DELTA DENTAL®

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0162-0001, 0003, 0004, 0005, 0006, 0007, 0008
New Paradigm for Education

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	50%	50%
Emergency Palliative Treatment – to temporarily relieve pain	100%	50%	50%
Sealants – to prevent decay of permanent teeth	100%	50%	50%
Brush Biopsy – to detect oral cancer	100%	50%	50%
Radiographs – X-rays	100%	50%	50%
Basic Services			
Minor Restorative Services – fillings and crown repair	75%	50%	50%
Endodontic Services – root canals	75%	50%	50%
Periodontic Services – to treat gum disease	75%	50%	50%
Oral Surgery Services – extractions and dental surgery	75%	50%	50%
Major Restorative Services – crowns	75%	50%	50%
Other Basic Services – misc. services	75%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	75%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	up to age 19	up to age 19	up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Subscribers who are eligible for Benefits are covered on the first day of the month following 90 days of employment.

Eligible People – All full-time employees of NPFE (0001), Glazer (0003), Loving (0004), NPCP (0005), Back Office (0006), University Yes Academy (0007) and Global Prep Academy (GPA) (0008) who choose the dental plan and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

Also eligible at your option are your legal spouse, your dependent children to the end of the calendar year in which they attain the age of 19, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under This Plan.

Benefits will cease on the last day of the month in which the employee is terminated.

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan

Summary of Benefits

HMO Alternate Plan

HMO
AA002688

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Fiscal Year		
Annual Deductible	$5,000 Individual; $10,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$5,000 Individual; $10,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$30 Copay - Deductible does not apply	N/A	
Telehealth Visit	$30 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$30 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$30 Copay - Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share.
Eye Exam Office Visit	$30 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share.
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Chiropractic Services	$30 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 10 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$30 Copay - Deductible does not apply		
Emergency Room Care	$250 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services.
Postnatal Office Visits	$30 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$30 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	50% Coinsurance after deductible	N/A	Does not include Rehabilitation Services.; Up to 60 consecutive days per illness or injury beginning with the first visit.
Hospice Care	Covered after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	50% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	Covered after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Covered after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy - Not Covered			

Value Plus

Template Rev 06/2017

Benefit Riders: H00B,H00T,H070,H132,H134,H148,H170,H201,HK71,H356,H586,HK18,XMHP,HMHE

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP could result in a reduction of benefits or nonpayment.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan

Summary of Benefits

HMO Alternate Plan

HMO
AA002688

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Fiscal Year		
Annual Deductible	$5,000 Individual; $10,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$5,000 Individual; $10,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$30 Copay - Deductible does not apply	N/A	
Telehealth Visit	$30 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$30 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$30 Copay - Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share.
Eye Exam Office Visit	$30 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share.
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Chiropractic Services	$30 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 10 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$30 Copay - Deductible does not apply		
Emergency Room Care	$250 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services.
Postnatal Office Visits	$30 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$30 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	50% Coinsurance after deductible	N/A	Does not include Rehabilitation Services.; Up to 60 consecutive days per illness or injury beginning with the first visit.
Hospice Care	Covered after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	50% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	Covered after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Covered after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy - Not Covered			

Benefit Riders: H00B,H00T,H070,H132,H134,H148,H170,H201,HK71,H356,H586,HK18,XMHP,HMHE

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP could result in a reduction of benefits or nonpayment.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
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Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan

Summary of Benefits

HMO BUY-UP PLAN

HMO
AA000410

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Fiscal Year		
Annual Deductible	$0 Individual; $0 Family	N/A	
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$5,000 Individual; $10,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	$30 Copay	N/A	
Related Laboratory and Radiology Services	Covered	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered	N/A	
Immunizations	Covered	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$30 Copay	N/A	
Telehealth Visit	$30 Copay	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$30 Copay	N/A	
Audiology Office Visit	$30 Copay	N/A	One routine hearing exam per benefit period at no cost share
Eye Exam Office Visit	$30 Copay	N/A	One routine eye exam per benefit period at no cost share
Allergy Treatment	Covered	N/A	
Allergy Injections	Covered	N/A	
Laboratory & Pathology	Covered	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	Covered	N/A	Services require preauthorization
Radiology (X-ray)	Covered	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	Covered	N/A	
Dialysis	Covered	N/A	
Chiropractic Services	$30 Copay	N/A	Manipulation of the spine for subluxation only; Up to 10 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	Covered	N/A	
Ambulatory Surgical Center	Covered	N/A	
Professional Surgical and Related Services	Covered	N/A	
Emergency/Urgent Care			
Urgent Care	$30 Copay		
Emergency Room Care	$50 Copay		Copay will be waived if admitted
Emergency Medical Transportation	Covered		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	N/A	
Bariatric Surgery and Related Services	$1,000 Copay	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	$30 Copay	N/A	Covered under Preventive Services.
Postnatal Office Visits	$30 Copay	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$30 Copay	N/A	
Other Services			
Home Health Care	50% Coinsurance	N/A	Up to 60 consecutive days per illness or injury beginning with the first visit; Does not include Rehabilitation Services.
Hospice Care	Covered	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	50% Coinsurance	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance	N/A	Coverage for approved equipment only
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$30 Copay	N/A	May be rendered at home; Up to 60 combined visits per benefit period
Habilitation Services	$30 Copay	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Covered	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered	N/A	Coverage for non-invasive treatments only.
Pharmacy - Not Covered			

Template Rev 06/2017

Benefit Riders: HMHE,HK71,H00T,H134,H170,H176,H201,X104,H132,H131,H070,H034,XMHP,H002,H00B

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP could result in a reduction of benefits or nonpayment.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

EHIM
Pharmacy Benefits. Managed.

