with the FLAGSHIP program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
7. Any service that is not specifically listed as a covered expense;
8. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function;
9. Prescription drugs;
10. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
11. Cases in which, in the professional judgment of the attending Plan Dentist or Plan Dental Specialist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
12. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by FLAGSHIP or needed emergency treatment, defined as the immediate relief of pain, swelling, or infection;
13. "Consultations" for noncovered benefits;
14. Soft tissue management (irrigation, infusion, special toothbrush);
15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ);

Restorative Treatment Exclusions

16. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
17. Restorative work caused by orthodontic treatment;

Oral Surgery Treatment Exclusions

18. Nitrous oxide and the services of a special anesthesiologist;
19. Cysts and malignancies;
20. Prophylactic removal of impactions (asymptomatic, nonpathological);
21. Extractions for the purpose of orthodontics;

Crowns, Fixed and Removable Prosthetic Treatment Exclusions

22. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
23. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
24. Extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework (major mouth reconstruction);
25. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
26. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
27. Implant placement, or implant removal associated with other procedures, including but not limited to prophylaxis and periodontal treatment;

B. The benefits, as previously outlined, are subject to the following limitations (all time limitations apply without regard to whether the earlier service(s) was covered under this or any other coverage contract):

General Limitations

1. Coverage is limited to the benefit customarily provided. In all cases in which the Covered Person selects a more expensive course of treatment or the selected treatment includes the use of specialized techniques instead of standard procedures, the Covered Person must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional or more expensive treatment plus any applicable copayment;
2. If a Covered Person is more than 35 miles from the office of the assigned Plan Dentist, and requires services for a "dental emergency", FLAGSHIP shall reimburse the Covered Person for the cost of such treatment, less any applicable copayment's, up to a maximum of $100.00 during any 12-month period upon submission to FLAGSHIP of a verifiable claim within 90 days after such treatment is received. A "dental emergency" is immediate treatment necessary to alleviate severe pain, swelling, bleeding or infection, or immediately necessary to avoid placing the Covered Person's health in serious jeopardy. The Covered Person must visit his Plan Dentist for further treatment. FLAGSHIP is not liable for actions resulting from the negligence, malpractice or other tortious or wrongful acts arising out of treatment provided by a non-Plan Dentist or non-Plan Specialist;
3. FLAGSHIP is not liable for specialty dental service claims submitted more than twelve months after the date of completion of the dental service;

Preventive and Diagnostic Limitations

4. Bitewing x-rays are limited to not more than one series of four films in any six-month period;
5. Full mouth x-rays and panoramic x-rays are limited to one set every thirty-six consecutive months;
6. Oral examinations are limited to two each twelve month period;
7. Prophylaxis is limited to two treatments each twelve month period (includes periodontal maintenance following active therapy);
8. Topical application of fluoride is limited to one application each twelve-month period for Dependent children up to age nineteen (19);
9. Sealant benefits include the application of sealants only to the occlusal surface of permanent molars for Covered Persons through age 15. The teeth must be free from caries or restorations on the occlusal surface. Sealant benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same Panel Dentist who placed the sealant;
10. Fixed and removable space maintainers are limited to one placement per tooth;

Restorative Treatment Limitations

11. Amalgam and resin restorations are limited to one treatment per tooth surface within ninety consecutive days;
12. Inlays and onlays are limited to one per tooth during any five consecutive years:

Endodontic Treatment Limitations

13. Root canal therapy, including all necessary post-operative care, is limited to one treatment per tooth;

Periodontal Treatment Limitations

14. Periodontal treatments are limited to four quadrants during any twenty-four consecutive months;
15. Gingivectomy or gingivoplasty, periodontal scaling and root planing are limited to one treatment per quadrant during any twenty-four consecutive months and osseous surgery is limited to one treatment per quadrant during any thirty-six consecutive months;
16. Full mouth debridement (gross scale) is limited to one treatment in any twenty-four consecutive month period;
17. Bone replacement grafts, pedicle soft tissue grafts and free soft tissue grafts are limited to one treatment per tooth in three consecutive years;

Crown, Fixed and Removable Prosthetic Limitations

18. Crown(s) and bridges are not to be replaced within any five-year period from initial placement;
19. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling (for example; the buccal or lingual walls are fractured to the extent that they do not hold a filling). If the tooth can be restored with a filling, any other restoration (crown or jacket) is considered optional and if performed, the Covered Person is responsible for the additional cost;
20. Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under twelve (12) years of age. An allowance will be made for an acrylic crown. If performed, the Covered Person must pay the additional fee;
21. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one per arch each in any five year period from initial placement;
22. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where repair, or the addition or replacement of teeth to the existing partial is not feasible;
23. If the Covered Person is missing teeth on opposite sides of the same arch, a removable partial denture is considered an adequate replacement. If the Covered Person elects another course of treatment, he/she must pay the additional cost;
24. Precious meal for removable appliances, precision abutments for partials or bridges (overlays, implants and appliances associated therewith), personalization and characterization, are all considered optional treatment. The Covered Person is responsible for the additional fee;
25. Denture relines and repairs are limited to one per denture during any twelve consecutive months;
26. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;

27. A fixed bridge is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement;
28. Fixed bridges are not a benefit for Covered Persons under the age of sixteen (16). If fixed bridges are used under these circumstances, it is considered optional and an allowance will be made for a space maintainer. The Covered Person would be responsible for the additional fee;
29. Fixed bridges used to replace missing teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Covered Person must pay the difference in cost between the Dentist's usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit;
30. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
31. If implants are utilized and appliances constructed, FLAGSHIP will make payment based on the cost of a standard full or partial denture. FLAGSHIP will not provide payment for the surgical removal of implants or the prosthetic crown on the implant;

ORTHODONTIC EXCLUSIONS AND LIMITATIONS

C. Orthodontic benefits are only provided through FLAGSHIP Plan Orthodontists and are subject to the following exclusions:

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of Covered Person cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely utilized in typical Phase II orthodontics;
9. Active treatment that extends more than 24 months from the point of banding;
10. Restorative work caused by orthodontic treatment;
11. Extractions for the purpose of orthodontics;
12. Treatment in progress at inception of eligibility;
13. Transfer to another orthodontist after banding has been initiated;
14. Composite or ceramic bands and lingual adaptation of orthodontic bands are considered optional treatment and would be responsible for the additional charges.

