PBC Preferred Benefit consultants

Home Care Association of America

Affordable Benefits for Everyday People

BENEFIT PLANS

PREFERRED BENEFIT consultants

PPO Benefit Summary

Monthly Rates	WellCare	PrimeCare	OptimaCare	EliteCare
Employee Only	$48	$75	$114	$144
Employee + Spouse	$90	$130	$218	$278
Employee + Child(ren)	$90	$130	$218	$278
Employee + Family	$135	$195	$327	$417

Benefit Summary	WellCare	PrimeCare	OptimaCare	EliteCare
Preventive / Wellness	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visits	-	$15 copay (3 per year, then Network Discount)	$15 copay	$15 copay
Specialist Visits	-	-	Network Discount	$15 copay
Urgent Care	-	-	$50 copay	$50 copay
Labs	-	-	Network Discount	$50 copay
X-Rays	-	-	Network Discount	$50 copay

Indeminity Summary	WellCare	PrimeCare	OptimaCare	EliteCare
Initial Hospital	-	-	-	-
Daily Hospital	-	-	-	-
Inpatient Surgery	-	-	-	-
Outpatient Surgery	-	-	-	-

Value Adds	WellCare	PrimeCare	OptimaCare	EliteCare
Telehealth	Unlimited $0 copay	Unlimited $0 copay	Unlimited $0 copay	Unlimited $0 copay
PPO Network	Multiplan	MultiPlan	Multiplan	Multiplan
Employee Perks Program	BenefitHub	BenefitHub	BenefitHub	BenefitHub
Behavorial Health	-	$50 fee (first 3 visits) $85 after	$50 fee (first 3 visits) $85 after	$50 fee (first 3 visits) $85 after
benieWALLET	Included	Included	Included	Included

Rx Benefits	WellCare	PrimeCare	OptimaCare	EliteCare
Generic Rx	Discount Only	Tier 1: $15 or less Tier 2: $30 or less	Tier 1: $15 or less Tier 2: $30 or less	Tier 1: $15 or less Tier 2: $30 or less
Brand Rx	Discount Only	Tier 3: $50 or less Tier 4: $75 or less	Tier 3: $50 or less Tier 4: $75 or less	Tier 3: $50 or less Tier 4: $75 or less

To locate providers participating in the MultiPlan PHCS network call (888) 263-7543 or visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner of the page and follow the steps below.

1. **After acknowledging you have read the disclaimer at the bottom of the screen, click on the green "Select Network "button.**
2. **When selecting your network, choose "PHCS," then "Limited Benefit Plan".**
3. **Enter one of the search criteria suggested in the search box to begin your search.**
4. **If your browser settings don't allow your location to be detected, enter a zip code.**

BENEFIT PLANS

PBC PREFERRED BENEFIT consultants

ADVANTAGE - Minimum Value Plan

Beni SOLUTIONS

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$399	$785	$739	$995

General Information	Coverage Information	
Annual Deductible	$1,500 Individual / $3,000 Family	
Out-of-Pocket Maximum[1]	$9,100 Individual / $18,200 Family	
Unlimited Telehealth through Recuro Health	$0 Copay	
Physician & Diagnostic Benefits (Non-Hospital Based)	**In-Network**	**Out-of-Network**
Preventive / Wellness	Covered at 100%	40% Coinsurance (after the Ded.)
Primary Care / Specialist Visits	$15 Copay	40% Coinsurance (after the Ded.)
Urgent Care	$50 Copay	40% Coinsurance (after the Ded.)
Laboratory Services / Radiology (X-ray, Ultrasound)	$50 Copay	40% Coinsurance (after the Ded.)
Advanced Imaging[RBP] (MRI, CT/PET scan)[2] (limit 1 per year)	$350 Copay	
Radiology / Advanced Imaging[2] (Medmo)[3] (subject to above limits)	Covered at 100%	
Hospital Benefits (All Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Outpatient Surgery[2] (limit 1 per year)	$250 Copay (after the Ded)	
Inpatient Hospitalization & Surgery[2] (limit 5 days & 2 surgeries per year)	$500 Copay per admission (after the Ded.)	
Emergency Services (limit 1 per year)	$500 Copay	
Additional Benefits	**In-Network**	**Out-of-Network**
Ambulance[RBP] (Ground Only) (limit 1 per year)	$500 Copay	
Physical / Speech / Occupational Therapy (limit 8 combined per year)	$50 Copay	40% Coinsurance (after the Ded.)
Chiropractic Services (limit 10 per year)	$50 Copay	40% Coinsurance (after the Ded.)
Home Health Care (limit 10 per year)	$50 Copay	40% Coinsurance (after the Ded.)
Outpatient Substance Abuse Treatment[RBP] (limit 8 per year)	$75 Copay	
Inpatient Substance Abuse Treatment[RBP] (limit 5 per year)	$750 Copay per day (after the Ded.)	
Chemotherapy / Radiation Therapy / Dialysis	Not Covered	
Maternity Benefits (Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Professional Services[2]	$350 Copay (after the Ded.)	
Inpatient Facility[2]	$1,500 Copay per admission (after the Ded.)	
Prescription Drug Benefits[5]	**Coverage Information**	
Generic (Tier 1)	$10 Copay	
Higher Tier Generics / Preferred / Non-Preferred Brand & Specialty	Discount Only	

