



Effective October 1, 2023 through September 30, 2024

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per Plan year	\$100 Individual \$300 Family	
Annual Medical Out-of-Pocket Maximum	The combined total for your deductible(s), coinsurance and copays per calendar year. Ambulance, blood bank and emergency room services apply towards the In-Network amount	\$2,200 Individual \$4,400 Family	\$3,300 Individual No family cap
Coinsurance		10%	30%
<ul style="list-style-type: none"> Be aware that your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill you for the difference between the amount charged and our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum. Medical Deductible applies unless otherwise stated below. UHC: Services provided at the University of Oregon Health Center (UHC) are covered in full unless otherwise noted. 			
Medical Services		What You Pay	
	UHC	In-Network	Out-of-Network
Primary and Specialist Care Visits (for Illness or Injury)	No charge, deductible waived	10%	30%
Urgent Care Visits	Not available	Covered the same as if you visit a health care provider's office or clinic (Primary Care Visit or Specialist Visit) or if you have a test (Radiology and Laboratory or Complex Imaging).	
Other Professional Services	No charge, deductible waived	10%	30%
Preventive Care	No charge, deductible waived	No charge, deductible waived	30%
<ul style="list-style-type: none"> Immunizations – Adult and Children 			
<ul style="list-style-type: none"> Routine Mammograms, Routine Colonoscopy, Prostate Cancer Screening 	Not available	No charge, deductible waived	30%
<ul style="list-style-type: none"> Routine Physicals, Well Baby, Well Child, Well Woman visits 	No charge, deductible waived	No charge, deductible waived	30%
Radiology and Laboratory - Outpatient	No charge, deductible waived	10%	30%
Complex Imaging	No charge, deductible waived	10%	30%
<ul style="list-style-type: none"> CT/PET, MRI, etc. 			
Acupuncture	10%, deductible waived	10%, deductible waived	30%, deductible waived
<ul style="list-style-type: none"> 20 visits per Plan year No preauthorization required 			
Ambulance Services	Not available	20%, In-Network deductible applies	20%, In-Network deductible applies
Ambulatory Surgical Center	Not available	5%	30%
Durable Medical Equipment	No charge, deductible waived	10%	30%
Emergency Room	Not available	\$50 copay, 10%	\$50 copay, 10%
Hearing Aids and Hearing Aid Assistive Technology	Not available	10%	30%
<ul style="list-style-type: none"> coverage is available for enrollees under 19 years of age or enrolled children 19 to 26 years of age. 			
Hearing Examinations – no limit	Not available	10%	30%
Home Health	Not available	10%	30%
Hospice	Not available	10%	30%
Hospital Care	Not available	10%	30%
Maternity Care	Not available	10%	30%
Mental Health / Substance Use Disorder - Inpatient	Not available	10%	30%

Medical Services		What You Pay	
	UHC	In-Network	Out-of-Network
Mental Health / Substance Use Disorder - Outpatient	No charge, deductible waived	10%, deductible waived	30%, deductible waived
Naturopath Office Visit	Not available	10%	30%
Neurodevelopmental Therapy	10%, deductible waived	10%, deductible waived	30%, deductible waived
Newborn Home Visits <ul style="list-style-type: none"> Within 6 months of age, at least one visit during first 3 months, with up to 3 more available 	Not available	No charge, deductible waived	Not covered
Nutritional Counseling <ul style="list-style-type: none"> 3 visits per Plan year 	Not available	10%	30%
Outpatient Surgery <ul style="list-style-type: none"> Professional & Facility charges 	Not available	10%	30%
Rehabilitation Services – Inpatient <ul style="list-style-type: none"> No limit 	Not available	10%	30%
Rehabilitation Services – Outpatient <ul style="list-style-type: none"> 60 visits per Plan year (30 PT max, 36 massage max) Physical, Occupational, Speech and Massage Therapy No preauthorization required 	10%, deductible waived	10%, deductible waived	30%, deductible waived
Skilled Nursing Facility <ul style="list-style-type: none"> 100 inpatient days per Plan year 	Not available	10%	30%
Spinal Manipulations <ul style="list-style-type: none"> 20 visits per Plan year. No preauthorization required 	10%, deductible waived	10%, deductible waived	30%, deductible waived
Therapeutic Injections	No charge, deductible waived	10%	30%
Virtual Care - Telehealth	Not available	10%, deductible waived	30%

