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"To think is easy. To act is difficult. To act as one thinks is the most difficult."

Johann Wolfgang Von Goethe

"Be the change that you want to see in the world."

Mohandas Gandhi

Welcome to the Egyptian Area Schools Employee Benefit Trust:

Wayne City CUSD #100
Oakland School District #5

Dependent Status Forms Due January 1, 2009

Action Required if you have a Covered Dependent age 19 or older

It's that time of the year again when we request updated Dependent Status Forms. If you have a dependent child age 19 or older enrolled in any of the Egyptian Trust Health, Dental, or Vision Plans you must submit an updated Dependent Status Form before any claims incurred January 1, 2009 forward will be considered for reimbursement. This includes filling prescription drugs. If your age 19 or older dependent is more than 50% dependent on the employee for support, the next update will be due April 1, 2009. If your age 19 or older dependent is a Full Time Student, the next update will be due September 1, 2009. You may obtain a copy of the form by visiting www.egtrust.org or requesting a copy from your Employer. If you have any questions please contact Meritain Health Customer Service Dept. at (800) 844-7979. Updated dependent status forms may be mailed to:

Meritain Health
300 Corporate Parkway
Amherst, NY 14226

Or fax to:
(888) 525-2799

'Tis The Season To Live Healthy

Surrender To Guilt-Free Cookies

Wave the white flag of surrender and bake a batch of these guilt-free cookies.

Chocolate-Chocolate Chip Cookies

Ingredients

1 cup	all-purpose flour	1/2 cup	sugar, granulated
1/4 tsp	baking soda	1/3 cup	unsweetened cocoa
1/8 tsp	salt	2	large egg whites
1/4 cup	butter, softened	1/3 cup	semi-sweet miniature chocolate chips
1/2 cup	brown sugar, packed		

Instructions

Combine flour, baking soda and salt in a large bowl. Set aside.

Beat Butter and brown sugar with mixer until light and fluffy. Add granulated sugar, cocoa and egg whites, continue beating.

Then add flour mixture. Stir in chocolate chips.

Spoon 1 ½ inches apart on a sheet coated with cooking spray. Bake at 350 degrees for 10 minutes.

Yield: 40 cookies

Serving size: 1 cookie

Weight Watchers® points value: 1 point

Best Wishes for Happy and Safe Holidays to you and yours from all of us at Meritain Health !

Bronze Health Plan Benefit Enhancements Effective January 1, 2009

Pending the Board of Manager's final approval at the January 21, 2009

meeting, the following Benefit Enhancements will become effective January 1, 2009. Each calendar year thereafter, the Bronze Plan will follow the guidelines as established below.

1. Tier I deductibles for Individual and Family amounts will be the minimum amounts established by the Federal Government each January 1.
2. Tiers II-IV deductible for an Individual will be \$400 higher than the Tier I amount.
3. Tiers II-IV deductibles for Families will be two times the Tier II-IV Individual deductible.
4. Tier II out of pocket maximums for the Individual and Families will be three times the Tier II deductibles.
5. Tiers III and IV out of pocket maximums will be the maximum amounts established by the federal government each January 1.

Maximums	Current Bronze Plan				January 1, 2009 Bronze Plan			
	Tier I	Tier II	Tier III	Tier IV	Tier I	Tier II	Tier III	Tier IV
Individual Deductible	\$1,100	\$1,500	\$1,500	\$1,500	\$1,150	\$1,550	\$1,550	\$1,550
Family Deductible	\$2,200	\$3,000	\$3,000	\$3,000	\$2,300	\$3,100	\$3,100	\$3,100
Individual Out of Pocket	\$5,600	\$5,600	\$5,600	\$5,600	\$3,450	\$4,650	\$5,800	\$5,800
Family Out of Pocket	\$11,200	\$11,200	\$11,200	\$11,200	\$6,900	\$9,300	\$11,600	\$11,600

You may not make any changes to your Health Plan or coverage elections on January 1, 2009 unless you have a qualifying event. See page 28 and 29 of your Plan Document for details.

The Bronze Plan is a High Deductible Health Plan (HDHP), designed to qualify for use with a Health Savings Account (HSA). All charges except charges for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. All benefits, unless otherwise specified, are based on Usual, Customary and Reasonable (UCR) charges, or the network contracted amounts, and are subject to the deductibles, benefit percentages and maximum amounts shown in the Schedule of Benefits. You may obtain a copy of the Bronze Plan Schedule of Benefits by visiting the Egyptian Trust website at www.egtrust.org.

