

# 2021 BlueCross BlueShield Medical Plans

Plan A		Plan B	Plan C	Plan F
Network	Preferred	Preferred & Choice	Preferred	Choice
General Plan Information				HSA ELIGIBLE Embedded Deductible
Calendar Year Deductible (CYD)	\$750 Ind / \$2250 Family	\$1250 Ind / \$3750 Family	\$1500 Ind / \$4000 Family	\$3000 Ind / \$6000 Family
Calendar Year Out of Pocket Max <small>Includes deductible and pharmacy/medical copays</small>	\$3000 Ind / \$9000 Family	\$3500 Ind / \$10500 Family BP \$4000 Ind / \$12000 Family BC	\$4000 Ind /\$12000 Family	\$6650 Ind / \$13000 Family
Member Coinsurance	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Primary Office Visit Copay Specialty Office Visit Copay	\$20 Copay \$40 Copay	\$25 BP/\$35 BC Copay \$40 BP/\$50 BC Copay	\$35 Copay \$50 Copay	20% after CYD
Preventive Care Visits (Well Baby, Adult/Child Immunizations, Routine Health Screenings)	No Charge	No Charge	No Charge	No Charge
Diagnostics Lab/X-Ray	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
In-Patient Hospitalization	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Out-Patient Surgery	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Allergy Treatment/Testing	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Emergency Room Urgent Care	\$100 Copay; then 20% after CYD (waived if admitted) \$40 Copay	\$150 Copay, then 20%/30% after CYD (waived if admitted) \$40 BP / \$50 BC Copay	\$150 Copay; then 20% after CYD (waived if admitted) \$50 Copay	20% after CYD
Health Risk Assessment	HA deductible credit applies to 2021 plan year and must be completed between 01/01/2021 and 12/31/2021. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.			HA \$200 deductible Credit. Same rules as Plans A, B & C.
Mental Health/Substance Abuse				
In-Patient	20% after CYD	20%/30% after CYD	20% after CYD	20% after CYD
Out-Patient	\$20 Office Visit Copay 20% after CYD for other services	\$25 BP / \$35 BC Copay 20%/30% after CYD for other services	\$35 Office Visit Copay 20% after CYD for other services	20% after CYD

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Network	Preferred	Preferred & Choice	Preferred	Choice
Rehabilitation Services: Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Habilitation Services: Inpatient: 30 day limit per benefit period. PA required.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Physical and chiropractic Therapy (combined limited to 60 visits per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Durable Medical Equipment (DME)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Skilled Nursing Facility (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Home Health Care (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Hospice (PA Required)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
<b>Pharmacy</b>				
Generic Drugs	Retail: 25% of allowed amount; \$25 Min / \$50 Max Mail Order: 25% of allowed amount; \$75 Min / \$150 Max			20% after CYD
Preferred Brand Name Drugs	Retail: 25% of allowed amount; \$25 Min / \$50 Max Mail Order: 25% of allowed amount; \$75 Min / \$150 Max			20% after CYD
Non-Preferred Brand Name Drugs	Retail: 50% of allowed amount; \$50 Min / \$100 Max Mail Order: 50% of allowed amount; \$150 Min / \$300 Max			20% after CYD
Specialty Drugs	50% of allowed amount; \$50 Min / \$100 Max (Limited to 30 day supply Must be ordered through Prime Therapeutics (no mail order available)			20% after CYD
	30 Day Supply Limit retail. Up to 90 Day Supply of Maintenance drugs. Up to 90 Day Supply Mail, Network Only			

# Delta Dental Program Highlights

For Employees of **OKLAHOMA HIGHER EDUCATION EMPLOYEES INTERLOCAL GROUP • 0006441**  
Delta Dental PPO – Point of Service – High Plan • January 2021

Your Program Highlights provides a brief description of the most important features of your group's dental benefits program. If you have more specific questions regarding your benefits, please contact Delta Dental of Oklahoma's Customer Service Department at **405-607-2100 (OKC Metro)** or **800-522-0188 (Toll Free)**.

