Benefits Eligibility

Eat'n Park Hospitality Group Team Members receive COBRA continuation coverage options because he or she was covered by our group health plan on the day before a "qualifying event." Depending on the circumstances, the following individuals may be qualified beneficiaries:

- An Employee who recently lost coverage because of a termination or retirement.
- Your legal spouse
- Children under 26 years of age including stepchildren, adopted children or children awarded coverage pursuant to a court order
- Disabled children over the age of 26, provided that the disability occurred prior to the child attaining age 26

Paying for Benefits

COBRA premiums are paid directly to WageWorks. You may choose to make recurring payments through Electronic Funds Transfer directly from your bank account. Visit mybenefits.wageworks.com and follow the login instructions to take advantage of this easy payment option. After you sign up, payments are automatically transferred from your bank account on or about the 1st of the month and will eliminate monthly premium invoices mailed to you. Before your automatic payments can begin, WageWorks is required to send a pre-authorization to your bank to verify your account information. You must continue to make payments using a different payment method until your banking information is verified. Other payment options include:

- Phone/IVR Option: You may choose to make payment via phone/IVR by calling 1-877-722-2667. Note: If paying online or through the IVR phone system, your payment must be made no later than midnight Central Time (CT) of the last day of your grace period.
- By Mail Option: You may choose to send your full premium payment to WageWorks, Inc. Please make checks payable to WageWorks, Inc. and write your account number 0130932053 on the memo portion of your check or money order. Please mail your payment with the remittance coupon to: WageWorks, Inc. PO Box 660212 Dallas, TX 75266-0212.

Changing Your Benefits

Changes that affect the status of either your coverage or your dependents can be made during Open Enrollment or when you experience a mid year change-in-status. Change-in-status events can include:

- Gaining or losing coverage through another source (i.e. Medicaid, another employer, spouse's employer, etc.)
- Marriage/Divorce
- Court decree/court order
- Change in number of dependents (birth, adoption) – newborns are not automatically covered under your plan for their first 30 days of life unless you add your newborn within 30 days of the date of birth
- Attaining age 26

Please send all correspondence, such as coverage changes due to life events (including Medicare entitlement), requests for cancellation, reduction of your coverage, or address changes through the Support link at mybenefits.wageworks.com, by email at customerdelivery@wageworks.com, by fax at 877-775-9399 or by mail at WageWorks, Inc. P.O. Box 226101 Dallas, TX 75222-6101. Verbal notice (including notice by telephone) is not acceptable.

COBRA participants can also cancel Benefits anytime by simply not paying the monthly premiums or informing HealthEquity to terminate coverage.

Medical and Prescription Drug (Rx)

Medical/Rx insurance is available through Highmark Blue Cross Blue Shield.

Plan	Option	Monthly Rate	Group Number
Plan A PPO Region 1 (Western PA, WV, OH, VA, IN, MI, WI, KY)	Team Member (TM) Only TM + Child(ren) TM + Spouse (SP) TM + Family	**$616.41** **$1,633.53** **$1,769.89** **$1,861.10**	049446-01
Plan A PPO Region 2 (Eastern PA, DE, MA, MD, ME, NH, NJ, NY, IL)	Team Member (TM) Only TM + Child(ren) TM + Spouse (SP) TM + Family	**$682.37** **$1,840.78** **$1,994.42** **$2,097.23**	049446-03
Plan B PPO with HRA Region 1 (Western PA, WV, OH, VA, IN, MI, WI, KY)	Team Member (TM) Only TM + Child(ren) TM + Spouse (SP) TM + Family	**$684.11** **$1,836.20** **$1,974.77** **$2,061.10** **-**	049446-05
Plan B PPO with HRA Region 2 (Eastern PA, DE, MA, MD, ME, NH, NJ, NY, IL)	Team Member (TM) Only TM + Child(ren) TM + Spouse (SP) TM + Family	**$751.61** **$2,057.78** **$2,212.87** **$2,307.47**	049446-07
Plan C PPO Broad Access (Region 1 & Region 2)	Team Member (TM) Only TM + Child(ren) TM + Spouse (SP) TM + Family	**$530.11** **$1,404.85** **$1,522.11** **$1,568.11**	014526-88

Region pricing depends on home residence

Differences in Medical Plans

Plan A PPO is a **Community Blue PPO** plan that has two levels of benefits, in-network, and out-of-network. Plan A PPO is a high performing, lower cost plan. You will have lower cost-sharing when you receive care from in-network quality and cost-effective providers. You can choose out-of-network coverage at the highest level of cost sharing. In Western PA, Plan A PPO has **limited access** to UPMC hospitals and providers.

