

## VISION INSURANCE

Company: NVA (National Vision Administrators)  
 Telephone: 1-800-672-7723  
 Group: 8662  
 Open Enrollment: May to be effective September 1  
 (One time to enroll or add dependents, if not done at the time of the event.)  
 Effective: 1st of the month after date of hire

### BENEFITS

#### EXAM

### IN-NETWORK

Covered 100%

### OUT-OF-NETWORK

Up to \$48

#### LENSES

Standard Glass or Plastic Covered 100%

Single Vision Up to \$63

Bi-Focal Up to \$72

Tri-Focal Up to \$90

Lenticular Up to \$110

#### LENS OPTIONS

Progressives (Standard) 100%

Progressives (Premium) 100%

N/A

N/A

#### FRAME

Covered up to \$44 (20% off remaining balance over \$44 allowance)

Up to \$44

#### CONTACT LENSES

Up to \$150 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over \$150)

Up to \$150

Benefit year: January - December

## FSA, HSA and DEPENDENT CARE ACCOUNT

Company: HealthEquity  
 Telephone: 1-866-346-5800  
 Plan year: September - August

## EMPLOYEE ASSISTANCE PROGRAM

Company: ULLIANCE  
 Telephone: 1-800-448-8326  
[www.lifeadvisor.com](http://www.lifeadvisor.com)

## FINANCIAL ASSISTANCE PROGRAM

Company: Your Moneline  
 Telephone: 1-833-890-4077  
[yourmoneyline.com/pccsk12](http://yourmoneyline.com/pccsk12)

**\*NOTE:** All insurance claim forms are available in the school office and in the Employee Benefit office.

<b>SEPTEMBER 1, 2025 - AUGUST 31, 2026</b>		
<b>BCBS BLUE CARE NETWORK HMO</b>	<b>Plan Choice #9 (BCN HMO) Compatible with FSA account</b>	<b>Plan Choice #10 (BCN HMO HSA) Compatible with HSA Account</b>
<b>Plan Design</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Deductible (Single/Family)</b>	<b>\$2,000/\$4,000</b>	<b>\$3,000 (need to meet before anything covered)/\$6,000 (2 or more members need to meet family deductible before anything is covered).</b>
<b>Office Visit / Urgent Care</b>	<b>\$30 office visit/\$65 urgent care copay</b>	<b>80% after deductible</b>
<b>Emergency Room</b>	<b>\$300 copay (waived if injury or if admitted)</b>	<b>80% after deductible</b>
<b>Preventive Care</b>	<b>100% (not subject to deductible)</b>	<b>100% (not subject to deductible)</b>
<b>Coinsurance</b>	<b>80% after deductible</b>	<b>80% after deductible</b>
<b>Coinsurance Maximum (Single/Family) Not Including Deductible</b>	<b>\$1,500 / \$3,000</b>	<b>N/A</b>
<b>Prescription Drugs</b>	<b>\$15 Generic \$50 Brand 50% (\$70 min/\$100 max) Non Preferred Brand (Mail Order x 2)</b>	<b>\$15 Generic after ded. \$50 Brand after ded. 50% (\$70 min/\$100 max) Non Preferred Brand after ded. (Mail Order x 2)</b>
<b>Out-of-Pocket Maximum</b>	<b>\$6,350 per member/\$12,700 for 2 or more members per calendar year</b>	<b>\$4,000 per member/\$8,000 for 2 or more members per calendar year</b>
<b>In-Network includes applicable deductibles, coinsurance and copays. Out-of-Network excludes copays</b>		