D. Orthodontic benefits are only provided through FLAGSHIP Plan Orthodontists and are subject to the following limitations:

1. Orthodontic treatment must be provided by a FLAGSHIP Plan orthodontist;
2. Lifetime Plan benefits cover 24 months of active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment.
3. For treatment plans extending beyond 24 months of active treatment, the Covered Person will be subject to a monthly office visit fee;
4. Should an Covered Person's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Covered Person and not FLAGSHIP will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Covered Person's payment shall be based on the provider's filed and submitted fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Covered Person on such terms and conditions as are arranged between the Covered Person and the orthodontist;
5. If treatment is not required or the Covered Person chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the Covered Person will be charged a consultation fee of $25 in addition to diagnostic record fees, not exceed $350.00;
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the Covered Person is responsible for the cost at the dentist's filed and submitted fee;
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Covered Person's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the FLAGSHIP Plan orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances;

DeltaCare QUESTIONS AND ANSWERS

Q. ***How do I Enroll?***
A. Once you decide to enroll, complete the enrollment form, indicate your dentist of choice from the panel list enclosed, and your employer (name of group). Return this card to your employer as directed by your Human Resources Department.

Q. ***Who is Flagship?***
A. Flagship is a subsidiary of Delta Dental of New Jersey and administers the DeltaCare program. DeltaCare is a dental HMO which offers dental care to its members through a network of private practice dental offices.

Q. ***My dentist is a Delta dentist, but he or she is not on the list. Can I still have treatment rendered by him or her?***
A. **No.** Delta has several other dental programs and not all Delta dentists participate with all Delta programs. **With this program, you MUST select only those dentists on the list. If you use a dentist who is not on the list, you will NOT be covered.**

Q. ***Will my entire family receive dental care from the same DeltaCare provider?***
A. **YES**. You and all eligible dependents will receive benefits in the same provider's office.

Q. How long does it take to get an appointment with a dentist?
A. Three or four weeks is a reasonable amount of time to wait for a standard appointment. If you require a specific time, you may have to wait longer for an appointment.

Q. If I have a pre-existing dental condition, may I join DeltaCare?
A. **YES.** Pre-existing conditions are not excluded under the DeltaCare program. However, benefits will not be provided for any dental ***treatments*** which began prior to becoming eligible under the DeltaCare program. (Work in progress, i.e. preparation for crowns, root canals, impressions for dentures, etc.)

Q. Does DeltaCare program provide coverage for specialty services?
A. **YES**. Flagship maintains a panel of specialists and coordinates all your specialty care needs with your primary care dentist. If specialty care is required, your primary care provider will request authorization from DeltaCare to refer you to the appropriate specialist. **Certain specialty care must be pre-authorized by Flagship**.

Q. Once I have selected a dental provider, may I change my primary care dentist?
A. **YES**. You may change your eligibility from one primary care dentist to another by phoning or writing Flagship by the 15th of the month. The change will be effective on the first day of the following month. However, requests to change dental providers should not be made if a patient is in the middle of treatment. A Flagship Customer Service Representative can advise you on the definition of "middle of treatment."

Q. Whom do I contact if I need assistance?
A. Flagship Customer Service can assist you in all matters pertaining to the DeltaCare program. You may reach a Flagship representative at one of the numbers listed on the back of this brochure. Office hours are 8:00 a.m. to 4:30 p.m., Monday through Friday.

If you have any questions or need additional information call or write:

DELTACARE®

FLAGSHIP DENTAL PLANS
1639 ROUTE 10
PARSIPPANY, NEW JERSEY 07054

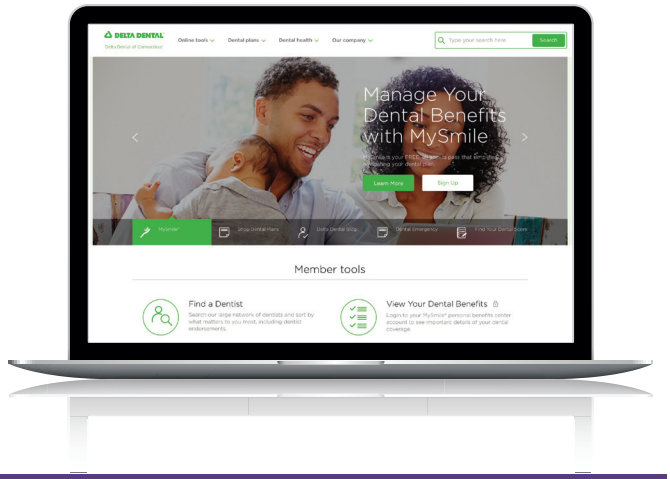
IN NEW JERSEY: 1-800-722-3524
OUT OF AREA: 1-800-848-3524

NOTE: THIS IS ONLY A SUMMARY OF THE PLAN. The dental health plan contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment.

