optionsplus
MEC PLANS | DISCOUNT BENEFITS

EliteCare MEC BENEFIT SUMMARY

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
MONTHLY	$149	$270	$270	$385

BENEFIT SUMMARY	ELITECARE MEC
Annual Deductible	$0
Wellness and Preventative	Covered at 100% *(See Covered Services Page)*
Rx Discount Plan	-
Telemedicine	$0 copay | unlimited
Virtual Behavioral Health	$50 copay | 3x/year
Primary Care Visits	$15 copay
Specialist Visits	$15 copay
Urgent Care Visits	$50 copay
Laboratory Services	$50 copay
X-Rays	$50 copay
Generic Rx	Tier 1: $10 copay | Tier 2: $25 copay
Brand Rx	Tier 3: $50 copay | Tier 4: $75 copay
MEC COMPANION	Discounts on Dental, Vision, Durable Medical Equipment, Hearing Aids, Diabetic Supplies, and Fitness

The Ultimate MEC plan excludes out-of-network services and covers ONLY the medical services listed above and on the covered services page.

PROVIDER INFORMATION

MEDICAL

To locate providers participating in the MultiPlan® PHCS network call (888) 794-7427 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. Click on the green "Select Network" button.
2. Choose "PHCS," "Specific Services"

TELEHEALTH

Provides fast and convenient access to a national network of board-certified physicians to diagnose illnesses, recommend treatment and prescribe medications 24 hours a day, 7 days a week and 365 days a year.

ACTIVATE YOUR ACCOUNT:
855.373.7450

MEC COMPANION CARD

ACTIVATE YOUR ACCOUNT & LOCATE PROVIDERS

1. Visit www.WellCardSavings.com
2. Click: "Click Here to Register"
3. Group ID: **MECPLUS**
4. Fill out your information
5. Click Save, Text, or Email card

PRESCRIPTIONS

Please present your medical identification card along with your prescription to any of our 60,000+ retail pharmacies every time you fill your prescription. You can access a participating phar-macy list at:
www.sbmabenefits.com/purerxstandard

COMPREHENSIVE DENTAL

MONTHLY	COMPREHENSIVE DENTAL	
Employee Only	$47.15	
Employee + Spouse	$91.20	
Employee + Child(ren)	$86.47	
Family	$137.99	
DENTAL BENEFITS	In-Network	Out-of-Network
Preventive & Diagnostic Exams; Cleanings; Bitewing X-Rays; Full Mouth X-Rays; Fluoride Treatments (Frequency limitations apply); Space Maintainers	100%	80%
Basic Fillings; Simple Extractions; Oral Surgery; Periodontics; Root Canals (Endodontics); Sealants	80%	50%
Major Crowns & Gold Restorations; Bridgework; Full & Partial Dentures; Repair of Dentures; Implants	50%	50%
Annual Maximum (per person)	$1,500	$1,500
Annual Deductible Per Person Family Maximum	 $50 $150	 $100 $300
Waived For		

DENTAL PROVIDER LOOKUP

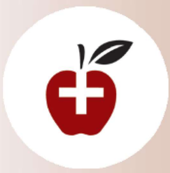
Visit: https://www.deltadental.com/us/en/member/find-a-dentist.html
Specialty: Choose one or Choose Any | Your Plan: Delta Dental PPO
Search by Current Location: No, Enter Zip Code | Find Dentists

DENTAL PLAN NOTES

Carryover Max℠ from Delta Dental allows you to increase your benefits.

This valuable benefit feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future- such as bridges, crowns, and root canals.

The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provisions, including limitations and exclusions, are provided in the group contract.



VSP by DELTA VISION
BENEFIT SUMMARY

RATES			
EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
$12.95	$22.90	$23.90	$37.85

BENEFITS	
Network/Plan	VSP Choice
Exam/lens/frame frequency (months)	12/12/24
Contacts (in lieu of glasses)	12
IN-NETWORK COVERAGE	
Eye Exam Copay	$10
Materials Copay	$25
Frame allowance	$130 | $70 Walmart/Sam's Club/Costco frame allowance
Elective contact lens allowance	$130
Necessary contact lenses	Covered in full after copay
Contact lens fit/evaluation copay	$60
Both frames and contacts in same year	No; allows contacts in lieu of frames
OUT-OF-NETWORK COVERAGE	
Examination, up to:	$45
Single vision lenses, up to:	$30
Bifocal lenses, up to:	$50
Trifocal lenses, up to:	$65
Progressive lenses, up to:	$50
Lenticular lenses, up to:	$100
Frames, up to:	$70
Elective contact lenses, up to:	$105
Necessary contact lenses, up to:	$210
LENS ENHANCEMENTS (MEMBER COST)*	
Anti-glare coating	$41 single/$41 multifocal
Impact - resistant lenses - adult	$31 single/$35 multifocal (covered for children)
Progressive lenses	Standard progressive lenses are covered
Light-reactive lenses	$75 single vision/$75 multifocal
Scratch resistant coating	$17 single vision/$17 multifocal

*Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices may vary and are valid only through VSP Choice Network and are subject to change without notice.

VISION PROVIDER LOOKUP

Visit: https://www.vsp.com/eye-doctor
Search by Location, Office Name, or Doctor Name

DeltaVision® in partnership with VSP®