[1]The out-of-pocket maximum refers to covered services only. Specific services are subject to Reference-Based Pricing (RBP) and patients may be billed beyond the out-of-pocket maximum for these services.
[2]Specific services, including advanced imaging, surgical procedures and maternity require precertification. Failure to obtain precertification will result in a denial of benefits.
[3]Medmo is a concierge scheduling service for radiology and imaging allowing members to maximize their benefits while minimizing costs to the patient.
[4]RBP reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. This plan pays up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
[5]Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit www.sbmabenefits.com/purerx-base. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.

This plan is a Qualified Health Plan that meets the standards of Actuarial Value under the Affordable Care Act (ACA).

BENEFIT PLANS

PBC PREFERRED BENEFIT consultants

PREMIUM - Minimum Value Plan

Beni SOLUTIONS

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$469	$849	$765	$1,149

General Information	Coverage Information	
Annual Deductible	$0	
Out-of-Pocket Maximum[1]	$9,100 individual / $18,200 family	
Unlimited Telehealth through Recuro Health	$0 Copay	
Physician & Diagnostic Benefits (Non-Hospital Based)	**In-Network**	**Out-of-Network**
Preventive / Wellness	Covered at 100%	40% Coinsurance
Primary Care / Specialist Visits	$15 Copay	40% Coinsurance
Urgent Care	$50 Copay	40% Coinsurance
Laboratory Services / Radiology (X-ray, Ultrasound)	$50 Copay	40% Coinsurance
Advanced Imaging[RBP] (MRI, CT/PET scan)[2] (limit 2 per year)	$350 Copay	
Radiology / Advanced Imaging[2] (Medmo)[3] (subject to above limits)	Covered at 100%	
Hospital Benefits (All Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Outpatient Surgery[2] (limit 1 per year)	$350 Copay	
Inpatient Hospitalization & Surgery[2] (limit 7 days & 3 surgeries per year)	$500 Copay per admission	
Emergency Services (limit 1 per year)	$500 Copay	
Additional Benefits	**In-Network**	**Out-of-Network**
Ambulance[RBP] (Ground Only) (limit 1 per year)	$500 Copay	
Physical / Speech / Occupational Therapy (limit 12 combined per year)	$50 Copay	40% Coinsurance
Chiropractic Services (limit 10 per year)	$50 Copay	40% Coinsurance
Home Health Care (limit 10 per year)	$50 Copay	40% Coinsurance
Outpatient Substance Abuse Treatment[RBP] (limit 8 per year)	$75 Copay	
Inpatient Substance Abuse Treatment[RBP] (limit 5 per year)	$750 Copay per day	
Chemotherapy / Radiation Therapy / Dialysis	Not Covered	
Maternity Benefits (Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Professional Services[2]	$350 Copay	
Inpatient Facility[2]	$500 Copay per admission	
Prescription Drug Benefits[5]	**Coverage Information**	
Generic (Tier 1)	$10 Copay	
Higher Tier Generics / Preferred / Non-Preferred Brand & Specialty	Discount Only	

[1]The out-of-pocket maximum refers to covered services only. Specific services are subject to Reference-Based Pricing (RBP) and patients may be billed beyond the out-of-pocket maximum for these services.
[2]Specific services, including advanced imaging, surgical procedures and maternity require precertification. Failure to obtain precertification will result in a denial of benefits.
[3]Medmo is a concierge scheduling service for radiology and imaging allowing members to maximize their benefits while minimizing costs to the patient.
[4]RBP reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. This plan pays up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
[5]Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit www.sbmabenefits.com/purerx-base. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.