Plan B PPO with HRA is a **Community Blue PPO** plan and includes a Health Reimbursement Account (HRA). It is employer funded and helps fund the first claims that go towards your deductible. In Western PA, Plan B PPO with HRA has **limited access** to UPMC hospitals and providers.

- If you are electing team member only coverage, you will have $500 in your HRA. If you are electing dependent coverage, you will have $1000 in your HRA.
- If you continue to be enrolled in Plan B in 2025, any funds that you do not use in 2024 will be rolled over to the 2025 plan year. The HRA rollover maximum will not exceed the amount of your deductible.
- If you cancel your medical coverage, the HRA is a closed account, and the money is forfeited.
- If you are enrolled in the Health Care Flexible Spending Account (HCFSA), you can only use your HCFSA dollars for deductible expenses AFTER your HRA is used in full.

UPMC Access in 2025

Access to UPMC hospitals and providers may differ by plan. To confirm your providers are in-network, please visit Myhighmark.com, or call 1-800-294-3802 prior to your appointment.

Plan C PPO Broad Access is a **PPO Blue** plan that has two levels of benefits, in-network and out-of-network. This plan is the lowest premium plan that provides minimal essential coverage to you and your dependents. In Western PA, Plan C PPO has **broad access** to UPMC hospitals and providers.



Virtual Medicine

When you and your family need quick care for minor illnesses, virtual medicine, also known as telemedicine, is a convenient option.
You can use online video 24/7 to visit US board-certified, state-licensed doctors who can diagnose, recommend treatment, and prescribe medication, when appropriate, for minor medical issues such as:

- Cold & Flu
- Earaches
- Rashes & Skin Issues
- Pinkeye
- Behavioral Health (depression, anxiety)

Virtual visits are covered in the same way as they would be if you received in-person care, however **virtual visits are available for a $0 co-pay**. Well360 can also be used for dermatology visits, women's health and virtual PCP .

Team Members have access to telemedicine services through Well360 Virtual Health Platform.

You will be able to access Well360 Virtual Health by:

- Visiting myhighmark.com
- Navigating to the Benefits section
- Clicking on Well360 Virtual Health
- Calling 1.800.294.3802

Highmark Advisor

Our dedicated service unit provides team members with the most comprehensive set of tools, resources & support to lead the healthiest lives possible. Call the dedicated service unit to get:

- Access to Diabetes Prevention and Smoking Cessation Programs
- Access to Best Doctors virtual expert second opinion program
- Encouragement in maintaining and adopting healthy lifestyles
- Engagement on how you want to be reached – secure text messaging, email, telephone, etc.
- Expert guidance in managing chronic conditions
- Guidance on how to use the online tools and resources to help you make an informed health care decision
- Personalized wellness coaching on individual lifestyle risk
- Support to choose the most cost-effective site of care

To use the dedicated service unit, call the 1-800-294-3802 number on the back of your medical ID card.

More about the medical plans:

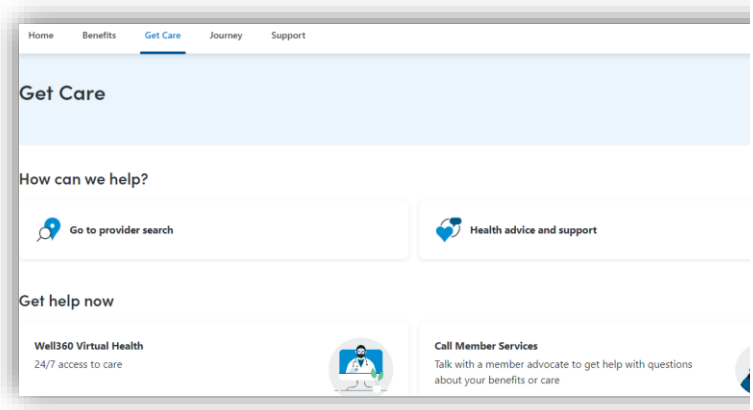
- All medical plans include Prescription (Rx) coverage through Highmark BCBS. For maintenance medications, you are required to fill your medication at a CVS Pharmacy, or through mail-order for a 90-day supply to avoid paying a higher cost.
- Prescriptions for asthma, depression, high blood pressure, high cholesterol and diabetes and part of the Rx for Health program which cuts the copays in half.
- **Preventive care is covered at 100% with in-network providers** (i.e. routine physical, flu shot, mammogram, colorectal cancer screening) with no copays or deductible expenses.
- Highmark's free tobacco cessation programs can help you quit smoking. You can choose a self-help, telephone-based or online coaching program that meets your needs. All programs are free to members. Call 1-800-345-2476 to get started.

