PSEACare Dental & Vision Plan Coverage

Quality/Affordable Insurance for Retirees

Program Information:

- PSEA-Retired Members and eligible dependents can enroll in the PSEACare Dental & Vision Insurance.
- Enroll anytime throughout the year, payments accepted within 60 days prior to the start of the coverage period.
- Payments can be made by your choice of monthly ACH withdrawals or yearly by check.

Dental Coverage Overview:

- Dental program is administered by United Concordia utilizing the **Advantage Plus** Network of Dentists. Visit www.ucci.com, click on **Find A Dentist** and select the Advantage Plus network for a list of providers in your area.
- For general questions regarding this program please call the PSEA Health & Welfare Fund @ (800)944-7732, ext. 7024. For claim and network questions please call UCCI @ (800)332-0366, group number 898381001

Vision Coverage Overview:

- Vision program is administered by National Vision Administrators (NVA). For a list of participating providers, visit www.e-nva.com, click on **Find Provider** and enter group/sponsor number 00350124.
- For general questions regarding this program please call the PSEA Health & Welfare Fund @ (800)944-7732, ext. 7024. For claim and network questions please call NVA @ (800)672-7723.

2024 Cost of Coverage for PSEACare Dental & Vision Plan:

Individual Coverage Annual Cost = $522 / Individual Coverage Monthly ACH Payment Option = $44

Two-party Coverage Annual Cost = $1044 / Two-party Coverage Monthly ACH Payment Option = $88

Family Coverage Annual Cost = $1566 / Family Coverage Monthly ACH Payment Option = $132

Rates shown are guaranteed for the 12 month benefit contract period.

Opting out of the program can only occur at each annual enrollment period. For those who pay via ACH, notification to the PSEA Health & Welfare Fund must be made at least 30 days prior to the start of the next contract year.

For additional information please call 1-800-944-7732 Ext. 7024

Details of benefits are listed on the reverse side ⟶

PSEACare Dental and Vision Coverage Summary

Dental Benefit Coverage [1]	In-Network	Out-of-Network Reimbursement
Class 1 - Diagnostic/Preventive Routine Oral Examinations and Cleanings - *Twice during the 12-month contract period* Routine Bitewing X-rays - *Twice during the 12-month contract period* Full Mouth X-rays - *Once every 36 months* Fluoride & Space Maintainers *(to age 14)*, Sealants *(to age 16)*	Covered at 100%	Covered at 100% (100% of MAC*)
Class 2 – Basic Services Basic Restorations – Amalgam or White Resin - White resin coverage available for all teeth Simple Extractions Endodontics – Pulpal therapy and root canal filling Denture Repair	Covered at 70%	Covered at 60% (60% MAC*)
Class 3 – Major Services Major Restorative – Inlays, onlays, single crowns (caps) Oral Surgery – Extraction and oral surgery procedures Prosthodontics – Construction/Repair of dentures, bridges etc Periodontics – Surgical and non-surgical treatment of gum disease	Covered at 60%	Covered at 50% (50% MAC*)
Implants (Implant coverage is available after being enrolled in the plan for at least 12 months)	Covered at 50%	Covered at 50% (50% MAC*)
Program Deductibles and Maximums Contract Year Deductible (Deductible does not apply to Class 1 Services) Contract Year Program Maximum Benefit Payments - Program Maximum Benefit Excludes Class 1 Claims	$50 per person $2,250 Per Person	

*MAC – Maximum Allowable Charge of United Concordia. Out-of-Network Providers may bill above the maximum allowable charge.

Vision Benefit Coverage [1]	In-Network	Out-of-Network Reimbursement
Examination (One vision exam every 24 months)	Covered in Full	$ 27 Maximum
Tonometry	Covered in Full	$ 3 Maximum
Frames (Frames and one pair of lenses every 24 months)	Up to $100 Retail	$ 30 Maximum
Lenses – Single Vision (pair)	Covered in Full	$ 24 Maximum
Lenses – Bifocal (pair)	Covered in Full	$ 36 Maximum
Lenses – Trifocal (pair)	Covered in Full	$ 46 Maximum
Lenses – Aphakic (pair)	Covered in Full	$ 72 Maximum
Low Vision Aids (Every 24 months, in lieu of exam, lenses, and frames)	Up to $250 Retail	$250 Maximum
Contacts - Medically Necessary **	Up to $250 Retail	$250 Maximum
Contacts - Cosmetic ** ** Every 24 months, in lieu of exam, lenses, and frames	Up to $75 max	$ 75 Maximum

[1] **Subject to limitations and exclusions, see Summary Plan Document for details at www.pseahwf.org/retired_members/**

Rev January 2024