Global Home Care
Group #861

Changes Effective February 1, 2022
Summary of Benefit for Full-Time Members:

Annual maximum $2,500 Per covered individual
Annual Calendar Year Deductible $100 per Individual, $300 per Family applies to Basic and Major only

In Network Benefits Only:
Preventive 100% of allowable charge, Basic 80% of allowable charge and Major 50% of allowable charge (Sele-Dent Fee Schedule)

FREQUENCIES:

- **Examination:** Two times per consecutive 12 months
- **Prophylaxis/Perio Maintenance:** Two times per consecutive 12 months to a maximum of 2 total prophy and Perio maintenance procedures in any 12 consecutive months
- **Full Mouth or Panoramic Xray:** Once every 36 months
- **Fluoride:** 1 per consecutive 12 months under the age of 16
- **Sealants:** 1 time per first or second permanent molar every 36 consecutive months under the age of 16
- **Perio Scaling 4341:** 1 time per quadrant per consecutive 24 months
- **Perio Surgery:** 1 quadrant or site per consecutive 36 months per area
- **Major work:** 5 years replacement on major
- **Anesthesia:** Covered when clinically necessary

Exclusions:

- **Implants, occlusal guards, veneers, Orthodontia and TMJ:** Not covered

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Vision Insurance for the whole family

VISION PLAN	
Vision Care Deductible	None
Annual Maximum per Plan year	$350 per Covered Individual

This plan has a $350 allowance per member, per plan year that can be applied to any covered procedure. Once allowance is met, any additional charges and/or expenses will be the Member's responsibility. Members are ultimately responsible for the verification as to the accuracy and appropriateness of all applicable fees.

Covered Procedures

Eye Exam: $0 Copay
Lenses:
    Standard Single Vision: $35 Copay
    Standard Bifocal: $50 Copay
    Standard Trifocal: $65 Copay
    Standard Progressive: $105 Copay
Frames: $85 Copay
Contact Lenses: $50 Copay
    Fit and Follow-up included

Limitations

Once a plan year benefit for exams, frames and lenses or elective contacts lenses. Contact Len sfit, evaluation and follow-up care cost may vary by provider. Member is responsible for all copa ysand balances after $350 allowance has been reached.

Vision Exclusions

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Corrective eyewear required by an employer as a condition of employment.
- Services provided as a result of any Workers Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, State or subdivisions thereof.
- Plano non-prescription lenses and non-prescription sunglasses.
- Services or materials provided by any other group benefit providing vision care.

For Benefits Information
Visit www.surecarebenefits.com
833-258-7516