Doctor and Hospital Search

If you have concerns about your doctor or hospital being in-network, visit myhighmark.com and click **FIND CARE.**

Pick a plan from the full list:
Plan A PPO = Community Blue PPO
Plan B PPO w/ HRA = Community Blue PPO
Plan C Broad Access = PPO Blue

You can search the doctor or hospital name, specialty, location.



Benefit	Plan A PPO		Plan B PPO with HRA		Plan C PPO Broad Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Period	Calendar Year		Calendar Year		Calendar Year	
Heath Reimbursement Account	None		$500 Individual/$1,000 Family		None	
Deductible (per benefit period)						
Individual	$2,750	$10,250	$2,750	$10,250	$5,000	$10,000
Family	$5,500	$20,500	$5,500	$20,500	$10,000	$20,000
Plan Pays	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period – does not include deductible or copays)						
Individual	$2,800	$10,250	$2,300	$10,250	$2,000	$10,000
Family	$8,100	$20,500	$6,800	$20,500	$4,000	$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (Once met, the plan pays 100% of covered services for the rest of the benefit period.)						
Individual	$5,900	Not Applicable	$5,400	Not Applicable	$7,650	Not Applicable
Family	$14,100	Not Applicable	$12,800	Not Applicable	$15,300	Not Applicable
	Office/Clinic/Urgent Care Visits					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Clinic Visits	100% after $20 copay	50% after deductible	100% after $15 copay	50% after deductible	100% after $25 copay	50% after deductible
Primary Care Provider Office Visits	100% after $20 copay	50% after deductible	100% after $15 copay	50% after deductible	100% after $25 copay	50% after deductible
Specialist Office Visits	100% after $35 copay	50% after deductible	100% after $30 copay	50% after deductible	100% after $40 copay	50% after deductible
Urgent Care Center Visits	100% after $40 copay	50% after deductible	100% after $35 copay	50% after deductible	100% after $45 copay	50% after deductible
Telemedicine/Virtual Medicine Services	100% after $0 copay	Not Covered	100% after $0 copay	Not Covered	100% after $0 copay	Not Covered
	Preventive Care					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Adult Physical Exams	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered
Adult Immunizations	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including Pap Test	100% (deductible does not apply)	50% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible

Benefit	Plan A PPO		Plan B PPO with HRA		Plan C PPO Broad Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Pediatric Physical Exams	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible	100% (deductible does not apply)	50% after deductible
	Emergency Services					
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Services	80% after $200 copay for first visit, 2+ visits $300 copay (waived if admitted)		80% after $200 copay for first visit, 2+ visits $300 copay (waived if admitted)		70% after $225 copay for first visit, 2+ visits $325 copay (waived if admitted)	
Ambulance – Emergency and Non-Emergency	80% after in-network deductible		80% after in-network deductible		70% after in-network deductible	
	Hospital and Medical/Surgical Expenses (including maternity)					
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital Inpatient & Outpatient	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) *Enrollment in Baby Blueprints is $500 claims credit*	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
	Therapy and Rehab Services					
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical Medicine Limit: 20 visits/benefit period	80% after $20 copay	50% after deductible	80% after $15 copay	50% after deductible	70% after $25 copay	50% after deductible
Respiratory Therapy	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Speech Therapy Limit: 20 visits/benefit period	80% after $20 copay	50% after deductible	80% after $15 copay	50% after deductible	70% after $25 copay	50% after deductible
Occupational Therapy Limit: 20 visits/benefit period	80% after $20 copay	50% after deductible	80% after $15 copay	50% after deductible	70% after $25 copay	50% after deductible
Spinal Manipulations	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
	Mental Health/Substance Abuse					
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Mental Health Services Inpatient Detox/Rehab	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Outpatient Mental Health Services	100% after $20 copay	50% after deductible	100% after $15 copay	50% after deductible	100% after $25 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $20 copay	50% after deductible	100% after $15 copay	50% after deductible	100% after $25 copay	50% after deductible

