2025-2026 LCSD Benefits

Medical Insurance	EMPLOYEE CONTRIBUTION 25-26	EMPLOYER CONTRIBUTION 25-26	
	Cost per Month	Cost per Month	
EPO3			
SINGLE	$135.44	$948.08	
EMPLOYEE + EMPLOYEE	$234.97	$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	$542.24	$1,337.52	
EMPLOYEE + CHILDREN	$419.91	$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	$537.67	$2,144.72	only 1 employee pays
EMPLOYEE + FAMILY	$874.95	$1,807.44	
POS 4			
SINGLE	$93.77	$948.08	
EMPLOYEE + EMPLOYEE	$162.67	$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	$469.94	$1,337.52	
EMPLOYEE + CHILDREN	$354.68	$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	$434.50	$2,144.72	only 1 employee pays
EMPLOYEE + FAMILY	$771.78	$1,807.44	
HDHP			
SINGLE	$52.09	$948.08	
EMPLOYEE + EMPLOYEE	$90.37	$1,644.78	only 1 employee pays
EMPLOYEE + SPOUSE	$397.64	$1,337.52	
EMPLOYEE + CHILDREN	$289.45	$1,276.04	
EMPLOYEE+ EMPLOYEE + FAMILY	$331.33	$2,144.72	
EMPLOYEE + FAMILY	$668.61	$1,807.44	only 1 employee pays

OPTIONAL ADDITIONS for LCSD INSURANCE -

DENTAL INSURANCE

	Additional cost per month
SINGLE	$36.19
FAMILY	$104.90

VISION INSURANCE -

	Additional cost per month
SINGLE	$4.75
FAMILY	$12.12

Lake County School District
Learning Beyond Walls

*All insurance selections and changes are through the **EASE** insurance portal.

Meritain Health®
an aetna company

A Quick Look at Your Health Plan

Lake County School District

Group #16035

When you enroll with Meritain Health®, you're taking the next step towards a healthier, more balanced you.

It's important for you to understand how your health plan works. This way, you can make the changes you want in your health and in your life.

Get the support you need for a healthy balance

Chances are, you try every day to keep a healthy balance in your life. But time can get away from you, or you might put other details first. That's why we're here: to help you focus and to support you each step of the way. You can think of your health care benefits as your resource to protect your body, mind and spirit.

Benefit Highlights

Protecting your healthy balance with preventive care

Question:

Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer:

Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.

Early detection, proper nutrition, and routine exercise are the keys to living a long and healthy life, and will also help to control long-term health care costs. Your employer encourages you to take the necessary steps—available to you right now—to ensure early detection and treatment of diseases.

Built into your health plan are preventive benefits that cover:

- Bone density test.
- Fecal occult screening.
- Mammogram.
- Pap smear.
- Physical exams.
- Prostate blood exam.
- Well-child care.

Save when you visit network providers

This plan offers a network of doctors and other health care professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: if you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Benefit Highlights

File claims quickly and easily

If you visit a provider in your network, you shouldn't need to submit a claim for services or pay at the time of your service with the exception of a copay, if applicable. Your provider will submit the claim on your behalf and you will later receive a bill for any out-of-pocket or other balances due.

If you have visited an out-of-network provider, you may need to file a claim form to ensure that the service is billed properly. Claim forms can be found online at **www.meritain.com** or you can obtain one from your Human Resources department. Submit the claim by fax or by mail to the fax number or mailing address listed on the claim form.

Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of **Meritain Health's Medical Management Program**. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Some of these services include:

- Before admission to the hospital for elective or non-emergency services.
- Within 48 hours (two working days) after an emergency or urgent hospital admission.
- Before elective inpatient, outpatient or ambulatory surgery.
- Before inpatient substance-abuse treatment or treatment for a mental health disorder.
- Before entering an extended-care, rehabilitation or skilled-nursing facility.

Consult your Summary Plan Description for a complete listing of health care services that require precertification with a medical management nurse.