Prescription Medication Benefits – Available at UOHC and a Participating Pharmacy		What You Pay
Tier 1	90-day supply for retail or home delivery (mail-order)	30% retail prescription* / 30% home delivery (mail-order Express Scripts) prescription / \$10 for each self-administrable Cancer Chemotherapy medication
Tier 2	90-day supply for retail or home delivery (mail-order)	30% retail prescription* / 30% home delivery (mail-order Express Scripts) prescription / \$50 for each self-administrable Cancer Chemotherapy medication
Tier 3	90-day supply for retail or home delivery (mail-order)	30% retail prescription* / 30% home delivery (mail-order Express Scripts) prescription / \$100 for each self-administrable Cancer Chemotherapy medication
Specialty Select	Limited to 30-day supply for retail	30% up to \$300 maximum for each Specialty Medication

*1 copay per 30-day supply

Insulin Cost Share Cap: Retail or home delivery (mail-order): \$80 cap on member cost share per 30-day supply; \$240 cap on member cost share up to 90-day supply

You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance
More information about prescription drug coverage is available at <https://regence.com/go/2023/OR/3tier>

Out-of-Area Services

Outside of the service area, members have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the BlueCross BlueShield Global™ Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Out-of-Network, you may be balance billed. Call 1 (800) 810 BLUE (2583) to learn how to get access

Frequently Asked Questions

How is my privacy protected?	Regence is committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information. You can view our full privacy practices online at regence.com .
What if I need access to specialty care? Do I need a referral?	You can receive care from any in-network provider without a referral. For some services, prior authorization may be required.
Is there a cost for "Covered in full"?	No, if your benefit is covered in full there is no copay or deductible.



VSP uses the last four digits of your SSN# as your ID!

~ NOT your Regence member # ~

LifeMap Choice Vision Insurance

with VSP®

For Graduate Teaching Fellows Federation (GTFF)

How the Plan Works

Schedule that annual eye exam and know you're doing good for your body, and with this coverage it won't hurt your wallet. And if you need glasses or contacts, you'll find hundreds of options at affordable prices. You can even choose from some of the latest designer frames.

- **Eligibility Requirement**
If you are a Graduate EE of the University of Oregon working 8 Hours Week and a member of GTFF - Local 3544, or an EE of the GTFF - Local 3544, or an EE of the GTFF Health & Welfare Trust, you will be covered with these benefits.
- **Who pays for the coverage?**
Vision Insurance premiums for employees and covered family members are shared between you and your employer. The premiums owed by you, the employee, will be through payroll deduction.
- **Trusted network**
The VSP network provides world-class services from high-caliber doctors. You also pay little out of pocket when you see an in-network eye doctor.
 - **Network:** VSP Choice Network

In-Network Benefits Summary

Benefit	Description	Copay
WellVision Exam	<ul style="list-style-type: none">• Focuses on your eyes and overall wellness• Every 12 months	\$10
Frame	<ul style="list-style-type: none">• \$200 allowance for a wide selection of frames• 20% off amount over allowance• Every 12 months	\$25 For frame and lenses
Lenses	<ul style="list-style-type: none">• Single vision, lined bifocal, and lined trifocal lenses• Polycarbonate lenses for dependent children• Every 12 months	
Elective Contacts (Instead of glasses)	<ul style="list-style-type: none">• \$200 allowance for contacts and contact lens exam (fitting and evaluation)• 15% off contact lens exam (fitting and evaluation)• Every 12 months	\$25
Additional Coverage	<ul style="list-style-type: none">• Low vision testing (every 24 months)	
Extra Savings and Discounts	Additional Glasses and Sunglasses 20% off from any VSP doctor	
	Retinal Screening Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam	
	Laser Vision Correction <ul style="list-style-type: none">• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

LifeMapCo.com

1 (800) 794-5390



This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.

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Coverage Outside the VSP Choice Network

Visit vsp.com for details if you plan to see an eye doctor outside the VSP network.

Exam	up to \$45	Lined Trifocal Lenses	up to \$65
Frames	up to \$70	Elective Contacts	up to \$105
Single Vision Lenses	up to \$30	Low Vision Test	up to \$125
Lined Bifocal Lenses	up to \$50		

Limitations & Exclusions

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, including any direct complications or consequences that arise from them, as follows:

- Select lens options or coatings
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above the Allowed Amount.
- Expenses incurred prior to the Member's Effective Date under this Policy or after coverage under this Policy terminates.
- Medical or surgical treatment of the eyes.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a $\pm .50$ diopter power).
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Two pair of glasses in lieu of bifocals.

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GTFF - PPO

Benefit Year: Contract Year

This plan covers the following services when performed by a provider to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food).