Dental benefits for participants and covered dependents are payable for eligible dental treatment not otherwise limited or excluded, and shall be paid in accordance with the benefit provisions of your plan, as follows:

## Percent Payable for Covered and Allowable Dental Services

	PPO Network	Premier Network	Out-of-Network
Class I: Diagnostic and Preventive Services	100%	100%	100%
Class II: Basic Services such as amalgam and composite fillings	85%	70%	70%
Class III: Major Services such as crowns, dentures and implants	60%	50%	50%
Class IV: Orthodontic Services are available to dependent children under age twenty-six (26)	50%	50%	50%

## Deductible and Maximum Amounts

Annual Maximum Benefit and Deductible Accumulation Period	January 1 - December 31
Annual Deductible Per Person – applies to Classes II and III	\$50*
Annual Maximum Benefit Per Person – applies to Classes I, II and III combined	\$2,000**
Lifetime Maximum Benefit Payment Per Child – applies to Class IV only	Unlimited

\*Family Deductible not to exceed 3 times the Annual Deductible Per Person.

\*\*Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Classes I, II and III combined services.

Endodontics, Periodontics and Oral Surgery are covered benefits under Class II Services.

Eligible dependent children can be covered to age twenty-six (26).

The information contained herein is not intended as a Summary Plan Description nor is it designed to serve as Evidence of Coverage for this program. Some benefits are subject to limitations such as age of patient, frequency of procedure, exclusions, etc.

Your dental benefits program allows payment for eligible services performed by any properly licensed dentist. However, maximum savings and lower out-of-pocket expenses are achieved when treatment is provided by a Delta Dental participating dentist. *Below is an illustration of a typical 100/80/50/50 plan, assuming annual deductible has been satisfied.*

Delta Dental PPO participating dentist		Delta Dental Premier participating dentist		Out-of-Network dentist	
Dentist Charge	\$100	Dentist Charge	\$100	Dentist Charge	\$100
PPO Maximum Allowable	\$70	Premier Maximum Allowable	\$85	Prevailing Fee	\$75
Plan pays 80% of PPO Allowable	\$56	Plan pays 80% of Premier Allowable	\$68	Plan pays 80% of Prevailing Fee	\$60
<b>You pay 20% of PPO Allowable</b>	<b>\$14</b>	<b>You pay 20% of Premier Allowable</b>	<b>\$17</b>	<b>You pay Balance of the dentist charge</b>	<b>\$40</b>

#### How to use your dental program:

Call the dental office of your choice and make an appointment. During your first appointment be sure to provide your dentist with the following information:

- Your Group name
- Your Group number
- The employee's social security or member ID number

#### Your dental program allows you to:

- Change dentists and visit a specialist of your choice at any time without preapproval
- Select a different dentist for each member of your family
- Receive dental care anywhere in the world

#### Find a Delta Dental participating dentist:

Two-thirds of the nation's practicing dentists are Delta Dental participating dentists. To find a participating dentist, refer to our National Dentist Directory at [www.DeltaDentalOK.org](http://www.DeltaDentalOK.org) or call Delta Dental's Customer Service Department at 405-607-2100 (OKC Metro) or 800-522-0188 (Toll Free).

#### Benefit Payment Procedure

Delta Dental pays participating dentists directly. You are responsible for any co-insurance percentages, deductible amounts, charges for non-covered services and amounts in excess of your annual maximum benefit. A Delta Dental participating dentist cannot charge you for amounts payable by Delta Dental. If you obtain treatment from a nonparticipating dentist, you may have to pay the entire bill in advance. Delta Dental will directly reimburse you, or any other participant or beneficiary, if required by law, up to your plan's maximum allowable amount.

#### The advantage of predetermination

If you are scheduled for dental treatment that will cost more than \$250, your dentist can request a predetermination of benefits by Delta Dental to determine if the proposed treatment is covered under your program, approximately how much the service will cost and your estimated share of the cost.

#### Filing your claim

A Delta Dental participating dentist will file your claim at no charge. If necessary, a printable claim form may be obtained on our website at [www.DeltaDentalOK.org](http://www.DeltaDentalOK.org). Completed claim forms should be submitted to the address below:

Delta Dental of Oklahoma - Claims Processing Center  
P.O. Box 548809  
Oklahoma City, OK 73154-8809

# Delta Dental Program Highlights

For Employees of **OKLAHOMA HIGHER EDUCATION EMPLOYEES INTERLOCAL GROUP • 0006441**

Delta Dental PPO – Point of Service – Low Plan • January 2021

Your Program Highlights provides a brief description of the most important features of your group's dental benefits program. If you have more specific questions regarding your benefits, please contact Delta Dental of Oklahoma's Customer Service Department at **405-607-2100 (OKC Metro)** or **800-522-0188 (Toll Free)**.