Benefit Highlights

Nationwide provider access at a discount

When you and your family seek health care services, you have access to Aetna's broad national provider network of health care providers and facilities. Aetna's network contains more than 664,000 participating physicians and ancillary providers, with 5,667 hospitals.[1] When you visit providers in the Aetna network, you will receive services at strong, negotiated rates, helping you to save on the cost of health care.

Locate your preferred providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or health care facility participates, visit **https://www.aetna.com/dsepublic/#/mymeritain**.

How to access your mobile web app

iPhone®

- Once you log in to your member website through **www.meritain.com**, click the icon at the bottom of the page.
- Then, scroll through the menu options and select *Add to Home Screen.*
- Click *Add* in the upper right-hand corner.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Then, you'll be able to log in through the app instead of going through the website.

Android™

- Once you log in to your member website through **www.meritain.com**, you'll be prompted with the pop-up message *Add Meritain Health to Home Screen* at the bottom of the page. Click this message.
- Then, you can click *Add* to add the logo to the home page or *Cancel* to opt-out.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Launch the app from your home screen and log in.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

[1] *https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html*

Benefits Summary

		EPO Plan 3	PPO Plan 4	
		IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL				
Deductible (Ded)		$1000/Individual $2000/Family	$2,000/Individual $4,000/Family	$4,000/Individual $8,000/Family
Out-of-Pocket Maximum (Including Deductible, Copayments & Coinsurance)		$3,000/Individual $6,000/Family	$4,500/Individual $9,000/Family	$9,000/Individual $18,000/Individual
Co-Insurance		80%	80%	60%
PREVENTIVE CARE		100%, Deductible Waived	100%, Deductible Waived	90% after Deductible
PHYSICIANS OFFICE VISITS		$40	$40	60% after Deductible
SPECIALIST OFFICE VISITS		$55	$40	60% after Deductible
URGENT CARE		$50	80% after Deductible	60% after Deductible
EMERGENCY ROOM		$250, then 100%	80% after Deductible	Paid at In Network
HOSPITAL INPATIENT CARE		$1000 copay per admission	80% after Deductible	60% after Deductible
HOSPITAL OUTPATIENT CARE		$750 copay per visit	80% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD				
Retail (31 days supply)	Generic	$20.00	$20.00	NA
	Preferred	$40.00	$40.00	NA
	Non-Preferred	$60.00	$60.00	NA
Mail Order (up to 90 days supply)	Generic	$40.00	$40.00	NA
	Preferred	$80.00	$80.00	NA
	Non-Preferred	$120.00	$120.00	NA

Benefits Summary

		HDHP Plan 5	
		IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL			
Deductible (Ded)		$3,000/Individual $6,000/Family	$6,000/Individual $12,000/Family
Out-of-Pocket Maximum **(Including Deductible, Copayments & Coinsurance)**		$6,000/Individual $12,000/Family	$12,000/Individual $24,000/Individual
Co-Insurance		80%	60%
PREVENTIVE CARE		100%, Deductible Waived	90% after Deductible
PHYSICIANS OFFICE VISITS		$45 after Deductible	60% after Deductible
SPECIALIST OFFICE VISITS		$45 after Deductible	60% after Deductible
URGENT CARE		80% after Deductible	60% after Deductible
EMERGENCY ROOM		80% after Deductible	Paid at In Network
HOSPITAL INPATIENT CARE		80% after Deductible	60% after Deductible
HOSPITAL OUTPATIENT CARE		80% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD			
Retail (31 days supply)	Generic	$20 after Deductible	NA
	Preferred	$40 after Deductible	NA
	Non-Preferred	$60 after Deductible	NA
Mail Order (up to 90 days supply)	Generic	$40 after Deductible	NA
	Preferred	$80 adfter Deductible	NA
	Non-Preferred	$120 after Deductible	NA

Your Guide to Enrollment

Completing your enrollment

Complete, sign and return your enrollment form to your employer within 30 days of your eligibility date whether you're enrolling or declining benefits.