DELTA DENTAL®

Connect with Your Benefits on MySmile®

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



Benefits Information with a Click (or Tap)

Access MySmile from your computer or mobile device to securely:

- View your coverage
- Check your dental claims
- View and print your ID card
- Review your treatment history
- Find a dentist
- Get a cost estimate
- 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!

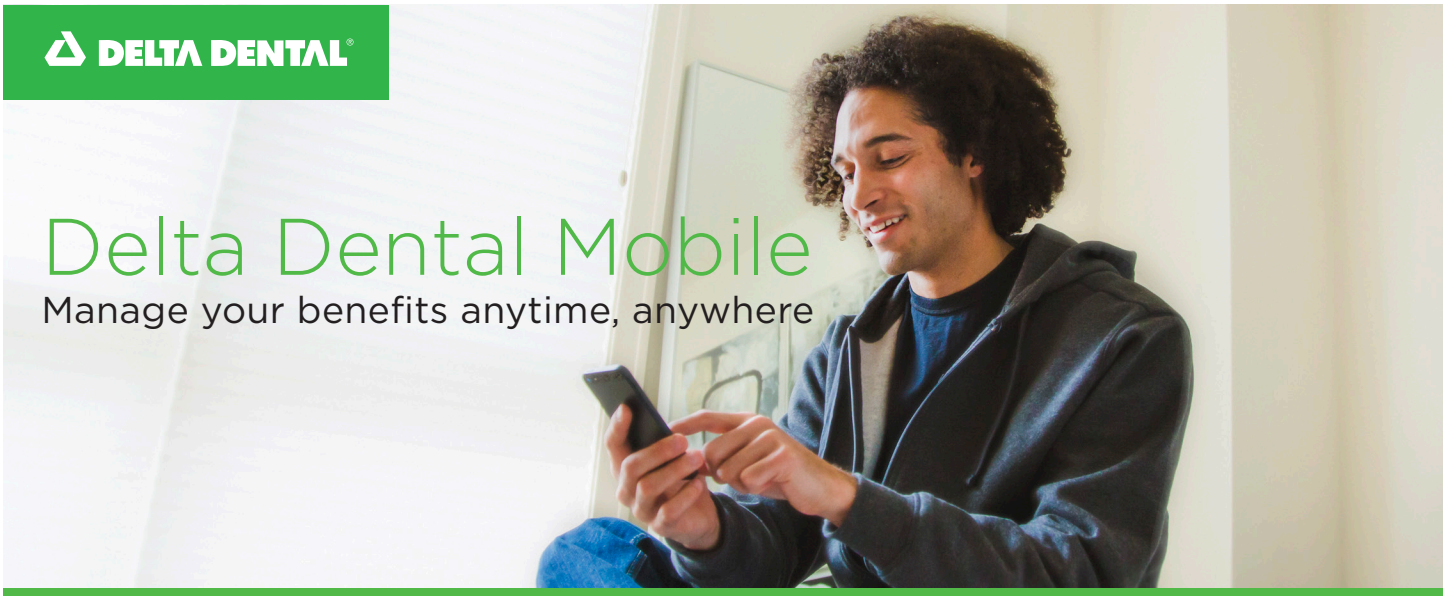
Download on the App Store

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

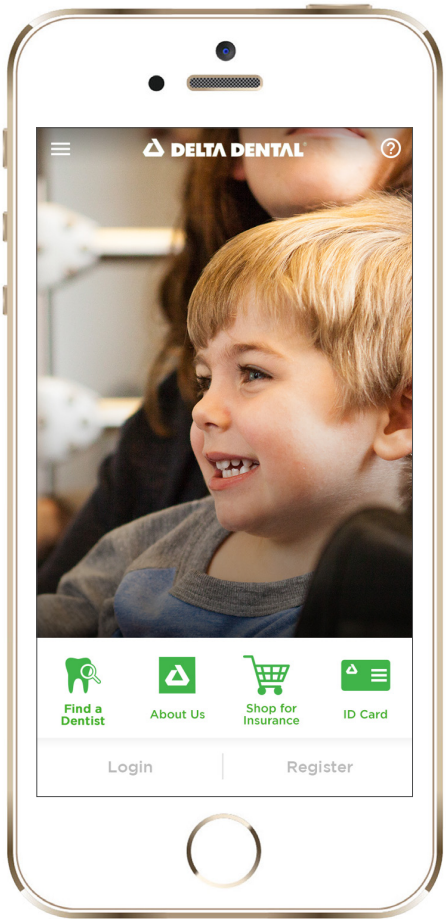
DELTA DENTAL



Delta Dental Mobile

Manage your benefits anytime, anywhere

Your dental health is important to Delta Dental – and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Access dentist search, check claims and coverage, view ID cards and more, right on your mobile device.



Getting Started

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.

SCAN TO DOWNLOAD DELTA DENTAL MOBILE

Using the App Without Logging In

Anyone can use Delta Dental Mobile without logging in to access our Dentist Search, Toothbrush Timer, LifeSmile Score risk assessment and Cost Estimator.