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BENEFIT PLANS

PBC PREFERRED BENEFIT consultants

MAX - Minimum Value Plan

Beni SOLUTIONS

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$599	$1,160	$1,020	$1,595

General Information	Coverage Information	
Annual Deductible	$0	
Out-of-Pocket Maximum[1]	$9,100 individual / $18,200 family	
Unlimited Telehealth through Recuro Health	$0 Copay	
Physician & Diagnostic Benefits (Non-Hospital Based)	**In-Network**	**Out-of-Network**
Preventive / Wellness	Covered at 100%	40% Coinsurance
Primary Care / Specialist Visits	$15 Copay	40% Coinsurance
Urgent Care	$50 Copay	40% Coinsurance
Laboratory Services / Radiology (X-ray, Ultrasound)	$50 Copay	40% Coinsurance
Advanced Imaging[RBP] (MRI, CT/PET scan)[2] (limit 3 per year)	$350 Copay	
Radiology / Advanced Imaging[2] (Medmo)[3] (subject to above limits)	Covered at 100%	
Hospital Benefits (All Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Outpatient Surgery[2] (limit 2 per year)	$350 Copay	
Inpatient Hospitalization & Surgery[2] (limit 14 days & 4 surgeries per year)	$500 Copay per admission	
Emergency Services (limit 1 per year)	$500 Copay	
Additional Benefits	**In-Network**	**Out-of-Network**
Ambulance[RBP] (Ground Only) (limit 2 per year)	$500 Copay	
Physical / Speech / Occupational Therapy (limit 12 days combined per year)	$50 Copay	40% Coinsurance
Chiropractic Services (limit 20 per year)	$50 Copay	40% Coinsurance
Home Health Care (limit 20 per year)	$50 Copay	40% Coinsurance
Outpatient Substance Abuse Treatment[RBP] (limit 12 per year)	$75 Copay	
Inpatient Substance Abuse Treatment[RBP] (limit 10 per year)	$750 Copay per day	
Chemotherapy / Radiation Therapy / Dialysis	Not Covered	
Maternity Benefits (Subject to Reference-Based Pricing)[4]	**Coverage Information**	
Professional Services[2]	$350 Copay	
Inpatient Facility[2]	$500 Copay per admission	
Prescription Drug Benefits[5]	**Coverage Information**	
Generic (Tier 1)	$10 Copay	
Tier 2 Generics & Preferred Brand / Tier 3 Generics & Non-Preferred Brand	$50 Copay / $75 Copay	
Specialty	Discount Only	

[1]The out-of-pocket maximum refers to covered services only. Specific services are subject to Reference-Based Pricing (RBP) and patients may be billed beyond the out-of-pocket maximum for these services.
[2]Specific services, including advanced imaging, surgical procedures and maternity require precertification. Failure to obtain precertification will result in a denial of benefits.
[3]Medmo is a concierge scheduling service for radiology and imaging allowing members to maximize their benefits while minimizing costs to the patient.
[4]RBP reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. This plan pays up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
[5]Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit www.sbmabenefits.com/purerx-base. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.

This plan is a Qualified Health Plan that meets the standards of Actuarial Value under the Affordable Care Act (ACA).

Minimum Value Plans

Notable Plan Exclusions
Abortion
Care related to or for the purpose of travel outside of the United States
Chemotherapy / Radiation Therapy
Cosmetic Surgery including cosmetic components of gender transition
Dialysis
Durable Medical Equipment / Prosthetics / Orthotics
Experimental / Investigational Treatments
Hospice Care
Infertility Services / Family Planning
Mouth, Jaws, and Teeth (Oral Surgery procedures, medical in nature)
Nutritional Supplements / Vitamins (except as specified under preventive care)
Non-Tier 1 Generic / Preferred Brand / Non-Preferred Brand / Specialty / Self-Injectable / GLP-1 Prescription Drugs
Skilled / Private Duty Nursing Care
Transplant Services

This form is a benefit highlight representing a brief description of the coverage available. Additional covered services, exclusions and limitations exist. Please refer to the plan administrator for additional plan information.