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the allowable fee. In-network providers agree not to collect more than the allowable fee. When you use an in-network provider, you will pay only the in-network provider amounts below. If you choose not to use an in-network provider, or don't have access to one, reimbursement is based on the allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	None/None	\$50 / \$150
Benefit Maximum Per Benefit Year		
\$1,500 per person. Applies to all covered services.		
Exclusion Period	Number of Consecutive Months	
Class II Services	None	
Class III Services (Initial placement of dentures, fixed bridges, and implants)	36	
Class III Services (All other benefits)	None	

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services		
Examinations	No deductible, 0%	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%	No deductible, 0%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Sealants	No deductible, 0%	No deductible, 0%
Space maintainers	No deductible, 0%	No deductible, 0%
Athletic mouth guards	No deductible, 0%	No deductible, 0%
Brush biopsies	No deductible, 0%	No deductible, 0%
Class II Services		
Fillings	No deductible, 20%	After deductible, 20%
Simple extractions	No deductible, 20%	After deductible, 20%
Periodontal scaling and root planing	No deductible, 20%	After deductible, 20%
Full mouth debridement	No deductible, 20%	After deductible, 20%
Complicated oral surgery	No deductible, 20%	After deductible, 20%
Pulp capping	No deductible, 20%	After deductible, 20%
Pulpotomy	No deductible, 20%	After deductible, 20%
Root canal therapy	No deductible, 20%	After deductible, 20%
Periodontal surgery	No deductible, 20%	After deductible, 20%
Tooth desensitization	No deductible, 20%	After deductible, 20%
Class III Services		
Crowns	No deductible, 40%	After deductible, 40%
Dentures	No deductible, 40%	After deductible, 40%
Bridges	No deductible, 40%	After deductible, 40%
Replacement of existing prosthetic device	No deductible, 40%	After deductible, 40%
Implants	No deductible, 40%	After deductible, 40%

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

GTFF - EPO

Benefit Year: Contract Year

The member is responsible for the following amounts:

ADA Code Procedure	Member Pays
General Office Visit Charge	\$25
Specialist Office Visit Charge	\$30
Emergency Office Visit Charge	\$50
Diagnostic and Preventive Services	
D0120 - Periodic oral evaluation	No co-pay
D0140 - Limited oral evaluation – problem focused	No co-pay
D0145 - Oral evaluation – patient under three years old	No co-pay
D0150 - Comprehensive oral evaluation	No co-pay
D0160 - Detailed and extensive oral evaluation	No co-pay
D0170 - Re-evaluation – limited	No co-pay
D0171 - Re-evaluation – post operative office visit	No co-pay
D0180 - Comprehensive periodontal evaluation	No co-pay
D0191 - Assessment of a patient	No co-pay
D0210 - Complete series x-rays	No co-pay
D0220 - Periapical – first film	No co-pay
D0230 - Intraoral – each additional film	No co-pay
D0240 - Intraoral – occlusal film	No co-pay
D0250 - Extraoral – first film	No co-pay
D0251 - Extraoral – posterior dental radiographic image	No co-pay
D0270 - Bitewings – single film	No co-pay
D0272 - Bitewings – two films	No co-pay

ADA Code Procedure	Member Pays
D0273 - Bitewings – three films	No co-pay
D0274 - Bitewings – four films	No co-pay
D0277 - Vertical bitewings	No co-pay
D0310 - Sialography	Not covered
D0320 - Temporomandibular joint arthrogram	Not covered
D0321 - Other Temporomandibular joint films	Not covered
D0322 - Tomographic survey	Not covered
D0330 - Panoramic x-rays	No co-pay
D0340 - Cephalometric film	No co-pay
D0350 - Oral/facial images	No co-pay
D0364 - Cone beam CT, limited view	No co-pay
D0365 - Cone beam CT, full arch – mandible	Not covered
D0366 - Cone beam CT, full arch – maxilla	Not covered
D0367 - Cone beam CT, both jaws	No co-pay
D0368 - Cone beam CT, Temporomandibular joint series	Not covered
D0391 - Interpret and report diagnostic image	Not covered
D0415 - Collection of microorganisms for culture and sensitivity	Not covered
D0425 - Caries susceptibility test	No co-pay
D0460 - Pulp vitality test	No co-pay
D0470 - Diagnostic casts	No co-pay
D1110 - Teeth cleaning (prophylaxis) – adult	No co-pay
D1120 - Teeth cleaning (prophylaxis) – child	No co-pay
D1206 - Topical fluoride – therapeutic application	No co-pay
D1208 - Topical fluoride	No co-pay
D1310 - Nutritional counseling	No co-pay
D1320 - Tobacco counseling	No co-pay
D1330 - Oral hygiene instruction	No co-pay