- **Write clearly.** If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don't forget the back side.** Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form.** Remember to sign and date the form, even if you're declining benefits.

Helpful tips

- Your health care plan includes a network of providers you can visit for health care services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card, and includes the Livinti customer service number and prescription copays.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Your Guide to Enrollment

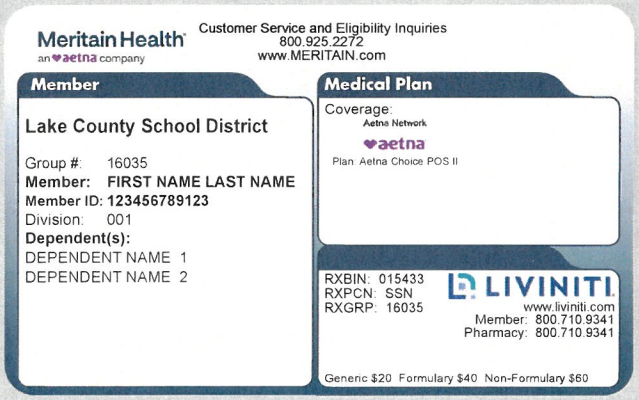
The final step toward better balance and better living

After you've completed enrollment, your employer has approved it and after any waiting period has passed, your benefits will be effective.

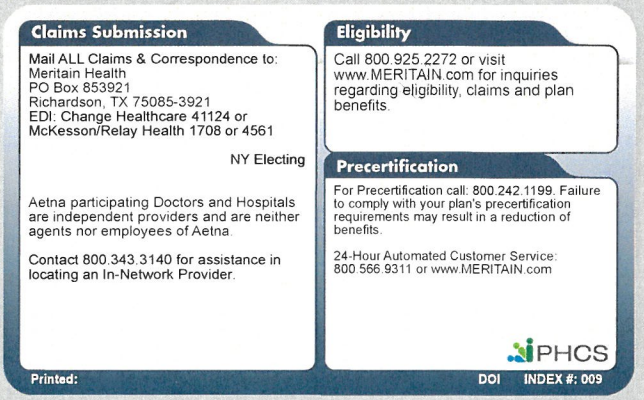
Your Meritain Health ID card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you. If you misplace your ID card, use the Meritain Health mobile app to access your member website to get a copy of your ID on the go!

Sample ID card

Card front



Card back



Convenient Tools and Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health member website**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter **www.meritain.com** into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1

Scan the QR code and click on the link to register or visit **www.meritain.com**. Then, in the top right corner, click *Register.*

2

Next, select *Member* under *I am a* and enter your group ID. You can find your group ID on the front of your member ID card. (If you are new to the plan, you will soon receive your member ID card in the mail.) Then, click *Continue.*

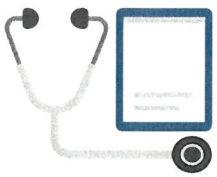
Please note: *You may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.*

3

You will need to fill in your:

- Group ID (located on your member ID card).
- Member ID (located on your member ID card).
- Date of birth
- Name.
- Zip code.
- Email address.

You can then create a username and password. After that, you will be asked to confirm your email address—then you're done! The next time you log in, just use the same username and password.



Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or health care operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their health care or payment thereof (e.g., family members, or close friends).

Convenient Tools and Resources

Important plan contacts

What do you need help with?