If you have any questions concerning this Health Plan please contact:

Meritain Health
Customer Service Dept.
at (800) 844-7979

Vendor/Consultant Websites/Phone

Health & Dental

View your protected claims and eligibility and more at:

www.myMeritain.com

**Member Services Phone
800-844-7979**

Prescription Drugs

View your protected prescription drug claims history and more at:

www.express-scripts.com

**Member Services Phone
800-451-6245**

Egyptian Trust

View information about Egyptian Trust, programs offered by the Trust, historical newsletters, and more at:

www.egtrust.org

HealthLink Providers

Find a Tier 1 or Tier 2 Participating Provider, create a Customized Directory, and more at:

www.healthlink.com

To pre-certify required procedures and hospital confinements contact HealthLink at:

**Member Services Phone
800-624-2356**

UniView Vision Plan

To find a participating Uniview provider go to:

www.unicare.com

**Member Services Phone
888-884-8428**

2008 Frequently Asked Questions

As 2008 comes to a close, Meritain Health has gathered a list of the most frequent inquiries over the past 12 months. As we move into the new year, we will continue to address your frequent inquiries and update the Egyptian Trust website as a single source for all of your Egyptian Trust needs including Schedules of Benefits, Plan Documents, Contact Information, links to all the contracted vendors, forms and many more items of interest. Visit the website at www.egtrust.org. The following information can also be found in your Health Plan Document, your Dental Plan Document, or your Life Insurance certificate.

Voluntary Dental Plan – Claims filing guidelines for 1 cleaning under health plan and 1 cleaning under voluntary dental plan.

If you are covered by one of the Egyptian Trust **Health** Plans, the Plan also includes minimal dental coverage. The **Health** Plan allows **1 preventive visit** payable at 100% each calendar year including the following services:

- Prophylaxis
- Bitewing X-rays
- Fluoride Treatment for dependents under age 19
- Oral Exam
- Full Mouth X-ray

If you are covered by one of the Egyptian Trust **Voluntary Dental Plans** (either High Plan or Low Plan), the Voluntary Dental Plan allows **1 preventive visit** each calendar year.

Your dental claims should be submitted to the following address regardless of whether you are filing under the Health Plan or the Voluntary Dental Plan:

Meritain Health
P. O. Box 853921
Richardson, TX 75085-3921
(800) 844-7979

www.myMERITAIN.com

Meritain Health will determine whether you are enrolled in one of the Health Plans, the Voluntary Dental Plan, or both and then process under the proper plan. Remember that you must be enrolled in one of the **Health** Plans and one of the Voluntary **Dental** Plans to be eligible for two preventive visits each calendar year.

I am over age 50 and had a colonoscopy as recommended by my physician. The Plan states the calendar year deductible does not apply for a routine colonoscopy. However, when my claim was processed, the calendar year deductible was applied.

When visiting your physician for preventive or routine purposes, your physician should submit the claim indicating the “preventive” or “routine” diagnosis codes. Often times, during a procedure being performed for preventive purposes, a medical condition is found. When this occurs, the provider may submit the claim with a medical diagnosis. In this case, the calendar year deductible will apply. To correct the claim and waive the calendar year deductible, the member will be required to contact their physician and either :

- a) have the physician resubmit the bill indicating the routine diagnosis or
- b) have the physician submit a written statement indicating the purpose for ordering the colonoscopy.

Upon receipt of the information, Meritain will adjust the claim as necessary.

If you receive a colonoscopy for purposes of a medical condition, the calendar year deductible will apply.

The Egyptian Trust Health Plans contain 4 tiers of benefits. What does this mean? Do I have to choose the “Tier” of provider when I enroll in one of the Health Plans?

Each of the Egyptian Trust Health Plans has 4 tiers of benefits. The benefit tier is based on the type of provider used. You may use any provider you choose, however, the benefits will differ dependent on the “tier” of the provider used. Tier 1 and Tier 2 providers are contracted with Healthlink to provide discounted services where Tier 3 and Tier 4 providers are Non-Network and do not provide discounted services.

Tier 1

Tier 1 providers are those who participate in Healthlink’s HMO network.

When you use a Tier 1 provider, your claims will be processed based on the calendar year deductible, maximum out of pocket, reimbursement percentage as shown under Tier 1. Utilizing Tier 1 providers will afford you the deepest discounts, lowest deductible and out of pocket, and the highest benefit reimbursement.

Tier 2

Tier 2 providers are those who participate in Healthlink’s PPO network.