ADA Code Procedure	Member Pays
D1351 - Sealant – per tooth	No co-pay
D1353 - Sealant repair – per tooth	No co-pay
D1354 - Interim caries arresting medicament application	No co-pay
Space Maintainers	
D1510 - Space maintainer – unilateral – fixed	No co-pay
D1516 - Space maintainer – fixed – bilateral, maxillary	No co-pay
D1517 - Space maintainer – fixed – bilateral, mandibular	No co-pay
D1520 - Space maintainer – unilateral – removable	No co-pay
D1526 - Space maintainer – removable – bilateral, maxillary	No co-pay
D1527 - Space maintainer – removable – bilateral, mandibular	No co-pay
D1551 - Re-cement or re-bond bilateral space maintainer – maxillary	No co-pay
D1552 - Re-cement or re-bond bilateral space maintainer – mandibular	No co-pay
D1553 - Re-cement or re-bond bilateral space maintainer – per quadrant	No co-pay
D1556 - Removal of fixed unilateral space maintainer – per quadrant	No co-pay
D1557 - Removal of fixed unilateral space maintainer – maxillary	No co-pay
D1558 - Removal of fixed unilateral space maintainer – mandibular	No co-pay
Restorative Dentistry - Amalgam Restorations	
D2140 - Fillings – one surface	No co-pay
D2150 - Fillings – two surfaces	No co-pay
D2160 - Fillings – three surfaces	No co-pay
D2161 - Fillings – four or more surfaces	No co-pay
Restorative Dentistry - Resin Restorations	
D2330 - Resin – one surface – anterior	No co-pay

ADA Code Procedure	Member Pays
D2331 - Resin – two surfaces – anterior	No co-pay
D2332 - Resin – three surfaces – anterior	No co-pay
D2335 - Resin – four or more surfaces – anterior	No co-pay
D2390 - Resin based composite crown	\$60
D2391 - Resin – one surface – posterior	\$60
D2392 - Resin – two surfaces – posterior	\$60
D2393 - Resin – three surfaces – posterior	\$60
D2394 - Resin – four or more surfaces – posterior	\$60
D2950 - Core buildup, including any pins	No co-pay
Restorative Dentistry - Inlay/Onlay (cast restorations)	
D2510 - Inlay – gold – one surface	\$200
D2520 - Inlay – gold – two surfaces	\$200
D2530 - Inlay – gold – three or more surfaces	\$200
D2542 - Onlay – gold – two surfaces	\$200
D2543 - Onlay – gold – three surfaces	\$200
D2544 - Onlay – gold – four or more surfaces	\$200
D2610 - Inlay – porcelain/ceramic – one surface	\$200
D2620 - Inlay – porcelain/ceramic – two surfaces	\$200
D2630 - Inlay – porcelain/ceramic – three or more surfaces	\$200
D2642 - Onlay – porcelain/ceramic – two surfaces	\$200
D2643 - Onlay – porcelain/ceramic – three surfaces	\$200
D2644 - Onlay – porcelain/ceramic – four or more surfaces	\$200
D2910 - Re-cement inlay, onlay, or partial coverage restoration	No co-pay
Restorative Dentistry - Crowns	
D2710 - Crown – resin laboratory	\$200
D2712 - Crown – ³/₄ resin-based composite	\$200
D2740 - Crown – porcelain/ceramic – anterior	\$200

ADA Code Procedure	Member Pays
D2751 - Crown – porcelain fused to base metal	\$200
D2752 - Crown – porcelain/noble	\$200
D2753 - Crown – porcelain fused to titanium or titanium alloy	\$200
D2782 - Crown – ¾ cast noble	\$200
D2792 - Crown – full cast noble	\$200
D2799 - Provisional crown	No co-pay
D2915 - Re-cement cast or prefabricated post and core	No co-pay
D2920 - Re-cement crown	No co-pay
D2930 - Stainless steel crown – primary	No co-pay
D2931 - Stainless steel crown – permanent	No co-pay
D2932 - Crown – prefabricated resin	No co-pay
D2933 - Crown – prefabricated stainless steel with resin window	No co-pay
D2940 - Sedative filling – temporary	No co-pay
D2950 - Core buildup, including any pins	No co-pay
D2951 - Pin retention – per tooth, in addition to restoration	No co-pay
D2954 - Prefabricated dowel post and core	No co-pay
D2955 - Post removal (no endodontic therapy)	No co-pay
D2957 - Each additional prefabricated post – same tooth	No co-pay
D2980 - Repair crown	No co-pay
Endodontics	
D3110 - Pulp cap – direct excluding final restoration	No co-pay
D3120 - Pulp cap – indirect excluding final restoration	No co-pay
D3220 - Pulpotomy	No co-pay
D3221 - Gross pulpal debridement – primary and permanent teeth	No co-pay
D3222 - Partial pulpotomy for apexogenesis	Not covered
D3230 - Pulpal therapy – primary anterior	No co-pay