Dental benefits for participants and covered dependents are payable for eligible dental treatment not otherwise limited or excluded, and shall be paid in accordance with the benefit provisions of your plan, as follows:

## Percent Payable for Covered and Allowable Dental Services

	PPO Network	Premier Network	Out-of-Network
Class I: Diagnostic and Preventive Services	100%	100%	100%
Class II: Basic Services such as amalgam and composite fillings	75%	70%	70%
Class III: Major Services such as crowns, dentures and implants	60%	50%	50%
Class IV: Orthodontic Services	N/A	N/A	N/A

## Deductible and Maximum Amounts

Annual Maximum Benefit and Deductible Accumulation Period	January 1 - December 31
Annual Deductible Per Person – applies to Classes II and III	\$100*
Annual Maximum Benefit Per Person – applies to Classes I, II and III combined	\$1,000**

\*Family Deductible not to exceed 2 times the Annual Deductible Per Person.

\*\*Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Classes I, II and III combined services.

Endodontics, Periodontics and Oral Surgery are covered benefits under Class II Services.

Eligible dependent children can be covered to age twenty-six (26).

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Delta Dental PPO participating dentist		Delta Dental Premier participating dentist		Out-of-Network dentist	
Dentist Charge	\$100	Dentist Charge	\$100	Dentist Charge	\$100
PPO Maximum Allowable	\$70	Premier Maximum Allowable	\$85	Prevailing Fee	\$75
Plan pays 80% of PPO Allowable	\$56	Plan pays 80% of Premier Allowable	\$68	Plan pays 80% of Prevailing Fee	\$60
<b>You pay 20% of PPO Allowable</b>	<b>\$14</b>	<b>You pay 20% of Premier Allowable</b>	<b>\$17</b>	<b>You pay Balance of the dentist charge</b>	<b>\$40</b>

#### How to use your dental program:

Call the dental office of your choice and make an appointment. During your first appointment be sure to provide your dentist with the following information:

- Your Group name
- Your Group number
- The employee's social security or member ID number

#### Your dental program allows you to:

- Change dentists and visit a specialist of your choice at any time without preapproval
- Select a different dentist for each member of your family
- Receive dental care anywhere in the world

#### Find a Delta Dental participating dentist:

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#### Benefit Payment Procedure

Delta Dental pays participating dentists directly. You are responsible for any co-insurance percentages, deductible amounts, charges for non-covered services and amounts in excess of your annual maximum benefit. A Delta Dental participating dentist cannot charge you for amounts payable by Delta Dental. If you obtain treatment from a nonparticipating dentist, you may have to pay the entire bill in advance. Delta Dental will directly reimburse you, or any other participant or beneficiary, if required by law, up to your plan's maximum allowable amount.

#### The advantage of predetermination

If you are scheduled for dental treatment that will cost more than \$250, your dentist can request a predetermination of benefits by Delta Dental to determine if the proposed treatment is covered under your program, approximately how much the service will cost and your estimated share of the cost.

#### Filing your claim

A Delta Dental participating dentist will file your claim at no charge. If necessary, a printable claim form may be obtained on our website at [www.DeltaDentalOK.org](http://www.DeltaDentalOK.org). Completed claim forms should be submitted to the address below:

Delta Dental of Oklahoma - Claims Processing Center  
P.O. Box 548809  
Oklahoma City, OK 73154-8809

# Delta Dental Program Highlights

For Employees of **OKLAHOMA HIGHER EDUCATION EMPLOYEES INTERLOCAL GROUP (OKHEEI) • 0006441**

Delta Dental PPO – Preventive Plan • January 2021

Your Program Highlights provides a brief description of the most important features of your group's dental benefits program. If you have more specific questions regarding your benefits, please contact Delta Dental of Oklahoma's Customer Service Department at **405-607-2100 (OKC Metro)** or **800-522-0188 (Toll Free)**.

