Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 098, 099
Section Code(s): 3000, 3100
PPO - SB HSA Plan, RX39
Effective Date: 01/01/2018
Benefits-at-a-glance

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Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,350 per member $2,700 per family	$2,700 per member $5,400 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$2,300 per member $4,600 per member in family plan $4,600 per family Includes Deductible, Coinsurance and Copays	$4,600 per member $9,200 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 80% after deductible	Covered - 60% after deductible
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Covered - 60% after deductible
Postnatal Care Visits	Covered - 80% after deductible	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 360 days	Covered - 80% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
• Online Behavioral Health Visits	Covered - 80% after deductible	Covered - 60% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 098, 099
Section Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2018
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$1,350 per individual $2,700 per family
Retail - 30 day supply	$20 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$40 copay after deductible - Generic drugs $80 copay after deductible - Preferred brand drugs $160 copay after deductible - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$20 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Not Covered

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 092
Section Code(s): 1010, 1110
PPO - SB Plan 3, RX35
Effective Date: 01/01/2018
Benefits-at-a-glance

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Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Chiropractic spinal manipulations • Primary Care Physician (PCP) office visits $40 copay for : • Specialist office visits $60 copay for : • Urgent care services $150 copay for : • Facility medical emergency	$150 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of: $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$2,500 per member $5,000 per family Includes Deductible, Coinsurance and Copays	$2,500 per member $5,000 per family Includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 pcp copay; $40 specialist copay	Covered - 70% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100% after $20 copay	Covered - 70% after deductible
Office Consultations	Covered - 100% after $20 pcp copay; $40 specialist copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after $60 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 360 days	Covered - 100%	Covered - 100%
Home Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 90% after deductible	Covered - 70% after deductible
• Online Behavioral Health Visits	Covered - 90% after deductible	Covered - 70% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per calendar year	Covered - 100% after $20 copay	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 092
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2018
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Preferred brand drugs $160 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Not Covered

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Delta Dental of Michigan
Dental Benefit Highlights for
Kalamazoo Regional Educational Service Agency #5395

Delta Dental PPO℠ (Point-of-Service) *Coverage effective January 1, 2017*	**Delta Dental PPO Dentist** **Plan Pays**	**Delta Dental Premier® Dentist** **Plan Pays**	**Non-participating Dentist** **Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	75%	75%	75%
Emergency Palliative Treatment - to temporarily relieve pain	75%	75%	75%
Sealants - to prevent decay of permanent teeth	75%	75%	75%
Brush Biopsy - to detect oral cancer	75%	75%	75%
Radiographs - X-rays	75%	75%	75%
Basic Services			
Minor Restorative Services - fillings and crown repair	75%	75%	75%
Endodontic Services - root canals	75%	75%	75%
Periodontic Services - to treat gum disease	75%	75%	75%
Oral Surgery Services - extractions and dental surgery	75%	75%	75%
Major Restorative Services - crowns	75%	75%	75%
Other Basic Services - misc. services	75%	75%	75%
Relines and Repairs - to bridges, implants, and dentures	75%	75%	75%
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		

** 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 your dentist charges and you are responsible for that difference.*

Maximum Payment – $1,000 per person total per calendar year on Diagnostic & Preventive, Basic Services, and Major Services. $1,500 per person total per lifetime on Orthodontics.

Deductible – None.

Note – *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists – there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, we pay more than 90% of claims in 10 days or less. Delta Dental also offers world-class customer service from our Certified Center of Excellence call center, as awarded by Benchmark Portal.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more – all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at (800) 524-0149 or look online at www.DeltaDentalMI.com.

Kalamazoo RESA

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 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $150 Allowance, 20% off balance over $150	Up to $105
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $30
Bifocal	$10 Co-pay	Up to $50
Trifocal	$10 Co-pay	Up to $70
Lenticular	$10 Co-pay	Up to $70
Standard Progressive Lens	$10 Co-pay	Up to $88
Premium Progressive Lens[Δ]	$30 Co-pay - $55 Co-pay	
Tier 1	$30 Co-pay	Up to $88
Tier 2	$40 Co-pay	Up to $88
Tier 3	$55 Co-pay	Up to $88
Tier 4	$10 Co-pay, 80% off charge less $120 Allowance	Up to $70
Lens Options		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68 Co-pay	N/A
Tier 1	$57 Co-pay	N/A
Tier 2	$68 Co-pay	N/A
Tier 3	80% of charge	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 follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off Retail Price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay; $150 Allowance, 15% off balance over $150	Up to $150
Disposable	$0 Co-pay; $150 Allowance; plus balance over $150	Up to $150
Medically Necessary	$0 Co-pay, 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 a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every plan year	
Lenses or Contact Lenses	Once every plan year	
Frame	Once every plan year	

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; 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; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; 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. 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 with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. The Certificate of Insurance is on file with your employer. The Certificate of Insurance is on file with your employer. [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. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

Benefits Snapshot

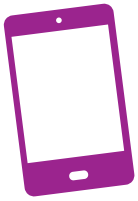
	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every plan year)	$0 Co-pay	Up to $40
Frames (once every plan year)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $105
Single Vision Lenses (once every plan year)	$10 Co-pay	Up to $30
or		
Contacts (once every plan year)	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $150

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

87% SAVINGS with us*

With EyeMed		Without Insurance**	
Exam	$0 Co-pay	Exam	$106
Frame	$163 -$150 Allowance $13 -$2.60 (20% discount off balance) $10.40	Frame	$163
Lens	$10 Co-pay $15 UV treatment add-on +$15 scratch coating add-on $40	Lens	$78 $23 UV treatment add-on +$25 scratch coating add-on $126
Total	$50.40	Total	$395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical | JCPenney optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.