ADA Code Procedure	Member Pays
D3240 - Pulpal therapy – primary posterior	No co-pay
D3310 - Root canal therapy – anterior	\$200
D3320 - Root canal therapy – bicuspid	\$200
D3330 - Root canal therapy – molar	\$200
D3331 - Treatment of root canal obstruction – non-surgical access	No co-pay
D3332 - Incomplete endodontic therapy – inoperable or fractured tooth	No co-pay
D3333 - Internal repair of perforation defects	No co-pay
D3346 - Retreatment – anterior	\$200
D3347 - Retreatment – bicuspid	\$200
D3348 - Retreatment – molar	\$200
D3351 - Apexification – initial visit	\$200
D3352 - Apexification – interim visit	No co-pay
D3353 - Apexification – final visit	No co-pay
D3410 - Apicoectomy – anterior	\$200
D3421 - Apicoectomy – bicuspid first root	\$200
D3425 - Apicoectomy – molar first root	\$200
D3426 - Apicoectomy – each additional root	No co-pay
D3430 - Retrograde filling – per root	No co-pay
D3450 - Root amputation per root	\$200
D3920 - Hemisection	\$200
D3950 - Canal prep – preformed dowel/post	No co-pay
Note: The treatment of a root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment charge. Thereafter, re-treatment of a root canal may be subject to an additional charge.	
Periodontics	
D4210 - Gingivectomy or gingivoplasty – four or more teeth	\$150

ADA Code Procedure	Member Pays
D4211 - Gingivectomy – one to three teeth	\$150
D4240 - Gingival flap – four or more teeth	\$200
D4241 - Gingival flap – one to three teeth	\$200
D4249 - Crown lengthening hard tissue	\$200
D4260 - Osseous surgery – four or more teeth	\$200
D4261 - Osseous surgery – one to three teeth	\$200
D4263 - Bone replacement graft – first site in quadrant	\$200
D4264 - Bone replacement graft – each additional site in quadrant	No co-pay
D4270 - Pedicle soft tissue graft procedure	\$200
D4273 - Subepithelial connective graft	\$200
D4274 - Distal wedge procedure	\$200
D4277 - Free soft tissue graft – first tooth or edentulous tooth position	\$200
D4341 - Periodontic scale and root plane – four or more teeth	\$150
D4342 - Periodontic scale and root plane – one to three teeth	\$150
D4355 - Full-mouth debridement	No co-pay
D4381 - Antimicrobial irrigation	No co-pay
D4910 - Periodontal maintenance following therapy	No co-pay
D4920 - Unscheduled dressing change	Not covered
Prosthodontics - Removable	
D5110 - Complete (upper denture)	\$150
D5120 - Complete (lower denture)	\$150
D5130 - Immediate (upper denture)	\$150
D5140 - Immediate (lower denture)	\$150
D5211 - Upper partial resin base	\$150
D5212 - Lower partial resin base	\$150

ADA Code Procedure	Member Pays
D5213 - Upper partial cast metal frame	\$150
D5214 - Lower partial cast metal frame	\$150
D5221 - Immediate maxillary partial denture – resin base	\$150
D5222 - Immediate mandibular partial denture – resin base	\$150
D5223 - Immediate maxillary partial denture – cast metal framework with resin denture bases	\$150
D5224 - Immediate mandibular partial denture – cast metal framework with resin denture bases	\$150
D5225 - Upper partial flexible base	Not covered
D5226 - Lower partial flexible base	Not covered
D5282 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – maxillary	\$150
D5283 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – mandibular	\$150
D5284 - Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	\$150
D5286 - Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	\$150
D5410 - Adjustment – complete denture, upper	No co-pay
D5411 - Adjustment – complete denture, lower	No co-pay
D5421 - Adjustment – partial denture, upper	No co-pay
D5422 - Adjustment – partial denture, lower	No co-pay
D5520 - Repair denture – replace missing or broken teeth (each tooth)	No co-pay
D5630 - Repair or replace partial clasp	No co-pay
D5640 - Replace teeth – partial per tooth	No co-pay
D5650 - Add tooth to existing partial	No co-pay
D5660 - Add clasp to existing partial	No co-pay
D5670 - Replace all teeth and acrylic on cast metal framework – maxillary	Not covered
D5671 - Replace all teeth and acrylic on cast metal framework – mandibular	Not covered