In-network doctors or hospitals

Meritain Health Customer Service **1.800.925.2272**

Access your Meritain Health member website at **www.meritain.com**

The Aetna Choice® POS II provider network

Aetna provider line **1.800.343.3140**

www.aetna.com/docfind/custom/mymeritain

My prescription drug benefits

Livinti Customer Service

1.800.710.9341

Precertification

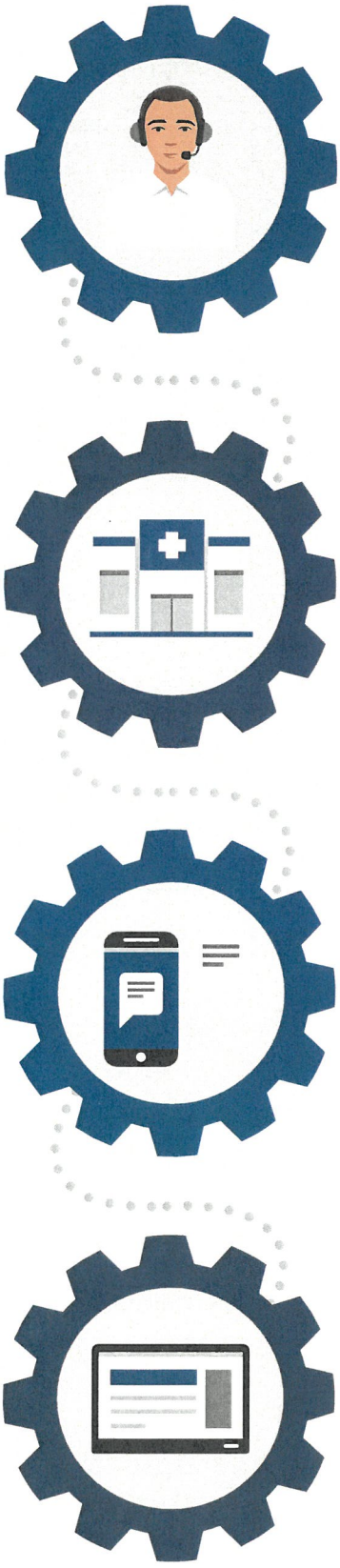
Meritain Health Medical Management **1.800.242.1199**

Enrollment/benefit elections

Lake County School District

Human Resources representative

1.719.486.6811



Notes

Simple. Transparent. Versatile.
At Meritain Health®, we're creating unrivaled connections.

Follow us: @meritainhealth | Meritain Health

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Meritain Health®

an aetna company

EXHIBIT A

MEDICAL SCHEDULE OF BENEFITS – EPO 3 PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE	
Single	$1,000
Family	$2,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)	
Single	$3,000
Family	$6,000
MEDICAL BENEFITS	
Acupuncture	80% after Deductible
Calendar Year Maximum Benefit	30 visits
Allergy Serums and Injections	$10 Copay then 100%; Deductible waived
NOTE: The above Copay applies when the only services received during an office visit is the administration of an allergy injection.	
Ambulance Services	$250 Copay per trip then 100%; Deductible waived
NOTE: Air ambulance services by a Non-Participating Provider for an Emergency Medical Condition will be paid at the Participating Provider level of benefits.	
Ambulatory Surgical Center	$750 Copay per occurrence then 100%; Deductible waived
Applied Behavioral Analysis (ABA)	
Office Visits	$40 Copay then 100%; Deductible waived
All Other Outpatient Care	$750 Copay per occurrence then 100%; Deductible waived
Biofeedback (Outpatient)	$40 Copay then 100%; Deductible waived
Birthing Center	$1,000 Copay per admission then 100%; Deductible waived
Cardiac Rehab (Outpatient)	$40 Copay then 100%; Deductible waived
Chemotherapy (Outpatient- includes all related charges)	80% after Deductible
Chiropractic Care/Spinal Manipulation	$40 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	20 visits
Cochlear Implants	80% after Deductible
Diabetic Education	
Primary Care Physician	$40 Copay then 100%; Deductible waived
Specialist	$55 Copay then 100%; Deductible waived