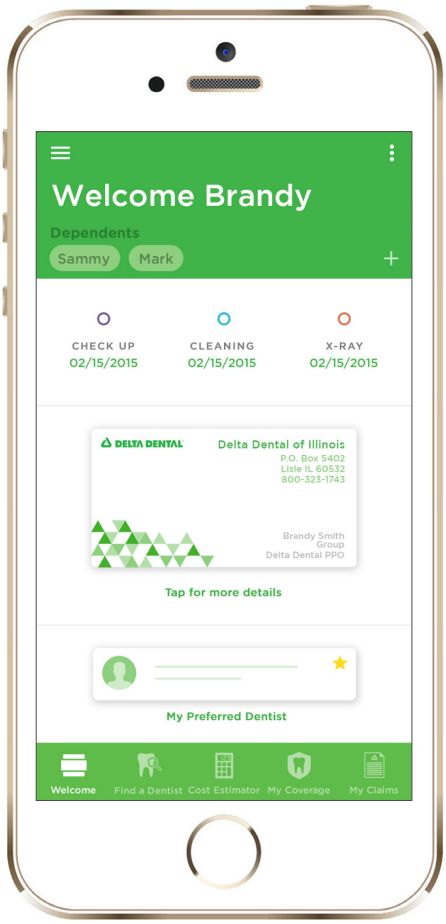
Logging In to View Benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company.

Delta Dental Mobile Features

Log in to access the full range of tools and resources



Mobile ID Card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

My Coverage and My Claims

View information on your plan and coverage details, and check the status of claims for you and your family. Easily add your dependents to your account so you can access the whole family's coverage in one spot.

Find a Dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Schedule Dental Appointments*

View and select open appointment times with participating dentists, making scheduling dental appointments more convenient than ever. (Powered by Brighter Schedule)

Dental Care Cost Estimator*

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.

LifeSmile Score

Do you know how your smile scores? Learn more about your personal oral health risk profile by taking our simple risk assessment survey.

Toothbrush Timer

Help your family keep up with their oral health routine by using this handy tool. Our timer counts down for two minutes while reminding you to brush each tooth.

*Feature not available in all geographic areas and is subject to dentist participation.

Secure Access to Your Benefits

You must log in each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

DELTA DENTAL®

how does dual coverage work?

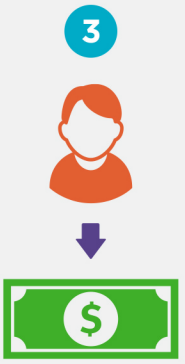
It's not uncommon to have coverage under two dental plans. For example, your children may have dental benefits through your employer and your spouse's employer. Anyone with dental coverage under two separate plans has dual coverage.

How It Works

The way benefits carriers work together when a person has dual coverage is called coordination of benefits or COB. Dual coverage *does not* mean double benefits. For example, if both of your plans cover two cleanings per year, having dual coverage won't provide coverage for four cleanings. Here's how it works:

1. The dentist bills the primary benefits carrier. The primary carrier pays its portion.

2. The remainder of the bill is sent to the secondary benefits carrier. In some cases, the secondary carrier may cover the rest of the bill, reducing your out-of-pocket costs.



3. The remainder (if any) is your responsibility.

! An exception to the rule: Some dental plans have a non-duplication of benefits clause. This rule prevents secondary plan coverage if the primary plan already paid as much or more than the secondary plan would have covered had it been primary. Check your plan information to see if your secondary plan has this rule before using your benefits.

1639 Route 10, Parsippany, NJ 07054 (800) 452-9310 www.deltadentalnj.com

Determining Which Plan Is Primary

The primary plan is the one billed first. The plan billed after the primary carrier has paid its portion is called the secondary plan. Which plan is primary varies by situation.

For yourself: Your primary carrier is typically the coverage you receive through your employer. Additional coverage through a spouse will be secondary.

For yourself, if you have two jobs: If you have dental benefits through both employers, the primary plan is usually the one that has provided coverage the longest.

For your children: The parent whose birthday falls first in the calendar year will have the primary plan. For example, if your birthday is August 9, and your spouse's birthday is July 21, your spouse's plan would be the primary plan. Birth year is not a factor.

For children of divorced parents: Primary benefits are typically through the parent with the most custody but can vary.

When Both Plans Are Delta Dental Plans

Dual coverage still applies if both of the plans are Delta Dental plans. The primary plan is billed first, and the secondary plan is billed next. Below is an example of standard COB. This example assumes your deductible has already been met and you haven't reached your annual maximum.

Procedure: Crown
$1,100

Primary Carrier Pays 50%
$550

Standard COB
Secondary Carrier Pays 50%
$550

If your primary or secondary plan is an HMO-type plan (such as DeltaCare® USA), please contact your carrier for specifics on how dual coverage is handled.