ADA Code Procedure	Member Pays
D5710 - Rebase complete upper denture	No co-pay
D5711 - Rebase complete lower denture	No co-pay
D5720 - Rebase upper partial	No co-pay
D5721 - Rebase lower partial	No co-pay
D5730 - Reline complete upper denture (chairside)	No co-pay
D5731 - Reline complete lower denture (chairside)	No co-pay
D5740 - Reline upper partial (chairside)	No co-pay
D5741 - Reline lower partial (chairside)	No co-pay
D5750 - Reline upper denture – lab	No co-pay
D5751 - Reline lower denture – lab	No co-pay
D5760 - Reline upper partial – lab	No co-pay
D5761 - Reline lower partial – lab	No co-pay
D5810 - Interim denture – upper	\$100
D5811 - Interim denture – lower	\$100
D5820 - Interim partial – upper	\$100
D5821 - Interim partial – lower	\$100
D5850 - Tissue conditioning – upper	No co-pay
D5851 - Tissue conditioning – lower	No co-pay
D5986 - Fluoride gel custom tray	No co-pay
Prosthodontics - Fixed	
D6210 - Pontic, cast (per tooth) traditional fixed partial dentures only	\$200
D6240 - Pontic (per tooth); porcelain/metal traditional fixed partial dentures only (bridges)	\$200
D6241 - Pontic (per tooth) Maryland bridge	\$200
D6545 - Cast metal retainer	\$200
D6549 - Resin retainer – for resin bonded fixed prosthesis	Not covered
D6720 - Crown – resin/metal abutment	\$200
D6750 - Crown – porcelain metal abutment	\$200

ADA Code Procedure	Member Pays
D6780 - Crown – ¾ cast metal abutment	\$200
D6790 - Crown – full gold abutment	\$200
D6975 - Coping – metal	No co-pay
D6980 - Bridge repair	No co-pay
Oral Surgery	
D7111 - Extraction coronal remnants primary tooth	No co-pay
D7140 - Extraction erupted tooth	No co-pay
D7210 - Surgical extraction – erupted	\$150
D7220 - Removal of impacted tooth – soft tissue	\$150
D7230 - Removal of impacted tooth – partial bony	\$150
D7240 - Removal of impacted tooth – complete bony	\$150
D7241 - Removal of impacted tooth – complete bony with complications	\$150
D7250 - Surgical removal residual root	\$150
D7251 - Coronectomy – intentional partial tooth removal	Not covered
D7260 - Oroantral fistula closure	\$150
D7261 - Primary closure of sinus perforation	Not covered
D7270 - Tooth re-implantation	\$150
D7280 - Surgical access unerupted tooth	\$150
D7283 - Ortho bracket to aid eruption if plan covers orthodontia	\$150
D7285 - Biopsy of oral tissue – hard (bone, tooth)	Not covered
D7286 - Biopsy of oral tissue – soft	Not covered
D7287 - Exfoliative cytological sample collection	Not covered
D7288 - Brush biopsy – transepithelial simple collection	No co-pay
D7291 - Transseptal fiberotomy	\$150
D7310 - Alveoloplasty with extractions – per quadrant 4 or more	\$150
D7320 - Alveoloplasty without extractions – per quadrant	\$150

ADA Code Procedure	Member Pays
D7321 - Alveoloplasty not with extractions	\$150
D7340 - Vestibuloplasty (secondary epithelialization)	\$150
D7350 - Vestibuloplasty (including soft tissue grafts)	\$150
D7450 - Remove benign odontogenic cyst up to 1.25 cm	\$150
D7451 - Remove benign odontogenic cyst greater than 1.25 cm	\$150
D7465 - Destruction of lesion(s) – physical or chemical method	\$150
D7471 - Remove lateral exostosis	\$150
D7510 - Incision and drainage of abscess – intraoral soft tissue	No co-pay
D7520 - Incision and drainage of abscess – extraoral soft tissue	No co-pay
D7530 - Remove foreign body – soft tissue	No co-pay
D7540 - Remove foreign body – hard tissue	No co-pay
D7550 - Partial ostectomy/sequestrectomy for removal of non vital bone	Not covered
D7560 - Maxillary sinusotomy for removal of tooth fragment	Not covered
D7670 - Stabilization splint – alveolus	No co-pay
D7770 - Alveolus – open reduction stabilization of teeth	Not covered
D7910 - Suture small wound up to 5 cm	No co-pay
D7911 - Complicated suture up to 5 cm	No co-pay
D7912 - Complicated suture greater than 5 cm	Not covered
D7940 - Osteoplasty	\$150
D7953 - Bone replacement graft for ridge reservation – per site	\$150
D7961 - Buccal/Labial frenectomy (frenulectomy)	\$150
D7962 - Lingual frenectomy (frenulectomy)	\$150
D7963 - Frenuloplasty	Not covered
D7970 - Excision hyperplastic tissue	\$150