HealthWallet

The HealthWallet mobile app puts your coverage in the palm of your hands

- Scan the QR code to the right, or search "The HealthWallet" in your app store
- Download the HealthWallet mobile app
- Login in with your social security number and date of birth
- Access your ID card(s), benefit information, and ancillary vender services

SCAN HERE

Locating a participating provider in the PHCS network all begins with the specific network logo on the front of your medical ID card. Please locate the PHCS logo on your card and follow the instructions below.

PHCS Practitioner & Ancillary Only

By phone: call **1.800.454.5231**
Online: visit www.multiplan.com/sbmapa and follow the steps below

1. Read the acknowledgment on the bottom of the screen and click OK
2. Enter a provider name, specialty, or facility type in the search box or choose one from the drop down
3. Enter your city/county and click on the magnifying glass icon to search
4. Read the statement at the bottom of the screen and click OK to view the results

RECURO HEALTH

Recuro Health's Virtual Urgent Care and Virtual Behavioral Health provide members with:

- 24/7 access to board-certified doctors for treatment of urgent medical concerns
- No-cost virtual access to a Psychiatrist or Licensed Counselor whenever and wherever they need it

Access care via the HealthWallet mobile app (scan the QR code above) or call 1-855-6RECURO

PureRx

Present your medical card with your prescription to any of our 60,000+ retail pharmacies to fill your prescription. Additional information will be provided on your medical ID card.

This plan is a Qualified Health Plan that meets the standards of Actuarial Value under the Affordable Care Act (ACA).

COVERED PREVENTIVE SERVICES

PREFERRED BENEFIT consultants

Preventive Benefits for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood Pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over living in a community setting
- Hepatitis B screening for people at high risk
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizations for adults — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Shingles, and Tetanus
- Lung cancer screening for adults 55 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 years at high risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults with symptoms at high risk

Preventive Benefits for Women

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk (counseling only; not testing)
- Breast cancer mammography screenings: every 2 years for women over 50 and older or as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast Cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Cervical Cancer screening: Pap test (also called a Pap smear) for women 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women

Preventive Benefits for Women (continued)

- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Expanded tobacco intervention and counseling for all pregnant tobacco users
- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for women

Preventive Benefits for Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents beginning at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunizations for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenza type B; Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Mumps; Pneumococcal, Rubella; and Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years • Phenylketonuria (PKU) screening for newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children
- Well-baby and well-child visits

For more information on preventive care benefits visit:
https://www.healthcare.gov/coverage/preventive-care-benefits/

DENTAL GROUP PPO

PREFERRED BENEFIT consultants

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$35.45	$71.64	$92.17	$133.21

Out-of-network % paid for usual, customary and reasonable treatment	90%
PREVENTIVE AND DIAGNOSTIC SERVICES • Routine exams and cleanings (two per year; plus two additional cleanings when recommended by a medical doctor due to an underlying medical condition). • Bitewing X-rays (one per 12 months). • Full-mouth X-rays (one every 36 months). • Sealants (for children under age 16; one tooth per 36 months). • Fluoride treatments (for children under age 19; one per 12 months). • Space maintainers.	100% Deductible is waived for preventive
BASIC SERVICES • Fillings (amalgam and composite). • Emergency palliative care. • Simple and surgical extractions. • Crown, bridge and denture repair.	80%
MAJOR SERVICES • Inlays, onlays, crowns, bridges and dentures. • Nonsurgical and surgical periodontics. • Endodontics. • Oral surgery. • Anesthesia. • Implants	10%
COINSURANCE	10% coinsurance applies across all years
WAITING PERIODS	None
DEDUCTIBLE • Waived for preventive. • No deductible starting in year three.	Year 1: $50/person (three per family) Year 2: $25/person (three per family) Year 3+: No deductible
ANNUAL MAX	1,000
DENTAL ACCIDENTAL INJURY BENEFIT	Coinsurance increased to 100% for covered dental injuries.
MAXIMUM CARRYOVER BENEFIT: Employees and their covered dependents may build up to $1,000 in their carryover account at any one time. Those carryover benefits may be used for any covered dental procedures. If a plan member fails to meet the stipulations shown above during a calendar year, the amount in the carryover account remains, as long as there is no break in coverage for any length of time, for any reason.	This benefit allows insured plan members to carryover $250 each calendar year, if: 1. An insured submits at least one qualifying claim for Class A dental expenses incurred during the calendar year, and/or 2. At least one qualifying claim for any other Class dental expense in excess of applicable deductible or co-pay fees, and 3. The total benefit amount paid stays below $500 for that calendar year.