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	
Lab Services	$40 Copay then 100%; Deductible waived
X-Rays	$50 Copay then 100%; Deductible waived
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	$500 Copay then 100%; Deductible waived
Durable Medical Equipment (DME)	80% after Deductible
Emergency Services/Emergency Room Services	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.	
Glasses After Cataract Surgery	80% after Deductible
Maximum Benefit	1 pair per Surgery; 2 per Lifetime
Hearing Aids (up to age 19)	80% after Deductible
Maximum Benefit	1 hearing aid every 5 Calendar Years (including replacement)
Hemodialysis (Outpatient)	80% after Deductible
Home Health Care	80% after Deductible
Calendar Year Maximum Benefit	100 visits
Hospice Care	80% after Deductible
Hospice Bereavement Counseling (within 12 months of death)	80% after Deductible
Lifetime Maximum Benefit	6 visits per family
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	$1,000 Copay per admission then 100%; Deductible waived
Room and Board Allowance*	*Semi-Private Room Rate
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Service and Supplies	80% after Deductible
Outpatient	$750 Copay per occurrence then 100%; Deductible waived
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Infertility (Diagnosis and Testing only)	80% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Mammogram (Medically Necessary to treat an Illness)	80% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Maternity (non-facility charges)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived
Lactation Consultations	100%; Deductible waived
All Other Prenatal and Postnatal Care	$40 Copay then 100%; Deductible waived (Copay applies to the initial visit only)
Delivery	80% after Deductible

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Lab Services	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
Mental Disorders and Substance Use Disorders	
Inpatient	$1,000 Copay per admission then 100%; Deductible waived
Outpatient	
Office Visits	$40 Copay then 100%; Deductible waived
All Other Outpatient Care	80% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
Outpatient Therapies (physical, speech, occupational, aquatic)	$40 Copay then 100%; Deductible waived
Combined Calendar Year Maximum Benefit	20 visits
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits:	
Primary Care Physician	$40 Copay* then 100%; Deductible waived
Specialist	$55 Copay* then 100%; Deductible waived
Physician Office Surgery:	
Primary Care Physician	$40 Copay* then 100%; Deductible waived
Specialist	$55 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	
Preventive Services and Routine Care	
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100%; Deductible waived
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	100%; Deductible waived
Colonoscopy/Sigmoidoscopy (Routine and Diagnostic) – age 50 and over	100%; Deductible waived
Routine Mammograms	100%; Deductible waived
Maximum Benefit – Ages 35 - 39	1 baseline mammogram
Calendar Year Maximum Benefit – Ages 40 - 49	1 mammogram
Calendar Year Maximum Benefit – Ages 50 and over	Unlimited
Routine Eye Exam	100%; Deductible waived
Private Duty Nursing (Outpatient)	$55 Copay then 100%; Deductible waived
Prosthetics	80% after Deductible