ADA Code Procedure	Member Pays
D7971 - Excision of pericoronal flap	\$150
D7980 - Sialolithotomy	\$150
D7981 - Excision of salivary gland	Not covered
D7982 - Sialodochoplasty	Not covered
D7983 - Closure of salivary fistula	Not covered
D7990 - Emergency tracheotomy	Not covered
D7997 - Appliance removal (not by dentist who placed appliance)	Not covered
Orthodontia	
D8010 - Limited orthodontic treatment of the primary dentition	Not covered
D8020 - Limited orthodontic treatment of the transitional dentition	Not covered
D8030 - Limited orthodontic treatment of the adolescent dentition	Not covered
D8040 - Limited orthodontic treatment of the adult dentition	Not covered
D8050 - Interceptive orthodontic treatment of the primary dentition	Not covered
D8060 - Interceptive orthodontic treatment of the transitional dentition	Not covered
D8070 - Comprehensive orthodontic treatment of the transitional dentition	\$3,000
D8080 - Comprehensive orthodontic treatment of the adolescent dentition	\$3,000
D8090 - Comprehensive orthodontic treatment of the adult dentition	\$3,000
D8210 - Removable appliance therapy	Not covered
D8220 - Fixed appliance therapy	Not covered
D8660 - Pre-orthodontic treatment visit	\$150^
D8670 - Periodic orthodontic treatment visit (as part of contract)	No co-pay

ADA Code Procedure	Member Pays
D8680 - Orthodontic retention (removal of appliances, construction)	No co-pay
D8681 - Removable orthodontic device adjustment	No co-pay
D8690 - Orthodontic treatment (alternative billing to a contract fee)	Not covered
D8691 - Repair of orthodontic appliance	Not covered
D8693 - Re-bonding or re-cementing; and/or repair, as required	No co-pay
D8698 - Re-cement or re-bond fixed retainer - maxillary	No co-pay
D8699 - Re-cement or re-bond fixed retainer – mandibular	No co-pay
Anesthesia	
D9210 - Local Anesthesia not in conjunction with operative or surgical procedures	Not covered
D9211 - Regional block anesthesia	Not covered
D9212 - Trigeminal division block anesthesia	Not covered
D9215 - Local anesthesia (Novocain)	No co-pay
D9222 - Deep sedation/general anesthesia – first 15 minutes	\$100
D9223 - Deep sedation/general anesthesia – each subsequent 15 minute increment	Not covered
D9230 - Nitrous oxide (per visit)	\$20
D9239 - Intravenous moderate (conscious) sedation – first 15 minutes	\$100
D9243 - Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	Not covered
D9248 - Non-intravenous conscious sedation	Not covered
Miscellaneous	
D9110 - Palliative (emergency) minor	\$50
D9120 - Fixed partial denture sectioning	Not covered
D9310 - Consultation – per session	No co-pay
D9410 - House/extended care facility call	Not covered

ADA Code Procedure	Member Pays
D9430 - Observation visit	No co-pay
D9440 - Emergency treatment – after office hours	No co-pay
D9610 - Therapeutic parenteral drug – single administration	Not covered
D9612 - Therapeutic parenteral drug – 2 or more	Not covered
D9630 - Other drugs and/or medicaments	Not covered
D9911 - Application of desensitizing medicaments	No co-pay
D9920 - Behavior management	Not covered
D9930 - Treatment of complications – post surgical	Not covered
D9944 - Occlusal guard – hard appliance, full arch	\$100
D9945 - Occlusal guard – soft appliance, full arch	\$50
D9951 - Occlusal adjustment – simple	No co-pay
D9952 - Occlusal adjustment – complete	No co-pay
Out-of-area emergency reimbursement	Reimbursed up to \$100
Exclusions	
See Exclusion section of the Member Handbook	

^ Fee credited towards comprehensive orthodontic copayment if patient accepts treatment plan.



TRAVEL ASSISTANCE PROGRAM

Gives you peace of mind, before, during and after travel.

So cruise the Caribbean with your family.
Take that honeymoon in Italy. Or fly to
Denmark for work. No matter your
whereabouts, we're here to help.



**Travel
Assistance
Program**

Within the United States
1 (800) 230-5170
Outside the United States
+1 (630) 766-7772



TRAVEL ASSISTANCE PROGRAM

Travel is exciting, but there are so many details to consider when planning a trip. That's why your LifeMap Life Insurance includes the Travel Assistance program—so you'll have a team that can help keep you well and informed when traveling 100 or more miles away from home for up to 120 days. Think of it as your worldwide team of personal concierges.