DELTA DENTAL®

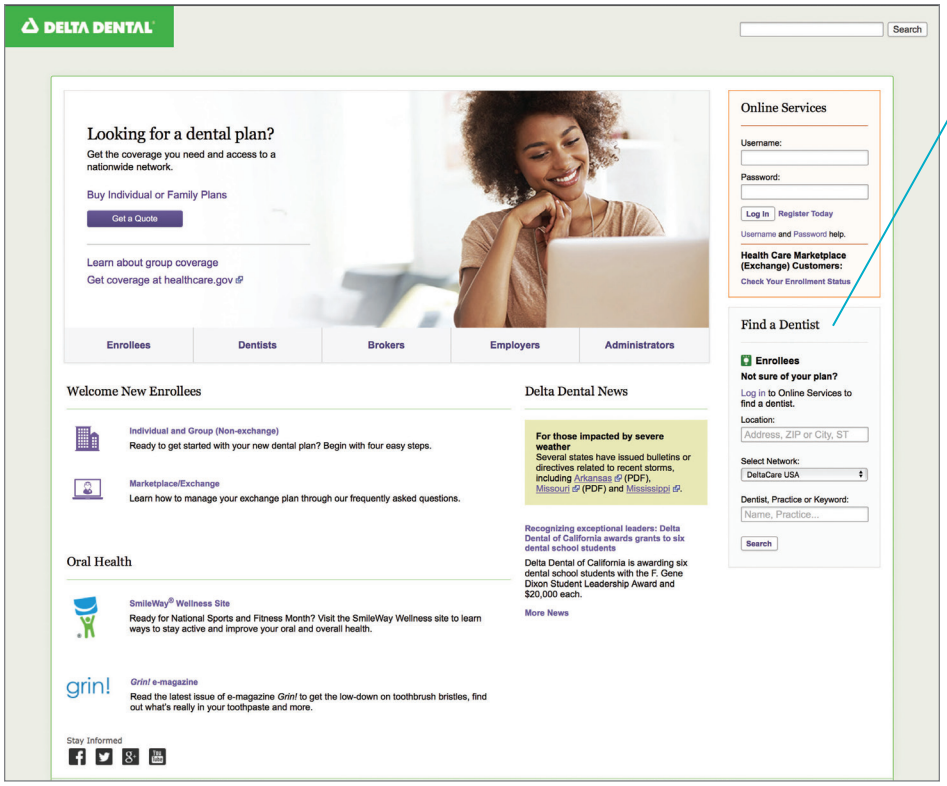
DeltaCare® USA

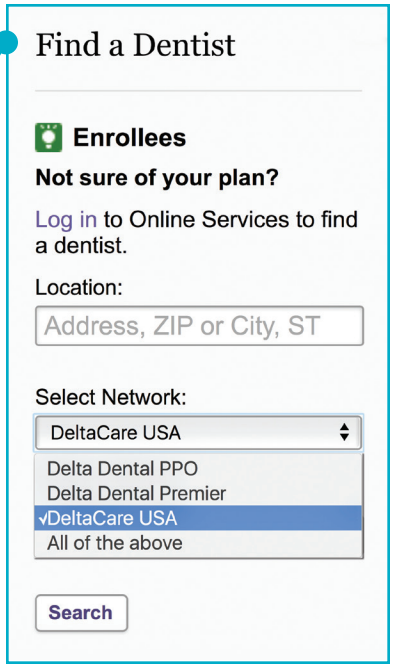
Find a Dentist

Search for a DeltaCare USA dentist in your area

How to search

1. Go to **deltadentalins.com**.
2. Look for the **Find a Dentist** tool on the right. Enter a location (address, ZIP code or city and state).
3. Select **DeltaCare USA** from the drop-down menu. For a more targeted search, you can enter the name of your dentist or dental office below.
4. Click **Search**.





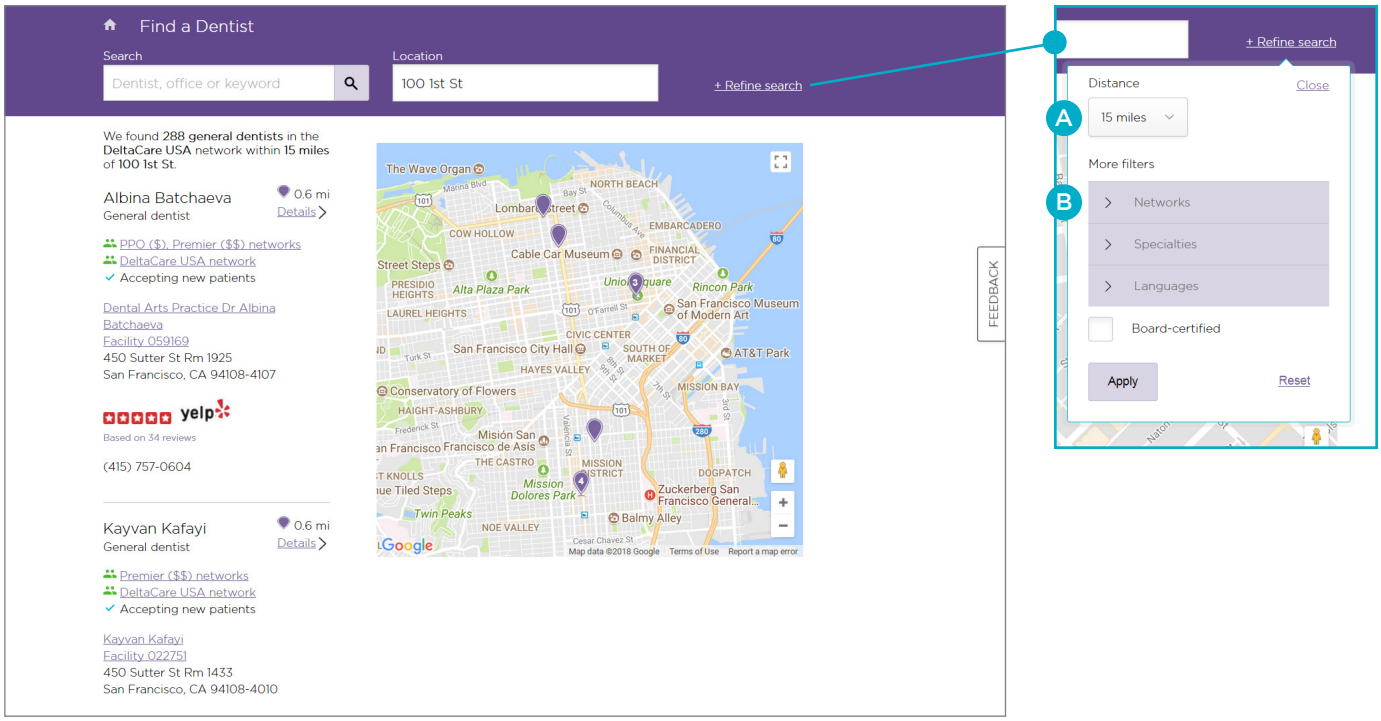
We keep you smiling®

deltadentalins.com/enrollees

How to refine your search results

A **Change the radius of your search.** By default the search will show dentists within 15 miles of a given location, but you can adjust this distance by clicking on “Refine search” and selecting any distance from “5 miles” to “60 miles” from the drop-down menu.