Benefit	Plan A PPO		Plan B PPO with HRA		Plan C PPO Broad Access	
	Other Services					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Allergy Extracts and Injections	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (Standard imaging, lab/pathology, allergy testing, diagnostic medical)	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Home Health Care	80% after deductible max of 100 visits, per benefit period aggregate with visiting nurse	50% after deductible max of 60 visits, per benefit period aggregate with visiting nurse	80% after deductible max of 100 visits, per benefit period aggregate with visiting nurse	50% after deductible max of 60 visits, per benefit period aggregate with visiting nurse	70% after deductible max of 100 visits, per benefit period aggregate with visiting nurse	50% after deductible max of 50 visits, per benefit period aggregate with visiting nurse
Hospice	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Skilled Nursing Facility Care	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
	Limit 180 days/benefit period		Limit 180 days/benefit period		Limit 170 days/benefit period	
Transplant Services	80% after deductible	50% after deductible	80% after deductible	50% after deductible	70% after deductible	50% after deductible
Precertification Requirements	Yes	Yes	Yes	Yes	Yes	Yes

Benefit	Plan A PPO		Plan B PPO with HRA		Plan C PPO Broad Access	
	Prescription Drugs					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Deductible						
Individual	$25	Not Covered	$25	Not Covered	$25	Not Covered
Family	$75		$75		$75	
Prescription Drug Program						
Retail Drugs	31-day supply		31-day supply		31-day supply	
Generic	$10 copay		$10 copay		$10 copay	
Brand Formulary	$45 copay		$35 copay		$45 copay	
Brand Non-Formulary	$65 copay		$65 copay		$75 copay	
Specialty	$125 copay		$125 copay		$125 copay	
Mail Order Maintenance Drugs	90-day supply		90-day supply		90-day supply	
Generic	$20 copay	Not Covered	$20 copay	Not Covered	$20 copay	Not Covered
Brand Formulary	$90 copay		$70 copay		$90 copay	
Brand Non-Formulary	$130 copay		$130 copay		$150 copay	
Specialty	$250 copay		$250 copay		$250 copay	
Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS, you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy						
	Rx for Health – prescriptions for high cholesterol, diabetes, high blood pressure, asthma, depression					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Rx for Health Retail Drugs	31-day supply		31-day supply		31-day supply	
Generic	$5 copay		$5 copay		$5 copay	
Brand Formulary	$22.50 copay		$17.50 copay		$22.50 copay	
Brand Non-Formulary	$32.50 copay		$32.50 copay		$37.50 copay	
		Not Covered		Not Covered		Not Covered
Rx for Health Mail Order	90-day supply		90-day supply		90-day supply	
Generic	$10 copay		$10 copay		$10 copay	
Brand Formulary	$45 copay		$35 copay		$45 copay	
Brand Non-Formulary	$65 copay		$65 copay		$75 copay	
Specialty Drugs are administered through Accredo Specialty Pharmacy						

Dental

UNITED CONCORDIA®

Dental insurance is available through United Concordia Dental (UCD). You have the freedom to select the dentist of your choice, however visiting an "In Network" dentist in the **Elite Plus** network will have lower out-of-pocket costs.

Dental is a stand-alone plan. Dental insurance is not dependent on having medical insurance.

Team Member Only	Team Member + 1 or more
$18.93	**$51.62**

Plan Features		Plan Pays
Diagnostic & Preventive Services	Examinations, routine cleanings (includes 1 additional cleaning during pregnancy), x-rays, fluoride treatments, space maintainers, sealants	100%*
Basic Services	Fillings	80%
Major Services	Crowns, inlays, onlays, cast restorations	50%
Endodontics	Root Canals	50%
Periodontics	Gum Treatment	50%
Oral Surgery	Incisions, excisions, surgical removed of tooth (includes simple extractions)	50%
Prosthodontics	Bridges, dentures, implants	50%
Orthodontics (children & adults)	Diagnostic, active, retention treatment	50%
Deductibles & Maximums	Calendar-year deductible (per person/per family)	$75/$225 (excludes diagnostic & preventive)
	Calendar-year maximum (per person)	$1,500 (excludes diagnostic & preventive)
	Lifetime orthodontic maximum	$1,000

*Includes Preventive Incentive – diagnostic & preventive services do not count toward your calendar-year maximum!