When you use a Tier 2 provider, your claims will be processed based on the calendar year deductible, maximum out of pocket and reimbursement percentage as shown under Tier 2.

Tier 3

Tier 3 providers are Non-Network providers.

Your benefits are paid at Tier 3 when you use Non-Network Providers outside the Metro St. Louis Area. The Metro St. Louis Area includes St. Charles County, St. Louis County and St. Louis City in Missouri, and Madison County, St. Clair County and Monroe County in Illinois.

Tier 4

Tier 4 providers are also Non-Network providers.

Your benefits are paid at Tier 4 when you use Non-Network Providers within the Metro St. Louis Area. The Metro St. Louis Area includes St. Charles County, St. Louis County and St. Louis City in Missouri, and Madison County, St. Clair County and Monroe County in Illinois.

How do I find a provider that is Tier 1 or Tier 2?

For information about providers in the HMO (Tier 1) and PPO (Tier 2) networks, refer to HealthLink’s website. The website is updated weekly and will provide the most current information. To find a network provider via Healthlink’s website:

Go to: www.healthlink.com

Click on “**Find a Doctor**”

Select a Network: Click on “Open Access III(includes Tier 1/HMO and Tier 2/PPO)”

You may then follow the steps to search for providers by specialty, name, facility name, location, etc. Your search will first display all HMO (Tier 1) providers and then PPO (Tier 2) providers.

You may also contact Healthlink at 1(800) 624-2356

Healthlink’s telephone numbers and website are also listed on your I.D. card and at the beginning of the Plan Document.

What is a “qualifying event” and why is it important to report a “qualifying event” to my employer? How many days do I have to report a “qualifying event” and when will the change become effective?

What is a “qualifying event”?

A “qualifying event” or “qualifying change in status” means:

- a) a Family Status change;
- b) an Employment Status change;
- c) entitlement to coverage under Medicare, Medicaid or any other government health insurance program, or loss of such coverage.

A **Family Status Change** means any of the following:

- a change in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;
- a change in the number of dependents, including birth, death, adoption and placement for adoption;
- an event that causes an eligible dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age, marriage, change in student status or other similar circumstance;
- a change in place of residence to a location outside the Plan’s Designated Area;
- a change that makes an Employee or dependent eligible for Special Enrollment Rights, as described below;
- a judgment, decree or order, including a Qualified Medical Child Support Order, that requires you to provide coverage for a child under this Plan or requires your spouse or former spouse to provide coverage for the child under another plan.

An **Employment Status Change** means any of the following events that changes your employment status or the employment or coverage status of your spouse or other dependent:

- commencement or termination of employment;
- a strike or lockout;
- commencement of or return from an approved leave of absence;
- a change in work location or other change in employment status with the consequence that you and/or your dependents become (or cease to be) eligible to participate in this Plan or in a plan sponsored by the employer of your spouse or dependent (e.g., a spouse changes from full-time to part-time or from salaried to hourly paid with the consequence that the spouse and/or dependents cease to be eligible to participate in an employer-sponsored plan);
- the open enrollment period for the health benefit plan of your spouse or dependent if that period does not coincide with the open enrollment period in this Plan;
- the annual TRS insurance plan open enrollment period for retired employees and their dependents.

Why is it important to report a “qualifying event” to my employer? How soon must I report a “qualifying event” to my employer?

When a “qualifying event” or “qualifying change in status” occurs you have special enrollment rights under federal law. However, there are limitations and time frames in which you must report the “qualifying event” in order to take advantage of your special enrollment rights. In most cases, you are required to provide your Employer with written evidence of the applicable change in status within 31 days of the qualifying event in order to change your coverage elections outside the annual open enrollment period.

Example 1: You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within **30 days** after your regular coverage under the Plan ends because of a qualifying event. You will have the same special enrollment right at the end of your period of COBRA coverage if you elect COBRA coverage for the maximum period available to you.

Example 2: If an Employee did not enroll in the Health Plan when first eligible, but then acquires a new dependent, the employee may exercise their right to enroll within **31 days** after acquiring a new dependent. In this case, the new dependent will not be subject to pre-existing conditions limitations because the dependent is enrolled when first eligible. However, the Employee who was eligible to enroll earlier but chose not to enroll at that time may be subject to a pre-existing conditions limitation period of up to 12 months. If you do not enroll in the Plan when you are first eligible and later enroll under these Special Enrollment Rights, you may still be subject to a pre-existing conditions limitation period of up to 12 months.