B **Filter your results.** Refine your search results by categories such as specialty and network.



EF59_DCU #111451 (rev. 02/18)

DELTA DENTAL

Save some green on your pearly whites

Everyone wants to save money while still receiving good service. With the Delta Dental PPO℠ network, you'll get great dental care at lower prices. Here's how the PPO network saves you money:

In-network dentists have agreed to pre-established fees for services. On average, patients save 31.5 percent on the fee typically submitted for a claim. Delta Dental PPO℠ dentists' rates are usually the best value, often better than other network rates.

Delta Dental PPO network dentists won't "balance bill" patients. That means they can't charge you the difference between their usual fee and the amount they've agreed to charge patients covered by Delta Dental.

Delta Dental PPO Network Dentists

Here's an example:

Let's say a procedure costs $1,200, but Delta Dental PPO network dentists have agreed to charge a pre-established fee.

$850

Your Delta Dental plan covers 50 percent of the cost.

$425

Assuming you already met your deductible for the year, you pay the other half of the bill.

$425

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Out-of-Network Dentists

Here's an example:

If you visit an out-of-network dentist, they can bill you the full $1,200. Delta Dental sets a limit to the amount accepted for a procedure, which is known as a maximum allowed fee.

$1,100

Delta Dental covers half of the maximum allowed fee.

$550

You pick up your half plus the $100 that is "balance-billed" by the out-of-network dentist. Because this is an out-of-network dentist, you can be billed the difference between the maximum allowed fee and the actual cost.

$650

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
Delta Dental PPO Network	$1,200	$850	50%	$425	$0	$425	$350
Out-of-Network	$1,200	$1,100	50%	$550	$100	$650	$0

As you can see, it pays to use Delta Dental network dentists – especially those in Delta Dental's PPO network. Visit deltadental.com today to find participating dentists in your area. **You can also download the free Delta Dental mobile app using an Apple or Android device to find dentists.**

A Look at Your VSP Vision Coverage

With VSP and Centenary University, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

Centenary University and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Signature

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME[+]	• $150 featured frame brands allowance • $130 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 24 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 24 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 24 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** 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.		
	Routine 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 GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

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

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP 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. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Browse with Benefits

Your vision and wellness come first with VSP. Now, your benefit includes eyeconic.com, the VSP preferred online retailer.

Eyeconic® seamlessly connects your eyewear, your insurance coverage, and the VSP® doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.

vsp vision care | eyeconic a vsp vision company

Online shopping with benefits

Online shoppers will love:

- A huge selection of contact lenses and designer frames 24/7—and the Virtual Try-On tool.
- Free shipping and returns.*
- Free frame adjustment or contact lens consultation.
- Verification of your prescriptions and the 25-point inspection process to ensure your eyewear is just right.

It's easy to use your VSP benefit

1. **Create an account at vsp.com**. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.
2. **Find superior eye care near you**. The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit **vsp.com** or call **800.877.7195** to find the best provider for you.
3. **Check out Eyeconic and browse the frame brands you love**. You can connect to your VSP benefits, upload your prescription at checkout, and order your glasses following your WellVision Exam®.

Already used your benefits for the year?

As a VSP member, you still receive 20% savings on glasses and sunglasses at Eyeconic.

Experience eyeconic.com®, a convenient retail option.

*Terms and conditions apply. Visit **eyeconic.com/faqs** for more details.

Premier Edge Promise

With thousands of locations, getting the most out of your benefits is easy with VSP Premier Edge™—including private practice doctors and Visionworks® retail locations nationwide. And, VSP® members are backed by the Premier Edge Promise, a worry-free eyewear guarantee. When you go to a Premier Edge location, you're protected from the unexpected—whether it's accidentally broken or damaged glasses, your prescription changes, or you don't love the glasses you chose.

What's Included

Broken or Damaged Glasses: If you purchase a Featured Frame Brand frame from a Premier Edge location and the frame is accidentally broken or damaged within the first 12 months of purchase, VSP will replace it at no cost.*

Prescription Change: If you experience a change in prescription, you can come back to your Premier Edge provider, and we'll cover an additional WellVision Exam® within 12 months of your original exam. If a prescription change is found, we'll also replace the lenses.*

Love Your Look: We guarantee you will love your Featured Frame Brand selection, if not, you can return them to your Premier Edge provider for a replacement pair within 100 days.*

Get more with Premier Edge

Free eyewear protection for your glasses when you purchase a Featured Frame Brand from a Premier Edge location.

Featured Frame Brands

Altair® • Anne Klein • bebe • Calvin Klein • Calvin Klein Jeans • Cole Haan • Columbia • Converse • Cutler and Gross • DKNY • Donna Karan • Dragon® • Draper James • Ferragamo • Flexon® • Genesis™ JOE Joseph Abboud • Joseph Abboud • Kilter® • Lacoste • Lanvin • Lenton & Rusby® • Longchamp • Marchon NYC™ • McAllister • MCM • Nautica • Nike • Nine West • Otis & Piper™ • Paul Smith • Pure® • Shinola • Skaga® • Spyder® • Sunlites™ • Victoria Beckham • ZEISS

Visit vsp.com/offers to learn more.