ORTHODONTIA (CHILD ONLY)	Employer option
WAITING PERIOD	12 months
ANNUAL MAX	$750
LIFETIME MAX	$1,500

VISION GROUP PPO

PREFERRED BENEFIT consultants

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$7.66	$15.33	$15.54	$22.48

In-Network Benefits

FREQUENCY	
Eye examinations inclusive of dilation (when professionally indicated)	Once every 12 months
Prescription lenses	Once every 12 months
Frame	Once every 24 months
Contact lens evaluation, fitting and follow-up care (in lieu of eyeglasses)	Once every 12 months
COPAYMENTS	
Eye examination	$10
Prescription lenses	$10
Contact lens evaluation, fitting and follow-up care	$0
EYEGLASS BENEFIT – FRAME	
Frame allowance (retail) 20% overage discount**	Up to $130 **OR** Up to $180*
DAVIS VISION FRAME COLLECTION (IN LIEU OF ALLOWANCE)	**Member copay**
Fashion level	$0
Designer level	$0
Premier level	$25
EYEGLASS BENEFIT – PRESCRIPTION LENSES	**Member copay**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$0
Tinting of plastic lenses	$0
Scratch-resistant coating	$0
Polycarbonate lenses (children/adults)	$0/$30
Ultraviolet coating	$12
Antireflective (AR) coating (Standard/Premium/Ultra/Ultimate)	$35/$48/$60/$85
Progressive lenses (Standard/Premium/Ultra/Ultimate)	$50/$90/$140/$175
High-index lenses	$55
Polarized lenses	$75
Plastic photochromic lenses	$65
Scratch-protection plan: single vision/multifocal lenses	$20/$40
CONTACT LENS BENEFIT (IN LIEU OF EYEGLASSES) – STANDARD AND SPECIALTY LENS TYPES	
Contact lens material allowance – plus 15% discount on any overage**	Up to $130
Evaluation, fitting and follow-up care – standard lens types (in lieu of eyeglasses)	15% discount**
Evaluation, fitting and follow-up care – specialty lens types (in lieu of eyeglasses)	15% discount**
COLLECTION CONTACT LENSES BENEFIT (IN LIEU OF CONTACT LENS MATERIAL ALLOWANCE)	
Materials disposable: up to	4 boxes/multi-packs
Planned replacement: up to	2 boxes/multi-packs
Evaluation, fitting and follow-up care	$0 copay
NONELECTIVE (VISUALLY REQUIRED) CONTACT LENSES (WITH PRIOR APPROVAL)	
Materials, evaluation, fitting and follow-up care	$0 copay
OUT-OF-NETWORK REIMBURSEMENT-ALLOWANCE SCHEDULE	**Up to**
Eye examination	$40
Frame	$50
Single-vision lenses	$40
Bifocal/progressive lenses	$60
Trifocal lenses	$80
Lenticular lenses	$100
Elective contact lenses	$105
Nonelective (visually required) contact lenses	$225

VOLUNTARY INSURANCE PLANS

PBC Preferred Benefit consultants

Plans that provide employees with additional coverage to help offset the potential out-of-pocket costs associated with hospitalization, accidents, critical illness or ultimately death.

INDIVIDUAL/FAMILY POLICIES:

- **Accident:** Helps with medical and out-of-pocket expenses after a covered injury, including treatment-related costs and everyday bills.
- **Short Term Disability:** Provides a source of income if a disability due to covered accident or illness.
- **Hospital:** A Hospital Confinement Insurance policy can help ease the financial burden of hospital stays by providing cash benefits.
- **Cancer:** For help with the high out-of-pocket costs associated with cancer - beyond what health insurance may cover - so you can focus on recovery, not finances.
- **Critical Care:** Assists with the cost of treatment in the event of a covered critical illness such as a heart attack, stroke or paralysis.
- **Life Insurance:** For assistance with end-of-life expenses and to help provide financial peace of mind to loved ones.

We can help provide financial protection if you get sick or hurt, with benefits paid directly to you - not to doctors or hospitals.

FOR MORE INFORMATION CONTACT

PREFERRED BENEFIT consultants

Suzanne DiCioccio

Director of Client Relations
Preferred Benefit Consultants

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Direct: 609.743.6081
Office: 610.510.3760

Certified Benefit Advisor for:

- HCAOA (Home Care Association of America)
- Pennsylvania Homecare Association
- HCAF (Florida Homecare Association)
- 5 National Franchisors