Dental benefits for participants and covered dependents are payable for eligible dental treatment not otherwise limited or excluded, and shall be paid in accordance with the benefit provisions of your plan, as follows:

## Percent Payable for Covered and Allowable Dental Services

Class I: Diagnostic and Preventive Services	100%
Class II: Basic Services such as amalgam and composite fillings	80%
Class III: Major Services such as crowns, dentures and implants	N/A
Class IV: Orthodontic Services	N/A

## Deductible and Maximum Amounts

Annual Maximum Benefit and Deductible Accumulation Period	January 1 - December 31
Annual Deductible Per Person – applies to Class II	\$50*
Annual Maximum Benefit Per Person – applies to Classes I and II combined	\$750**

\*Family Deductible not to exceed 2 times the Annual Deductible Per Person.

\*\*Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Classes I, II and III combined services.

Endodontics, Periodontics and Oral Surgery are covered benefits under N/A Services.

Eligible dependent children can be covered to age twenty-six (26).

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Your dental benefits program allows payment for eligible services performed by any properly licensed dentist. However, maximum savings and lower out-of-pocket expenses are achieved when treatment is provided by a Delta Dental participating dentist. *Below is an illustration of a typical 100/80/50/50 plan, assuming annual deductible has been satisfied.*

Delta Dental PPO participating dentist		Delta Dental Premier participating dentist		Out-of-Network dentist	
Dentist Charge	\$100	Dentist Charge	\$100	Dentist Charge	\$100
PPO Maximum Allowable	\$70	Premier Maximum Allowable	\$85		
Plan pays 80% of PPO Allowable	\$56	Plan pays 80% of PPO Allowable	\$56	Plan pays 80% of PPO Allowable	\$56
<b>You pay 20% of PPO Allowable</b>	<b>\$14</b>	<b>You pay Difference between PPO Payment and Premier Allowable</b>	<b>\$29</b>	<b>You pay Balance of the dentist charge</b>	<b>\$44</b>

#### How to use your dental program:

Call the dental office of your choice and make an appointment. During your first appointment be sure to provide your dentist with the following information:

- Your Group name
- Your Group number
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#### Your dental program allows you to:

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Delta Dental of Oklahoma - Claims Processing Center  
P.O. Box 548809  
Oklahoma City, OK 73154-8809





Life is  
better in  
focus.™

## Get access to the best in eye care and eyewear with Oklahoma Higher Education Employees and VSP® Vision Care.



Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at low out-of-pocket costs.

### You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and low out-of-pocket costs.
- **High Quality Vision Care.** You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—with the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

### Using your VSP benefit is easy.

- **Create an account at [vsp.com](https://vsp.com).** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit [vsp.com](https://vsp.com) or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on [vsp.com](https://vsp.com).

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

### Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.<sup>1</sup> Visit [vsp.com](https://vsp.com) to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.<sup>2</sup> Prefer to shop online? Check out all of the brands at [eyeconic.com](https://eyeconic.com)®, VSP's preferred online eyewear store.

Enroll in VSP today.  
You'll be glad you did.  
Contact us. **800.877.7195**  
[vsp.com](https://vsp.com)

# Your VSP Vision Benefits Summary

VSP Coverage Effective Date: 01/01/2019

Oklahoma Higher Education Employees and VSP provide you with a choice of affordable vision plans – choose the plan that's right for you.