*A $40 processing fee may apply. The Premier Edge Promise is not an insurance plan. The program provides additional warranty protection for accidental breakage, unexpected prescription change and frame style change only on VSP covered services and cannot be used to replace lost or stolen glasses. Lens and frame replacement is based on the professional judgment of the VSP network doctor. To qualify for the Premier Edge Promise you must purchase an eligible featured frame from a practice location participating in Premier Edge. The Premier Edge Promise is available for one year from the original date of purchase of an eligible featured frame brand for breakage, one additional WellVision Exam with replacement lenses, if needed, one year from the original exam date of service for prescription changes and one style change 100 days from the date of purchase for a frame style change. For breakage, if the original frame is not available, another featured frame brand of similar style and cost may be used. Check with your doctor's office on which brands and styles are currently available. Additional lens enhancements not on the original order may be added at special eyewear guarantee pricing. VSP reserves the right to change or cancel this program at any time without notice. Premier Edge is intended to help VSP members maximize their vision care benefits and its banner is not meant as a designation of care quality as all of our doctors meet high-quality standards of VSP for professional services. The doctor's information, participation in Premier Edge and featured frame brands are subject to change.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Savings Never Looked So Good

Get access to more than $3,000 in savings from VSP and other popular brands for your eye care and overall wellness needs.

Frames shown are by Lenton & Rusby®.

Discover Exclusive Member Extras

vsp exclusive member extras

Eyewear and eye care Special Offers are available at all VSP® network doctor locations! This interactive flier allows you to click on any offer shown below and find out more details.

GLASSES AND SUNGLASSES

Extra **$20** to Spend

Get more value with an **Extra $20** to spend on Featured Frame Brands like bebe, Calvin Klein, Cole Haan, Dragon®, Flexon®, Lacoste, Nike, and more.[1,2]

Extra **$40** to Spend

Get an **Extra $40** to spend on select Featured Frame Brands.[1,3]

Up to **40% Off** Lens Enhancements

Upgrade your lenses and save up to 40% off lens enhancements such as anti-glare coatings and light-reactive lenses.[2,3]

eyeconic a vsp vision company

Savings on Eyeconic® when you shop online for glasses, sunglasses, and contacts with your VSP benefits.

HOYA

Get 6-month satisfaction guaranteed protection with Hoya lenses.

Save 20% on additional pairs of Nike glasses and sunglasses.

sunsync

Save up to 40% on SunSync® Light-Reactive Lenses.[2,3]

techshield

Save up to 40% on all TechShield® Anti-Reflective Coatings.[2,3]

unity

Try Unity® single vision or progressive lenses risk-free with The Unity Promise for six months.

ZEISS

Try ZEISS Lenses risk-free for six months.

vsp PREMIER PROGRAM Premier Offers

Maximize your savings with Premier Offers only available at Premier Program locations.

Eyewear Protection — Get a one year worry-free warranty on Featured Frame Brands.

BAUSCH + LOMB See better. Live better. — Save up to $310 on an annual supply of contact lenses.

Glasses Rebate — Get up to a $100 rebate on the perfect pair of glasses.[4]

HOYA — Try Hoya lenses worry-free for six months.

unity — Try Unity® lenses risk-free with The Unity Promise for 12 months.

ZEISS — Try ZEISS Lenses risk-free for 12 months.

Improve Your Health and Increase Your Savings

vsp exclusive member extras

CONTACTS

BAUSCH + LOMB
See better. Live better.

Receive savings of up to $300 in rebates and rewards when you purchase an annual supply of Bausch + Lomb contact lenses from your VSP network doctor.

HEARING HEALTH

TruHearing®

Save up to 60% on top-of-the-line hearing aids, get 120 batteries shipped to your door for only $39, and access a free online hearing screening.[5]

LASIK

LasikPlus

Save up to $1,000 off LASIK.[6]

The LASIK Vision INSTITUTE

Save up to $1,000 off LASIK.[6]

NVISION EYE CENTERS

Get up to $1,000+ off all custom LASIK and PRK.[6]

TLC Laser Eye Centers®

Get up to $1,000 off LASIK at TLC.[6]

HEALTH & WELLNESS

Support for Diabetes Management

Find resources to help prevent or delay Type 2 Diabetes like lifestyle coaching, diabetes educational materials, and more.

LEISURE & LIFESTYLE

vsp simple values

Receive free access to a variety of everyday savings like family entertainment, health and wellness, cash rewards, travel, and more.[7]

HEALTH & FINANCIAL WELL-BEING

CareCredit™

Get instant, in-office application for promotional financing available on eye care and eyewear.

everplans™

Get your home and life organized with a smart digital vault built to securely store your important documents and information for just $27 a year.

View all Exclusive Member Extras at vsp.com/offers.

Offers subject to change without notice. Some members may not be eligible for all offers. Visit **vsp.com/offers** for terms and conditions on specific offers.

1. Brands and promotions are subject to change. **2.** Available to VSP members with applicable plan benefits. **3.** Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. **4.** Perfect Pair up to $100 rebate expires 11/30/2022, rebate offer terms and conditions apply and are subject to change. Rebate offer valid from 7/1/2022 through 11/30/2022, and must be redeemed by 12/31/2022. The Sponsor/Offeror of this rebate is Plexus Optix, Inc. **5.** VSP is providing information to its members but does not offer or provide any discount hearing program. VSP makes no endorsement, representations, or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information please visit **https://www.vsp.com/offers/special-offers/hearing-aids/truhearing**. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California. **6.** Not all locations are on the VSP Laser VisionCare Network. Please call VSP Member Services at **800.877.7195** to confirm the location you're interested in visiting is in-network. **7**. Some members may not be eligible for this program; visit **vsp.com/simplevalues** for terms and conditions.