More about the dental plan:

- United Concordia's nationwide dentist network means you can find affordable, quality care with great service. Their network includes over 95,000 dentists so no matter where you live, you'll probably find two or more in-network dentists within 10 miles of your home.
- To find an in-network dentist, visit www.unitedconcordia.com to search, compare & get directions with their **Find A Dentist** tool.
- United Concordia's **My Dental Assessment** tool helps identify oral health risks and shows how your lifestyle and medical conditions impact the health of the mouth. The assessment generates a detailed report card and includes information for the most common dental issues. Visit www.mydentalassessment.com for more information.
- Teledentistry (Virtual dentistry) - If you have a minor dental problem, virtual visits let you see a dentist right away! Get started at UnitedConcordia.com/Teledentix
- The **Smile for Health** dental benefit provides pregnant women with an additional cleaning during pregnancy.
- United Concordia offers the **College Tuition Benefit** savings program where points can be redeemed for tuition discounts at more than 400 participating private colleges and universities. Sign up at www.unitedconcordia.com.

Remember! Oral Health in Every Stage of Life - Whether you're a kid, senior or somewhere in between, maintaining good oral care keeps you healthier. Brushing, flossing and regular dental checkups are cornerstones of a healthy smile and overall lifestyle.

Vision

Vision insurance is available through EyeMed. You have the freedom to select the provider of your choice, however visiting an "In Network" provider in the **Insight** network will have lower out-of-pocket costs.

Vision is a stand-alone plan. Vision insurance is not dependent on having medical insurance.

Team Member Only	Team Member + 1	Team Member + Family
$7.96	**$14.48**	**$19.66**

Frequency of Service:

	Team Member	Spouse	Children (up to age 26)
Vision Exam	12 months	12 months	12 months
Lenses (in lieu of contact lenses)	12 months	12 months	12 months
Contact Lenses (in lieu of lenses)	12 months	12 months	12 months
Frames	12 months	12 months	12 months

All benefits refresh every January 1.

Service	In-Network	Out-of-Network Reimbursed Amount
Exam (with dilation as necessary)	$0 copay	$30
Frames	$0 copay, $150 allowance, 20% off balance over $150	$40
Contact Lenses (declining balance)		
Conventional	$0 copay, $100 allowance, 15% off balance over $100	$100
Disposable	$0 copay, $100 allowance, plus balance over $100	$100
Medically Necessary	$0 copay, paid-in-full	$250
Standard Plastic Lenses		
Single Vision	$0 copay	$30
Bifocal	$0 copay	$40
Trifocal	$0 copay	$60
Lenticular	$0 copay	$80
Standard Progressive	$55 copay	$60
Premium Progressive Tier 1	$85 copay	$60
Premium Progressive Tier 2	$95 copay	$60
Premium Progressive Tier 3	$110 copay	$60
Premium Progressive Tier 4	$175 copay	$60
Covered Lens Options		
Standard Anti-Reflective	$45 copay	$5
Premium Anti-Reflective Tier 1	$57 copay	$5
Premium Anti-Reflective Tier 2	$68 copay	$5
Premium Anti-Reflective Tier 3	$85 copay	$5
Standard Polycarbonate – under age 19	$0	$5
Standard Polycarbonate – over age 19	$40	$0
Standard Plastic Scratch Coating	$0 copay	$5
UV Treatment – Standard Lenses	$0 copay	$5
Tint (Solid & Gradient) – Standard Lenses	$0 copay	$5
Retinal Imaging	Up to $39	$0
Standard Contact Lens Fit & Follow-up*	$40	$0
Premium Contact Lens Fit & Follow-up	10% off retail price	$0
Photochromic/Transitions Lens	$75	$0

*Contact lens fitting and exam fee are not subtracted $100 contact lens allowance

Eye360 allows members to gain an additional $50 in frame allowance (up to $200) at PLUS Providers in the Insight network. Other discounts through EyeMed include Lasik, Hearing Care, Diabetic Care Services.

Flexible Spending Accounts (FSA)

COBRA participants are eligible to continue their FSA benefit to help pay for health care and dependent care expenses.

	Used For	Minimum Annual Election	Maximum Annual Election
Health Care FSA (HCFSA)	Co-pays, deductibles, Rx, eyeglasses, etc.	$260	$3,200

- Any balance carried over through COBRA.
- Ends at the end of the calendar year.
- A full list of HCFSA eligible expenses is available at https://www.wexinc.com/discovery-benefits/