Example 3: If you (an Employee or dependent) declined coverage when you were first eligible because you had coverage under another medical plan, you will not be considered a Late Entrant if you enroll in this Plan within **31 days** after you lose the other coverage, if the reason you lose the other coverage is one of the following reasons:

- the other coverage was COBRA continuation coverage and your period of COBRA coverage was exhausted;
- the other coverage was terminated as a result of loss of eligibility, including loss of eligibility due to separation, divorce, death, termination of employment, or reduction in the number of hours worked; or
- the other coverage was terminated because the employer ceased making contributions for the coverage.

[In the case of a “qualifying event” where I wish to change my coverage, when will the change become effective?](#)

The effective date of your coverage change as the result of a “qualifying event” will be the date of the “qualifying event”.

If you are ever in doubt of your options to add or change your coverage, advise your Employer of your situation who will be able to assist you in determining the options available to you and your family. All of this information is also contained in your Plan Document Booklet.

While attempting to fill a prescription drug, the pharmacist is telling me I have been denied for coverage.

There are several reasons a prescription drug may be turned down at the pharmacy. Following are the most commonly identified reasons for denial:

1. **Dependents over age 19** – Meritain has not received the updated Dependent Status form indicating the dependent over age 19 continues to be either a Full Time Student or more than 50% dependent upon the Employee for support.

If the dependent is a Full Time Student you are required to submit this form no less than twice per calendar year. If the dependent is more than 50% dependent on the Employee for support you are required to submit this form no less than four times per calendar year. You may obtain the Dependent Status form from your employer or at www.egtrust.org.

Upon receipt of this information, Meritain Health will update the eligibility records accordingly and the dependent child will have the ability to fill their prescription drug.

2. **Member is not covered** – When a member enrolls for health plan coverage, the enrollment information is submitted by the employer’s Bookkeeper to Meritain Health. Meritain Health enters the enrollment information and then updates the Express Scripts records. From the time that Meritain Health receives the enrollment information, it normally takes 72 hours to update our records, issue an ID card, and update Express Scripts records. If you require a prescription prior to the time allowed to get the Express Scripts records updated, you may contact Meritain Health at 1(800)844-7979 and the Customer Service Dept. will assist you in getting your prescription drug filled.

3. **Drug requires Prior Authorization** - Certain drugs require prior authorization which must be obtained prior to filling your prescription. You must contact Meritain Health at 1-800-844-7979 to obtain prior authorization. Fertility Drugs and Prescription strength vitamins are examples of drugs that require prior authorization.

4. Step Therapy Drugs – The Plan uses a step-therapy program for certain classes of medications. For new prescriptions in these drug classes, you must try a “step-one” drug (generally a generic drug) first. If the step-one drug does not work for you, your physician may provide documentation of such and you may obtain a step-two drug in the same class. Your pharmacist will notify you if a new prescription is subject to step-therapy. You may also contact Express Scripts with questions about step-therapy.

If you ever have questions about your prescription drug plan please contact the following:

Pharmacy Help Desk: (800) 235-4357
Member Customer Services: (800) 451-6245

www.express-scripts.com

Basic Life Insurance and Optional Life Insurance - Eligibility for Coverage

In order to be eligible for the Employee Basic Life Insurance you must :

- a. be actively employed a minimum of 10 hours per week and
- b. enroll within 31 days of your eligibility date.

In order to be eligible for the Optional Employee Life Insurance you must:

- a. Be actively employed a minimum of 10 hours per week and
- b. Participate in the Basic Life Insurance then
- c. *The employee may elect up to \$75,000 of insurance with no medical underwriting (guaranteed issue) as long as the employee enrolls within 31 days of the date first eligible.

*If the employee enrolls more than 31 days after the date first eligible, they may enroll in the program. However, all amounts are then subject to medical underwriting and coverage is not guaranteed.

In order to be eligible for the Optional Spouse Life Insurance you must:

- a. The employee must be employed a minimum of 10 hours per week and
- b. The employee must participate in the Basic Life Insurance and
- c. The employee must elect Optional Employee Life Insurance then
- d. *The spouse may elect up to 50% of the amount of the Optional Employee Life Insurance up to \$25,000 of insurance with no medical underwriting (guaranteed issue) as long as the employee and spouse enroll within 31 days of the date first eligible.