HOW IT WORKS

LifeMap has partnered with AXA Assistance USA, Inc. to offer you and your loved ones the best in travel aid. Your no-cost Travel Assistance program includes help with travel and medical services.

1

Just pick up the phone

When traveling 100+ miles away from home—or outside the country—your AXA team is simply a call away.

2

Help 24/7

Whether traveling for business or pleasure, AXA has the professional staff and resources to provide you with around-the-clock support.

3

One for all (and all for one)

Immediate family members have access to the program when they travel, too. That means they can also receive emergency medical and travel assistance 24 hours a day—anywhere in the world.

WHAT TO EXPECT

As a worldwide leader in travel assistance, you'll get no less than the best from AXA—no matter what you need.

Pre-trip help

Be it help with an embassy, your passport, currency exchange or even the weather, you'll have someone to turn to 24/7.

Travel assistance

Need a translator or a legal referral while abroad? Whatever it is, your AXA team will get it done.

Medical Services

Call for doc referrals, replacement medications, medical record transfers or Critical Care Monitoring.

Repatriation

Should you need to come home for medical reasons, AXA will bring you back safely.

Travel assistance services are subject to specific terms, conditions and limitations. For questions about the program, call 1 (800) 230-5170 or collect at +1 (630) 766-7772.

● LifeMapCo.com

CALL AXA IF YOU REQUIRE:

- Medical and Dental Referrals
- Medical Evacuation or Repatriation
- Hospital Admission and Critical Care Monitoring
- Return of Mortal Remains
- Dispatch of Prescription Medication
- Lost Document and Luggage Assistance
- Emergency Cash and Bail Assistance
- General Travel Information

THIS IS NOT A MEDICAL INSURANCE CARD.
ALL SERVICES MUST BE AUTHORIZED AND PROVIDED
BY AXA ASSISTANCE USA, INC. NO CLAIMS FOR
REIMBURSEMENT WILL BE ACCEPTED

No claims for reimbursement for out-of-pocket expenses will be accepted. All additional costs are the responsibility of the member. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. Members subject to eligibility verification. Services will be provided as permitted under applicable law. Travel Assistance services are not insurance.

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Insurance for every step of life.



Basic Life and AD&D Insurance

For Graduate Teaching Fellows Federation (GTFF)

How the Plan Works

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- Eligibility Requirement**
 If you are a Graduate EE of the University of Oregon working 8 Hours Week and a member of GTFF - Local 3544, or an EE of the GTFF - Local 3544, or an EE of the GTFF Health & Welfare Trust, you will be covered with these benefits.
- Who pays for the coverage?**
 Life and AD&D Insurance premiums are paid for by your employer.
- Guarantee Issue**
 With no questions asked, you will be covered for up to \$10,000 in Basic Life and AD&D Insurance.

Benefits Summary

Plan Benefits

Employee Life Insurance	\$10,000
Employee AD&D Insurance	\$10,000

Guarantee Issue Amount

Employee	\$10,000
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Plan Features

Accelerated Benefit – Life Only	A covered employee who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion – Life Only	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Portability – Life Only	You may elect to port your Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium – Life Only	Life coverage continued without payment of premium if insured becomes totally disabled prior to age 60 (proof of disability required). Coverage may be continued up to age 65.

Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85, and to 10% at age 90.

Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

- | | |
|---|---|
| <ul style="list-style-type: none"> Adaptive Home/Vehicle Benefit Rehab Benefit Air Bag and Seat Belt Spouse and Child Education | <ul style="list-style-type: none"> Coma Day Care Exposure and Disappearance Felonious Assault |
|---|---|

LifeMapCo.com
1 (800) 794-5390

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.

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Additional Benefits

- **Travel Assistance**
When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.
- **Repatriation**
If death occurs more than 100 miles from your primary residence, a benefit may be payable to prepare and ship your body to the place of burial or cremation.
- **Seat Belt**
If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of \$10,000 in addition to the Basic Life and Basic AD&D benefits described above.

Limitations & Exclusions

- **Life:** No restrictions or exclusions regarding time, place or circumstances of death.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
 - suicide, self-inflicted injuries, or such attempts;
 - active participation in a riot;
 - war or act of war;
 - military service for any country;
 - committing or attempting to commit an assault or felony;
 - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
 - heart attack or stroke;
 - bodily infirmity or disease from bacterial or viral infections not the result of an injury;
 - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician.
 - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
 - the insured Employee's intoxication

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