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Radiation Therapy (Outpatient – includes all related charges)	80% after Deductible
Respiratory/Pulmonary Therapy (Outpatient)	$40 Copay then 100%; Deductible waived
Skilled Nursing Facility and Rehabilitation Facility	$1,000 Copay per admission then 100%; Deductible waived
Combined Calendar Year Maximum Benefit	45 days
Sleep Studies	$750 Copay then 100%; Deductible waived
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)
Temporomandibular Joint Dysfunction (TMJ)	
Office Visits: Primary Care Physician Specialist	 $40 Copay then 100%; Deductible waived $55 Copay then 100%; Deductible waived
All Other Outpatient Care	$750 Copay per occurrence then 100%; Deductible waived
Transplants	
Facility Fee	$1,000 Copay per admission then 100%; Deductible waived (Aetna IOE program)* Not Covered (All Other Network Providers)
Professional Fees	80% after Deductible (Aetna IOE program)* Not Covered (All Other Network Providers)
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.	
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.	
Urgent Care Facility	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	
Wig (see Eligible Medical Expenses)	80% after Deductible
Lifetime Maximum Benefit	$3,000
All Other Eligible Medical Expenses	80% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS - EPO 3 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	$3,000
Family	$6,000
Retail Pharmacy: 30-day supply	
Generic Drug	$20 Copay
Formulary Drug	$40 Copay
Non-Formulary Drug	$60 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Generic Drug	$20 Copay
Formulary Drug	$40 Copay
Non-Formulary Drug	$60 Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	$40 Copay
Formulary Drug	$80 Copay
Non-Formulary Drug	$120 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS – POS 4 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$2,000	$4,000
Family	$4,000	$8,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$4,500	$9,000
Family	$9,000	$18,000
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	30 visits	
Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	80% after Deductible	60% after Deductible
Applied Behavioral Analysis (ABA)		
Office Visits	$40 Copay then 100%, Deductible waived	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
Biofeedback (Outpatient)	$40 Copay then 100%, Deductible waived	60% after Deductible
Birthing Center	80% after Deductible*	60% after Deductible
* If the pregnancy spans over 2 Calendar Years only one Calendar Year Deductible will apply per pregnancy.		
Cardiac Rehab (Outpatient)	$40 Copay then 100%, Deductible waived	60% after Deductible
Chemotherapy (Outpatient- includes all related charges)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	$40 Copay then 100%, Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	20 visits	
NOTE: X-rays will be subject to the Deductible and Coinsurance.		
Cochlear Implants (age 18 months and over)	80% after Deductible	60% after Deductible
Diabetic Education	$40 Copay then 100%, Deductible waived	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Lab Services	$40 Copay then 100%, Deductible waived	60% after Deductible
X-Rays	80% after Deductible	60% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services/Emergency Room Services	80% after Deductible	Paid at the Participating Provider level of benefits
Glasses After Cataract Surgery	80% after Deductible	60% after Deductible
Maximum Benefit	1 pair per Surgery; 2 per Lifetime	
Hearing Aids (up to age 19)	80% after Deductible	60% after Deductible
Maximum Benefit	1 hearing aid every 5 Calendar Years (including replacement)	
Hemodialysis (Outpatient)	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	80% after Deductible	60% after Deductible
Hospice Bereavement Counseling (within 12 months of Covered Person's death)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	6 visits per family	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infertility (Diagnosis and Testing only)	$40 Copay then 100%, Deductible waived.	60% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%, Deductible waived	90%, Deductible waived
Lactation Consultations	100%, Deductible waived	100%, Deductible waived
All Other Prenatal and Postnatal Care	80% after Deductible** $40 Copay then 100% Deductible waived (initial visit only)	60% after Deductible**
Delivery	80% after Deductible**	60% after Deductible
Lab Services	100%, Deductible waived	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations. ** If the pregnancy spans over 2 Calendar Years only one Calendar Year Deductible will apply per pregnancy.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient		
Office Visits	$40 Copay then 100%, Deductible waived	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Therapies (physical, speech, occupational, aquatic)	$40 Copay then 100%, Deductible waived	60% after Deductible
Combined Calendar Year Maximum Benefit*	20 visits**	
* The combined Calendar Year maximum benefit does not apply to speech therapy in association with autism. ** Additional Calendar Year visits may by available when Medically Necessary. **NOTE:** Coverage for speech therapy is allowed for Covered Persons up to age 19, without regard to diagnosis.		
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits	$40 Copay* then 100%, Deductible waived	60% after Deductible
Physician Office Surgery	$40 Copay* then 100%, Deductible waived	60% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Pre-Admission Testing (Outpatient)	80% after Deductible	60% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%, Deductible waived	90%, Deductible waived