Your Rx Benefits

26711 Northwestern Highway, Suite 400 · Southfield, MI 48033-2154 · 800-311-3446 · 248-948-9900 · www.ehimrx.com

No Changes

We are pleased to announce that there will be NO changes to your existing pharmacy benefit plan for the upcoming year!

You can continue to utilize the current ID card that you have.

Summary of Copayments

Copayments are the dollar amount which will be collected at the pharmacy every time you receive a prescription. Generally, your copayment will be lowest for generic prescriptions and highest for medications that are considered Non-Preferred under your plan design. Below highlights your plan's copay levels:

Customer Service

800-311-3446 • 24/7/365

EHIM's primary mission is to provide our members with the best customer service possible. If you are experiencing a problem ***filling a retail or mail order prescription,*** contact EHIM's Pharmacy Help Desk.

For your convenience, our help desk has a representative available ***24 hours a day, 7 days a week, 365 days a year.***

Our toll free number is ***printed on the front of your ID card*** for easy reference.

EHIM values our clients and we appreciate the opportunity to continue to service our members.

$10.00 (20% if cost is over $100)	Copayment on any generic medication
$40.00 (20% if cost is over $150)	Copayment on any Preferred Brand Medication
40%	Copayment on any Non-Preferred Brand Medication
$40.00 (20% if cost is over $150)	Copayment on any Multi-Source Brand Medication (Brand Name Drugs that are dispensed when an exact generic is available) The *physician* will indicate "DAW" or "Dispense as Written" on the prescription.
$40.00 (20% if cost is over $150)	Copayment **plus the difference** in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when an exact generic is available) The *patient* indicates the brand to be dispensed. DAW penalty does not count towards the OOP Max
Generic: 2x Brand: 3x NP Brand: 40%	Standard Copayment for all eligible maintenance medication filled in a three month supply. Brand & Generic eligible maintenance medications can be filled through the Local Retail Pharmacy in order to obtain them in a 3 month supply.

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Quantity Limits for Certain Medications

Certain medications under your program may be subject to quantity limits. Medications that are subject to quantity limits are to help ensure these medications are not utilized inappropriately or recommended maximum dosages are not exceeded. EHIM's Quantity Limitations are based on FDA-approved dosing recommendations, pharmaceutical guidelines and have been reviewed and approved by our licensed, clinical staff.

EHIM Maintenance List (Three Month Supplies)

EHIM has a list of commonly used medications that are eligible to be filled in higher quantities (three month supplies) This list of medications approved to be filled in three month supplies is known as EHIM's Maintenance List. This list is extensive, yet does NOT include every single medication. Types of medications found on the maintenance list are: Insulin, Blood Pressure medications, Heart medications, Cholesterol medications, and Thyroid medications. Your physician must write for a three month supply of medication to be dispensed at one time. You may pick up your three month supply at any participating retail pharmacy. To determine whether or not your medication is on the Maintenance List, please contact our Pharmacy Help Desk at 800-311-3446.

Non-Preferred Drug List (40% Copay)

Some medications under this program are classified as "Non-Preferred". This means there are alternative medications which are therapeutically equivalent. If your physician writes for a medication that is part of our Non-Preferred List, you may want to discuss alternative medications that are just as effective.

EHIM Pharmacy Network

EHIM has over 62,000 participating pharmacies across the country including all of the major chain pharmacies, regional pharmacies and most independent pharmacies. You may visit our website at www.ehimrx.com for our National Pharmacy Directory and Pharmacy Locator tool.

EHIM Pharmacy Help Desk

EHIM's Pharmacy Help Desk is available for your convenience 24 hours a day, 7 days per week, 365 days per year. Our toll free number is (800) 311-3446 and will be printed on the back of your ID card and on all of our communication pieces. If you have any questions regarding your benefits or just need help finding a participating pharmacy, please contact our Pharmacy Help Desk. You may also contact our helpdesk through our website at www.ehimrx.com.

New Paradigm for Education

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$0 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $120 allowance, 20% off balance over $120	Up to $84
Standard Plastic Lenses		
Single Vision	$20 Copay	Up to $30
Bifocal	$20 Copay	Up to $50
Trifocal	$20 Copay	Up to $70
Lenticular	$20 Copay	Up to $70
Standard Progressive Lens	$85 Copay	Up to $50
Premium Progressive Lens[Δ]	$105 Copay - $130 Copay	Up to $50
Tier 1	$105 Copay	Up to $50
Tier 2	$115 Copay	Up to $50
Tier 3	$130 Copay	Up to $50
Tier 4	$85 Copay, 20% off charge less $120 Allowance	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	20% off Retail Price	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off retail price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $150 allowance, 15% off balance over $150	Up to $150
Disposable	$0 copay, $150 allowance, plus balance over $150	Up to $150
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

QL-0000030280

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

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*Based on a sample transaction on the Insight network with a covered exam and eyewear benefits

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