Essential Medical Eye Care

VSP® Vision Care is committed to providing eye care that supports our members' overall health and wellness. That's why we offer Essential Medical Eye Care. With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care.

vsp vision care

What's Included With Essential Medical Eye Care?

- Fully covered retinal screening for members with diabetes. These high-resolution images of the inside of the eye are a non-invasive way to monitor diabetes.
- Exams and services to treat immediate issues like pink eye and sudden changes in vision.
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more.

If You Need Treatment

1. Contact your VSP network doctor to schedule an appointment.
2. If you don't have an eye doctor, visit **vsp.com** to find one and receive the eye care you need from an eye care expert.
3. When your VSP network doctor participates in your medical insurance plan's network, your medical insurance will be billed. You may be able to coordinate with your VSP benefits to help reduce out-of-pocket costs. If your VSP doctor doesn't participate with your medical insurance plan, VSP has you covered with only the cost of your copay.*

Find a VSP network doctor at vsp.com or call 800.877.7195.

*A standard copay of up to $20 is required for medical eye exams. Other covered services are covered-in-full, including retinal screening for members with diabetes. Log in to **vsp.com** to view your benefits.

Save Up to 60% on Brand-Name Hearing Aids

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000,* and few people have hearing aid insurance coverage.

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible too.

In addition to great pricing, TruHearing provides you with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid for non-rechargeable models

Plus, with TruHearing you'll get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Discounted pricing on a wide selection of the latest brand name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if you already have a hearing aid allowance from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

vsp exclusive member extras

TruHearing®

truhearing.com/vsp

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

*Based on a 2018 third-party survey of nationwide provider and manufacturer retail pricing.

VSP is providing information to its members, but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit http://www.vsp.com/offers/special-offers/hearing-aids/truhearing. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.

Check Out vsp.com

As a VSP® member, you have access to **vsp.com** and the VSP Vision Care App. Both offer easy navigation and a personalized dashboard, so you can get the benefit information you need, exactly when you need it.

Your VSP Dashboard

Once logged in, **My Dashboard** is your homepage. You'll find a quick view of your benefit information, access to your claim history, and you can print your Member ID Card, plus more.

Personalized Benefits Section

The **My Benefits** tab shows your benefits history and an explanation of how you and your dependents can use your benefits.

Special Offers and Savings

We put our members first by providing exclusive offers from VSP and leading industry brands, totaling more than $3,000 in savings. Log in to your VSP account and take advantage of these offers and save even more.

Improved Find a Doctor Page

The search capabilities are endless on the **Find a Doctor** page. View a map and use the drop-pin functionality to find the right VSP network practice location for you. You can also filter by business hours or appointment availability. Look for the orange **Premier Program** banner to find a VSP network eye doctor that will help you maximize your savings!

vsp vision care

VSP Vision Care App

Scan the QR code below to download the VSP Vision Care App from the **Apple App** or **Google Play Stores**. Get instant access to your benefit coverage, Member ID Card, Exclusive Member Extras, and more.

Create a vsp.com account to get the most out of your vision benefits.

Better benefits at work.

Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Who is covered?

Unum's EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Employee Assistance Program — Work/Life Balance

Toll-free 24/7 access:

- 1-800-854-1446 (multi-lingual)
- www.unum.com/lifebalance

Turn to us, when you don't know where to turn.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

Help is easy to access:

- **Online/phone support:** Unlimited, confidential, 24/7.
- **In-person:** You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

unum.com

Better benefits at work.

Don't forget this travel essential!

Pack your worldwide emergency travel assistance phone number and leave travel worries at home

Whether traveling for business or pleasure, one phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

With the Assist America Mobile App, you can:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-trip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy
- Read Assist Alerts

Download and activate the app today from the Apple App Store or Google Play.

Reference Number:
01-AA-UN-762490

If you experienced a medical emergency while traveling, would you know who to call?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

24/7 services anywhere in the world

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

MORE You can access travel assistance services through the **phone number on your travel assistance wallet card**. If you have misplaced your card, contact your human resources department and ask for a replacement.


If you need travel assistance anywhere in the world, contact us day or night:

- **Within the U.S.:** 1-800-872-1414
- **Outside the U.S.:** (U.S. access code) +609-986-1234
- **Via e-mail:** medservices@assistamerica.com

Reference number: 01-AA-UN-762490

Employer's name (please write above)

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Better benefits at work.

For reference only. Not actual card.

Travel assistance FAQs

Q. Which countries can I travel to?

A. Assist America's services have no geographical exclusions. Its worldwide network stands ready to help wherever your travels take you.

Q. Is my family covered?

A. Your spouse and dependent children up to age 19 (or the age specified by your medical plan) are covered. Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

Q. Are pre-existing conditions excluded?

A. No. Whether your medical emergency is the result of a new or pre-existing condition, Assist America's trained representatives will help you find qualified medical care and facilities.

Q. What about sports-related injuries?

A. Whether you've been involved in recreational or extreme sporting, worldwide emergency travel assistance will provide support for all your medical needs.

Q. Who pays for the services I use if I have a travel emergency?

A. Assist America arranges and pays for 100% of the services the company provides, with no caps or charge-backs to either you or your employer. But you must call Assist America first — you can't be reimbursed for services you arrange on your own.

* Hospital admission is coordinated by Assist America, Inc. It may require a validation of your medical insurance or an advance of funds to the foreign medical facility. You must repay any expenses related to emergency hospital admissions to Assist America, Inc. within 45 days. Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to change and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details. All emergency travel assistance must be arranged by Assist America, which pays for all services it provides. Medical expenses such as prescriptions or physician, lab or medical facility fees are paid by the employee or the employee's health insurance.

Insurance products underwritten by the subsidiaries of Unum Group.

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