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%, Deductible waived	90%, Deductible waived
Colonoscopy/Sigmoidoscopy (Routine and Diagnostic) ages 50 and over	100%, Deductible waived	90%, Deductible waived
Routine Mammograms	100%, Deductible waived	90%, Deductible waived
Maximum Benefit For Covered Persons Ages 35 – 39	1 baseline mammogram	
Calendar Year Maximum Benefit For Covered Persons Ages 40 – 49	1 mammogram	
Calendar Year Maximum Benefit For Covered Persons Age 50 and over	Unlimited	
Routine Eye Exam	100%, Deductible waived	100%, Deductible waived
Private Duty Nursing (Outpatient)	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Radiation Therapy (Outpatient- includes all related charges)	80% after Deductible	60% after Deductible
Respiratory/Pulmonary Therapy (Outpatient)	$40 Copay then 100%, Deductible waived	60% after Deductible
Second Surgical Opinion	$40 Copay then 100%, Deductible waived	60% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit	45 days	
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)	Paid same as PCP office visit benefits (no maximums or exclusions applied)
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)
Temporomandibular Joint Dysfunction (TMJ)		
Office Visits	$40 Copay then 100%, Deductible waived	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	80% after Deductible	60% after Deductible
Wig (see Eligible Medical Expenses)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	$3,000	
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS - POS 4 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) Single Family	 $4,500 $9,000
Retail Pharmacy: 30-day supply	
Generic Drug	$20 Copay
Formulary Drug	$40 Copay
Non-Formulary Drug	$60 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Generic Drug	$20 Copay
Formulary Drug	$40 Copay
Non-Formulary Drug	$60 Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	$40 Copay
Formulary Drug	$80 Copay
Non-Formulary Drug	$120 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

EXHIBIT B

MEDICAL SCHEDULE OF BENEFITS – HDHP 5 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card)		
Single	$3,000	$6,000
Family	$6,000	$12,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$6,000	$12,000
Family	$12,000	$24,000
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	30 visits	
Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	80% after Deductible	60% after Deductible
Applied Behavioral Analysis (ABA)		
Office Visits	80% after Deductible	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
Biofeedback (Outpatient)	80% after Deductible	60% after Deductible
Birthing Center	80% after Deductible	60% after Deductible
Cardiac Rehab (Outpatient)	80% after Deductible	60% after Deductible
Chemotherapy (Outpatient- includes all related charges)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	20 visits	
NOTE: X-rays will be subject to the Deductible and Coinsurance.		
Cochlear Implants (age 18 months and over)	80% after Deductible	60% after Deductible
Diabetic Education	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Lab Services	80% after Deductible	60% after Deductible
X-Rays	80% after Deductible	60% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services/Emergency Room Services	80% after Deductible	Paid at the Participating Provider level of benefits
Glasses After Cataract Surgery	80% after Deductible	60% after Deductible
Maximum Benefit	1 pair per Surgery; 2 per Lifetime	
Hearing Aids (up to age 19)	80% after Deductible	60% after Deductible
Maximum Benefit	1 hearing aid every 5 Calendar Years (including replacement)	
Hemodialysis (Outpatient)	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	80% after Deductible	60% after Deductible
Hospice Bereavement Counseling (within 12 months of Covered Person's death)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	6 visits per family	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infertility (Diagnosis and Testing only)	80% after Deductible	60% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	80% after Deductible	60% after Deductible
Delivery	80% after Deductible	60% after Deductible
Lab Services	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Therapies (physical, speech, occupational, aquatic)	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit*	20 visits**	
* The combined Calendar Year maximum benefit does not apply to speech therapy in association with autism. ** Additional Calendar Year visits may be available when Medically Necessary. **NOTE:** Coverage for speech therapy is allowed for Covered Persons up to age 19, without regard to diagnosis.		
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits	80% after Deductible	60% after Deductible
Physician Office Surgery	80% after Deductible	60% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Pre-Admission Testing (Outpatient)	80% after Deductible	60% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	60% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	60% after Deductible
Colonoscopy/Sigmoidoscopy (Routine and Diagnostic) ages 50 and over	100%; Deductible waived	60% after Deductible
Routine Mammograms	100%; Deductible waived	60% after Deductible
Maximum Benefit For Covered Persons Ages 35 – 39	1 baseline mammogram	
Calendar Year Maximum Benefit For Covered Persons Ages 40 – 49	1 mammogram	
Calendar Year Maximum Benefit For Covered Persons Age 50 and over	Unlimited	
Routine Eye Exam	100%; Deductible waived	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Private Duty Nursing (Outpatient)	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Radiation Therapy (Outpatient- includes all related charges)	80% after Deductible	60% after Deductible
Respiratory/Pulmonary Therapy (Outpatient)	80% after Deductible	60% after Deductible
Second Surgical Opinion	80% after Deductible	60% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit	45 days	
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)	Paid same as PCP office visit benefits (no maximums or exclusions applied)
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)
Temporomandibular Joint Dysfunction (TMJ)		
Office Visits	80% after Deductible	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	80% after Deductible	60% after Deductible
Wig (see Eligible Medical Expenses)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	$3,000	
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