**If the employee enrolls more than 31 days after the date first eligible, they may enroll in the program. However, all amounts are then subject to medical underwriting and coverage is not guaranteed

In order to be eligible for the Optional Dependent Life Insurance you must:

- a. The employee must be employed a minimum of 10 hours per week and
- b. The employee must participate in the Basic Life Insurance and
- c. The employee must elect Optional Employee Life Insurance then
- d. The employee may enroll for Dependent Life Insurance in the amount of \$5,000 or \$10,000.

Note: You are not required to participate in the Health Plan in order to be eligible for the Basic or Optional Life Insurance.

Basic Life Insurance and Optional Life Insurance - Termination of Coverage

Your Basic Life Insurance and Optional Life Insurance will end when

- a. You retire or
- b. Your employment terminates or
- c. Premium payment discontinues or
- d. You request termination of the coverage

Ceasing Active Work results in termination of insurance; but coverage may be continued as follows:

- 1) If the Insured Person is disabled due to illness or injury, then coverage may be continued:
 - a. Until the Person is no longer disabled;
 - b. Provided premium payments are made on his or her behalf; or
 - c. For life insurance, the date the Insured Person qualifies for any Extension of Death Benefit under the Policy.
- 2) If the Insured Person ceases work due to a temporary lay off, an approved leave of absence, or a military leave; then coverage may be continued:
 - a. For six Insurance Months after the lay off or leave begins;
 - b. Provided premium payments are made on his or her behalf.

Note: Upon your retirement or termination of employment you may choose to convert your life insurance to an individual policy. You may do so by contacting Lincoln Financial Group at:

Phone: 1(800) 423-2765

www.lfg.com

This information is also available at www.egtrust.org

– Step Therapy – Overview

1. What Is Step Therapy?

Step Therapy is a program especially for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma or high blood pressure. The program is a new approach to getting you the prescription drugs you need, with safety, cost and – most importantly – your health in mind.

The program makes prescription drugs more affordable for most members and helps our organization control the rising cost of drugs. It allows you and your family to receive the affordable treatment you need and helps our organization continue with prescription-drug coverage.

In Step Therapy, the covered drugs you take are organized in a series of —steps,[®] with your doctor approving and writing your prescriptions.

The program usually starts with generic drugs in the “first step.” Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by our plan have been proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable: Your copayment is usually the lowest with a first-step drug.

More expensive brand-name drugs are usually covered in the “second step,” even though the generics covered by our plan have been proven to be effective in treating many medical conditions.

Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs covered by our plan. For instance, your doctor must write your new prescription when you change from a second-step drug to a first-step one.

2. Who decides what drugs are covered in Step Therapy?

Step Therapy is **developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts**. Together with Express Scripts — the company chosen to manage our pharmacy benefit plan — they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Then they recommend appropriate prescription drugs for the Step Therapy Program, **and our organization’s pharmacy benefit plan chooses the drugs that will be covered**.

What Happens at the Pharmacy

3. Why couldn’t I fill my prescription at the pharmacy?

The first time you submit a prescription that isn’t for a first-step drug, your pharmacist will tell you there’s a note on the computer system indicating that our plan uses Step Therapy. This simply means that if you’d rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug.

To receive a first-step drug:

Ask your pharmacist to call your doctor and request a new prescription,
OR

Contact your doctor to get a new prescription.

Only your doctor can change your current prescription to a first-step drug covered by your program.

4. How do I know what “first-step” drug my doctor should prescribe?

You can call Express Scripts at the number on the back of your prescription card. An agent can give you some examples of possible prescription drugs for you to discuss with your doctor.

5. I need a prescription filled immediately. What can I do?

At the pharmacy, you may be informed that your drug isn't covered if you've just started taking a prescription drug regularly or if you're a new member of our plan. If this occurs, and you need your medication quickly, you can:

Talk with your pharmacist about filling a small supply of your prescription right away. You may have to pay full price for this drug. Then, ask your doctor to write you a new prescription for a first-step drug, so you're sure your medication will be covered by our plan. Remember: Only your doctor can approve and change your prescription to a first-step drug.

To Receive a Second-Step Drug

6. I've already tried the first-step drugs on the list. What can I do?

With our Step Therapy Program, more expensive brand-name drugs are usually covered in a later step if:

- 1) you've already tried the generic drugs covered in our Step Therapy Program,
- 2) you can't take them (for instance, because of an allergy), or
- 3) your doctor decides you need a brand-name drug for medical reasons.

If one of these applies to you, your doctor can ask for a —prior authorization for you to take a second-step prescription drug. Once the prior authorization is approved, you pay the appropriate copayment for this drug. If the prior authorization is not approved, you may have to pay the full price for the drug.

