2024 Optional Benefits
### 2024 Vision Plans

Vision Plans offered and contracted through Vision Service Plan (VSP)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>VSP Plan A (Voluntary)</th>
<th>VSP Plan B (Voluntary)</th>
<th>VSP Plan C (Voluntary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan ID</td>
<td>VA01</td>
<td>VA02</td>
<td>VA03</td>
</tr>
<tr>
<td>Prescription glasses copayment</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
</tbody>
</table>

#### Benefits Frequency

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>Every calendar year&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Reimbursed up to $45</td>
</tr>
<tr>
<td>Lenses</td>
<td>Every other calendar year&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Reimbursed up to $30&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Frames</td>
<td>Every other calendar year&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Reimbursed up to $50&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Contact Lenses (in lieu of glasses)</td>
<td>Every other calendar year&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Reimbursed up to $65&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

#### In-Network Benefits

**Vision Care Services**

- **WellVision Examination**: Covered in full

**Prescription Glasses**

- Lenses: single vision: Covered in full<sup>2</sup>
- Lenses: bifocal: Covered in full<sup>2</sup>
- Lenses: trifocal: Covered in full<sup>2</sup>
- Lenses: lenticular: Covered in full<sup>2</sup>
- Frames: Covered up to plan allowance of $120<sup>2</sup>

**Contact Lenses (in lieu of glasses)**

- Professional fees and materials: Covered up to plan allowance of $120

#### Out-of-Network Benefits

**Vision Care Services**

- **WellVision Examination**: Reimbursed up to $45

**Prescription Glasses**

- Lenses: single vision: Reimbursed up to $30<sup>2</sup>
- Lenses: bifocal: Reimbursed up to $50<sup>2</sup>
- Lenses: trifocal: Reimbursed up to $65<sup>2</sup>
- Lenses: lenticular: Reimbursed up to $100<sup>2</sup>
- Frames: Reimbursed up to $70<sup>2</sup>

**Contact Lenses (in lieu of glasses)**

- Professional fees and materials: Reimbursed up to $105

#### Value-Added Discounts (apply only to In-Network Benefits)

- **Frames**: 20% off the amount over allowance
- **Lens Enhancements**: 30% average savings on some lens enhancement options
- **Sunglasses**: 20% discount
- **Contact Lens Exam Services**: 15% discount off fitting and evaluation
- **TruHearing Hearing Aids**: Savings up to 60% on brand-name hearing aids
- **Laser Vision Correction**: 15% average discount off the regular price or 5% off the promotional price for laser vision correction provided by VSP contracted facilities

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<sup>1</sup> Calendar year begins January 1

<sup>2</sup> Indicates subject to prescription glasses copayment

This is only a summary. For a complete list of vision services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.
2024 Dental Plan offered and contracted through Delta Dental

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Small Group (Adult) Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan ID</td>
<td>DS01</td>
</tr>
</tbody>
</table>

**Dignostic Services**
- Periodic oral examinations: No charge
- X-rays: No charge

**Preventive Services**
- Teeth cleaning (prophylaxis): No charge
- Topical fluoride - child (adult at different cost share): No charge

**Restorative Services: Filling - Permanent**
- Amalgam-four (+) surfaces: primary or permanent: No charge
- Crown: porcelain fused to predominantly base metal: $410

**Oral Surgery Services**
- Simple extraction of erupted tooth or exposed root: $18
- Surgical extraction of erupted tooth: $30
- Removal of impacted tooth: full bony: $80

**Endodontic Services**
- Root canal: anterior: $110
- Root canal: bicuspid/premolar: $195
- Root canal: molar: $245

**Periodontic Services**
- Gingivectomy: one to three teeth per quadrant: $50
- Gingivectomy-four (+) contiguous teeth per quadrant: $165
- Scaling/root planing: one to three teeth per quadrant: $40

**Prosthodontic Services**
- Complete denture: $510
- Partial denture - resin base: $535

**Orthodontic Services (medically necessary)**
- Comprehensive Treatment - Child (ages 13-18): N/A
- Comprehensive Treatment - Adult (age 19+): $2,900

**Other Services**
- Office visit: after hours: $35
- Local anesthesia: No charge

This is only a summary. For a complete list of dental services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.
2024 **Chiropractic and Acupuncture Plans**<sup>1</sup>
offered and contracted through ACN Group of California, Inc.

<table>
<thead>
<tr>
<th></th>
<th>CA01</th>
<th>CA02</th>
<th>CA05</th>
<th>CA06</th>
<th>CA09</th>
<th>CA10</th>
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<tbody>
<tr>
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<td>30</td>
<td>20</td>
<td>30</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Copayment per visit</td>
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<td>$20</td>
<td>$15</td>
<td>$15</td>
<td>$10</td>
<td>$10</td>
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<table>
<thead>
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<th>AA02</th>
<th>AA05</th>
<th>AA06</th>
<th>AA09</th>
<th>AA10</th>
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<td>30</td>
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<tr>
<td>Copayment per visit</td>
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<td>$20</td>
<td>$15</td>
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<table>
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<td>Max visits per year</td>
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<td>30</td>
<td>Unlimited</td>
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<td>30</td>
<td>Unlimited</td>
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<tr>
<td>Copayment per visit</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$15</td>
<td>$15</td>
<td>$15</td>
<td>$10</td>
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2024 **Infertility/Special Footwear and Orthotics Plans**<sup>2</sup>

<table>
<thead>
<tr>
<th>Infertility</th>
<th>Plan ID</th>
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<tbody>
<tr>
<td>Copayment per treatment and services</td>
<td>50%</td>
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</table>

<table>
<thead>
<tr>
<th>Orthotics and Special Footwear</th>
<th>Plan ID</th>
<th>OP20&lt;sup&gt;3&lt;/sup&gt;</th>
<th>OH20&lt;sup&gt;4&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Copayment per treatment and services</td>
<td>20%</td>
<td>20% after deductible</td>
<td></td>
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</tbody>
</table>

<sup>1</sup> Available for small and large group plans only. Not available for election with high-deductible health plans (HDHPs).
<sup>2</sup> Available for large group offerings only.
<sup>3</sup> Not available with large group HDHPs.
<sup>4</sup> Only available with large group HDHPs.

This is only a summary. For a complete list of chiropractic, acupuncture, infertility or special footwear and orthotics services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.