Base Option			VSP Provider Network: VSP Choice			Enhanced Option			VSP Provider Network: VSP Choice		
Benefit	Description		Copay			Benefit	Description		Copay		
Your Coverage with a VSP Provider						Your Coverage with a VSP Provider					
WellVision Exam	<ul style="list-style-type: none"><li>Focuses on your eyes and overall wellness</li><li>Every calendar year</li></ul>		\$10			WellVision Exam	<ul style="list-style-type: none"><li>Focuses on your eyes and overall wellness</li><li>Every calendar year</li></ul>		\$10		
Prescription Glasses					\$25	Prescription Glasses					\$25
Frame	<ul style="list-style-type: none"><li>\$150 allowance for a wide selection of frames</li><li>\$170 allowance for featured frame brands</li><li>20% savings on the amount over your allowance</li><li>Every calendar year</li></ul>		Included in Prescription Glasses			Frame	<ul style="list-style-type: none"><li>\$150 allowance for a wide selection of frames</li><li>\$170 allowance for featured frame brands</li><li>20% savings on the amount over your allowance</li><li>Every calendar year</li></ul>		Included in Prescription Glasses		
Lenses	<ul style="list-style-type: none"><li>Single vision, lined bifocal, and lined trifocal lenses</li><li>Polycarbonate lenses for dependent children</li><li>Every calendar year</li></ul>		Included in Prescription Glasses			Lenses	<ul style="list-style-type: none"><li>Single vision, lined bifocal, and lined trifocal lenses</li><li>Polycarbonate lenses for dependent children</li><li>Every calendar year</li></ul>		Included in Prescription Glasses		
Lens Enhancements	<ul style="list-style-type: none"><li>Standard progressive lenses</li><li>Premium progressive lenses</li><li>Custom progressive lenses</li><li>Average savings of 20-25% on other lens enhancements</li><li>Every calendar year</li></ul>		\$0 \$95 - \$105 \$150 - \$175			Lens Enhancements	<ul style="list-style-type: none"><li>Standard progressive lenses</li><li>Premium progressive lenses</li><li>Custom progressive lenses</li><li>Average savings of 20-25% on other lens enhancements</li><li>Every calendar year</li></ul>		\$0 \$95 - \$105 \$150 - \$175		
Contacts (instead of glasses)	<ul style="list-style-type: none"><li>\$150 allowance for contacts; copay does not apply</li><li>15% Discount Contact lens exam (fitting and evaluation)</li><li>Every calendar year</li></ul>					Contacts (instead of glasses)	<ul style="list-style-type: none"><li>\$150 allowance for contacts; copay does not apply</li><li>15% Discount Contact lens exam (fitting and evaluation)</li><li>Every calendar year</li></ul>				
Diabetic Eyecare Plus Program	<ul style="list-style-type: none"><li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li><li>As needed</li></ul>		\$20			Diabetic Eyecare Plus Program	<ul style="list-style-type: none"><li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li><li>As needed</li></ul>		\$20		
						Additional Pairs of Eyewear					
						Second Pair	<ul style="list-style-type: none"><li>This enhancement allows you to get a second pair of glasses or contacts, subject to the same copays as your first pair benefit.</li></ul>				
Extra Savings	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"><li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details.</li><li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li></ul>										
	<b>Retinal Screening</b> <ul style="list-style-type: none"><li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li></ul>										
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"><li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li></ul>										
Your Coverage with Out-of-Network Providers											
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.											

Coverage with a participating retail chain may be different. Once your benefit is effective, visit [vsp.com](http://vsp.com) for details. 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.

1. Brands/Promotion subject to change.

2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

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VSP, VSP Vision care for life, eyeconic.com and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

**2021 NOC MEDICAL PREMIUMS**

<b>BCBS Plan A</b>	Monthly Medical Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$784.08	784.08	0
Employee + Spouse	\$1,526.42	784.08	\$742.34
Employee + Child	\$1,001.99	784.08	\$217.91
Employee + Children	\$1,354.27	784.08	\$570.19
Employee + Family	\$1,955.69	784.08	\$1,171.61

<b>BCBS Plan B</b>	Monthly Medical Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$684.60	684.6	0
Employee + Spouse	\$1,240.52	784.08	\$456.44
Employee + Child	\$879.69	784.08	\$95.61
Employee + Children	\$1,195.09	784.08	\$411.01
Employee + Family	\$1,624.83	784.08	\$840.75

<b>BCBS Plan C</b>	Monthly Medical Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$581.18	581.18	0
Employee + Spouse	\$1,118.30	784.08	\$334.22
Employee + Child	\$770.69	770.69	0
Employee + Children	\$1,077.07	784.08	\$292.99
Employee + Family	\$1,491.63	784.08	\$707.55

<b>BCBS Plan F</b>	Monthly Medical Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$587.22	587.22	0
Employee + Spouse	\$1,105.41	784.08	\$321.33
Employee + Child	\$749.17	749.17	0
Employee + Children	\$1,061.29	784.08	\$277.21
Employee + Family	\$1,523.82	784.08	\$739.74

<b>Delta Dental High</b>	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$39.82	\$39.82	\$0.00
Employee + Children	\$75.82	\$39.82	\$36.00
Employee + Child	\$58.64	\$39.82	\$18.82
Employee + Spouse	\$79.60	\$39.82	\$39.78
Employee + Family	\$119.56	\$39.82	\$79.74