7. What happens if my doctor's request for a prior authorization is denied?

Our pharmacy benefit plan's guidelines exclude certain drugs from coverage. To learn more about what drugs are excluded under our plan, look in your copy of your member handbook.

For a copy of the criteria our plan uses to decide which prior authorizations will be covered, call the Patient Care Contact Center at Express Scripts — the company we've chosen to manage our pharmacy benefit. An agent can send you a copy of the criteria. The number to call is on the back of your prescription card.

OR

If you want to file an appeal to have your prescription drug covered, our plan has an appeals process. Call Express Scripts at the number on the back of your prescription card to get the address you should to.

8. I filed an appeal and it was denied. What can I do?

You can talk with your doctor again about prescribing one of the safe, effective first-step drugs covered by our plan's Step Therapy Program. Your copayment will usually be the most affordable for one of these drugs. Or you can pay the full price of a drug that isn't covered by our pharmacy benefit plan.

More About Generic Drugs

9. What are generic drugs?

Generic alternatives have the same chemical makeup and same effect in the body as an original brand-name drug, except generics usually have a different name, color and/or shape. Generics have been rigorously tested by the U.S. Food & Drug Administration (FDA) and approved as safe and effective.

Unlike manufacturers of brand-name drugs, the companies that make generic drugs don't spend a great deal of money on research and advertising. So their generic drugs cost less than the original brand name — and they can pass the savings on to you.

Following are some commonly asked questions that new UniView Vision members may have. We hope you will find this helpful in assisting you in understanding our program.

1. What is covered in a comprehensive eye exam?

Some of the tests and procedures performed with these exams include:

- Case history
- Evaluation of visual system's status
- Refractive status
- Binocular function
- Assessment, diagnosis and treatment plan

2. Are contact lens fitting fees included in the vision exam?

Professional contact lens fitting fees are not considered a part of routine eye care and are not included in the vision exam. However, members who receive a contact lens fitting from a provider who also dispenses their contact lenses can apply the excess of their materials benefit, if any, toward the cost of the fitting. It is important to remember that contact lenses must be purchased from the same provider who performed the fitting, and that only the balance of the materials benefit, after purchasing contact lenses, can be applied toward the fitting fee.

3. Are disposable contact lenses covered?

Disposable contact lenses and daily wear are covered under the materials benefits.

4. Can I purchase contact lenses and glasses?

Members who choose the contact lens benefit elect to receive contact lenses in lieu of frames and spectacle lenses. However, members are able to purchase additional eyewear from UniView Vision providers from a 15%- 40% discount.

5. Does UniView Vision cover lasik surgery?

UniView Vision offers discounts on lasik surgery through Special Offers.

6. Does UniView Vision cover nonprescription items like sunglasses?

UniView Vision providers offer members a discount pricing, which is significantly below retail. They receive substantial savings (15%-40% or more) on additional eyewear pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items.

7. Do I have a UniView Vision identification number?

Members and their dependents will receive an Identification card with an ID number. Members should present their ID card at the time of service.

8. Do I have to use UniView Vision providers?

Our national network was established to provide all members with convenient access to a panel provider; however, for those members who prefer to visit an out-of-network provider, a separate benefit is available for most plans.

9. How often can I use my benefits?

Members can contact the UniView Vision customer service by calling 888-884-8428 for frequency and benefit information. Once a member's benefits are exhausted, he/she is entitled to purchase materials from UniView Vision providers utilizing the Additional Savings Program as frequently as desired.

10. Do you offer a provider directory?

PDF provider directories are available at:

http://worknet.auth.wellpoint.com/specialtyseiorstatesponsored/specialty/specialty-sales/articles/PW_A000764.do. Up to date provider information is available by visiting www.UniView.com or by calling the customer service phone number 888-884-8428.

11. Will UniView Vision add providers to the network at our request?

UniView Vision continuously monitors our network to determine areas where recruiting would be beneficial. Our Provider Relations Department has associates solely devoted to provider recruiting who will work with clients to improve access in key areas as needed. Additionally, UniView Vision can extend a credentialing packet to eye care providers who your employees have identified as preferred providers. These providers would need to accept all terms under our Professional Provider Agreement and be credentialed before accepting UniView Vision members as patients.

12. Is there a copay on frames & lenses?

The co-pay on materials applies to the lenses. There is not a separate copay on the frames.

13. Who do I call if I need further information?

Members are encouraged to call the Customer Service phone number at 888-884-8428 for more information regarding their benefits or locating providers in their area.