<b>Delta Dental Low</b>	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$29.96	\$29.96	\$0.00
Employee + Children	\$53.80	\$39.82	\$13.98
Employee + Child	\$44.06	\$39.82	\$4.24
Employee + Spouse	\$64.28	\$39.82	\$24.46
Employee + Family	\$90.10	\$39.82	\$50.28

<b>Delta Dental Preventative</b>	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$18.26	\$18.26	\$0.00
Employee + Children	\$39.58	\$39.58	\$0.00
Employee + Child	\$30.24	\$30.24	\$0.00
Employee + Spouse	\$37.52	\$37.52	\$0.00
Employee + Family	\$60.18	\$39.82	\$20.36

<b>VSP Vision Base</b>	Monthly Vision Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$6.54	\$0.00	\$6.54
Employee + Children	\$14.00	\$0.00	\$14.00
Employee + Child	\$12.82	\$0.00	\$12.82
Employee + Spouse	\$13.10	\$0.00	\$13.10
Employee + Family	\$22.36	\$0.00	\$22.36

<b>VSP Vision Buy-up</b>	Monthly Vision Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$12.29	\$0.00	\$12.29
Employee + Children	\$26.33	\$0.00	\$26.33
Employee + Child	\$24.09	\$0.00	\$24.09
Employee + Spouse	\$24.63	\$0.00	\$24.63
Employee + Family	\$42.04	\$0.00	\$42.04



# how it works

1

## First Step

Your doctor says you need a procedure or surgery. You always have the ability to see your regular doctor. He or she will often determine what type of procedure or service you may need.



2

## Second Step

Just call or email us to see if your procedure is covered under The Zero Card. Once you have a diagnosis we can see what is available. Not everything is covered but we are always adding new providers and services.



3

## Third Step

Once you call, we will take care of every detail. We will help with determining what is available, appointment scheduling, the transfer of medical records and even travel and lodging if necessary. We will help you along throughout the whole process.



4

## Fourth Step

Everything is paid at 100%. You will always pay \$0. You will never have to worry about a deductible, copay or coinsurance. No more bills and no more surprises.



**855.816.0001**

thezerocard.com





## Now Offering Lab Services



you  
always  
pay \$0

save money, use your zero card

When you choose to use your Zero Card to obtain lab work, there is no cost to you  
- the labs are covered at 100%. No co-pays.

### how it works

1. When your physician orders lab work, show your Zero Card/Lab Card to your provider and request to use the Lab Card program. If your physician is a Lab Card provider, they will collect your labs utilizing the Lab Card benefit.
2. Any physician can collect your labs and call Quest Diagnostics at 1.800.646.7788 for courier pick-up and supplies.
3. If your physician does not participate in the Lab Card program, take your lab orders to an approved Quest Diagnostics location. Present your Zero Card/Lab Card at the time of service. Quest Diagnostic locations can be found by calling the Zero Card or visiting Labcard.com.
4. Your labs will be processed through the Lab Card program and results are sent back to your physician (usually within 24-48 hours).

**855-816-0001**



**Lab Card**





## Frequently Asked Questions

The Zero Card is a new benefit option for you and your families. The Zero Card offers hundreds of procedures and services that cost you \$0.

### **You might be wondering how do I use The Zero Card?**

When your doctor tells you that you need a service or procedure, call your personal health assistant at 855.816.0001. We take care of the details and you always pay zero.

### **What does The Zero Card cover?**

The Zero Card includes services such as surgeries, orthopedics, lab, x-ray, advanced imaging (MRI, CT, Ultrasound) and many others.

### **What does it cost me to use The Zero Card?**

When you choose to use The Zero Card, your health plan pays 100% of the charges. That means no deductible, no co-pay and no co-insurance coming out of your pocket.

### **What do I do if I receive a bill?**

Receive a bill, no worries! Simply call us at 855.816.0001 and one of our staff will ensure we get the bill taken care of for you.

### **How do I know what providers are covered?**

Most providers are listed on our website, [thezerocard.com](http://thezerocard.com); however, we always encourage you to call as we are always adding additional providers.

Still have questions? Call The Zero Card at **855.816.0001** and one of our staff will be happy to help answer your questions.