EXHIBIT C

PRESCRIPTION DRUG SCHEDULE OF BENEFITS - HDHP 5 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible) Single Family	 $3,000 $6,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) Single Family	 $6,000 $12,000
Retail Pharmacy: 30-day supply	
Generic Drug	Deductible, then $20 Copay
Formulary Drug	Deductible, then $40 Copay
Non-Formulary Drug	Deductible, then $60 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100%; Deductible waived)
Mandatory Specialty Pharmacy Program: 30-day supply	
Generic Drug	Deductible, then $20 Copay
Formulary Drug	Deductible, then $40 Copay
Non-Formulary Drug	Deductible, then $60 Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	Deductible, then $40 Copay
Formulary Drug	Deductible, then $80 Copay
Non-Formulary Drug	Deductible, then $120 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100%; Deductible waived)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

DELTA DENTAL

Delta Dental PPO plus Premier
LAKE COUNTY SCHOOL DISTRICT – GROUP # 12558

CALENDAR YEAR MAXIMUM BENEFIT	$1,750 per individual
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major	Individual Deductible - $ 50.00 Family Deductible - $150.00

PPO Dentist	PREMIER Dentist	OON Dentist	COVERED SERVICES	BENEFIT INFORMATION
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a 12-month period. Two additional cleanings for special needs
			Sealants	Once per tooth for permanent molars in children through age 14
			Bitewing X-Rays	Once in a 12-month period
			Full Mouth X-Rays	Once in a 60-month period
			Fluoride	Twice in a 12-month period, through age 15
			Space Maintainers	Children through age 13
BASIC SERVICES – DEDUCTIBLE APPLIES				
80%	80%	80%	Fillings	Once per tooth in a 12-month period; amalgam fillings on back teeth; composite (white) fillings on front teeth
			Simple Extraction	
			Oral Surgery (General Anesthesia)	
			Endodontics/Periodontics	
MAJOR SERVICES – DEDUCTIBLE APPLIES				
50%	50%	50%	Crowns / Implants	Once per tooth in a 60-month period
			Dentures/Bridges	One in a 60-month period, only when an existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit for children under age 16
ORTHODONTICS - $2,000 LIFETIME MAXIMUM				
50%	50%	50%	Children to age 19; $2,000 lifetime maximum	

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist, but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Out-of-Network Dentist – Payment is based on the out-of-network Maximum Plan Allowance (MPA). Members re responsible for the difference between the out-of-network MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

Open Enrollment applies. Members may add coverage once per year.

This is a brief description of services covered under your dental plan. Please refer to the Employee Benefit Booklet for full plan details. If differences exist between this summary and the Employee Benefit Booklet, the Employee Benefit Booklet will govern.

Delta Dental of Colorado Customer Service: 1.800.610.0201 - customer_service@ddpco.com. Find us online at www.deltadentalCO.com.

Lake County School District

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Progressive - Standard	$90 copay	Up to $50
Progressive - Premium Tier 1 - 3	$110 - 135 copay	Up to $50
Progressive - Premium Tier 4	$90 copay; 20% off retail price less $120 allowance	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $130
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $130
Contacts - Medically Necessary	$0 copay	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 24 months from the date of service	Once every 24 months from the date of service
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service
Contact Lenses	Once every 24 months from the date of service	Once every 24 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Discounts are not insured benefits. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

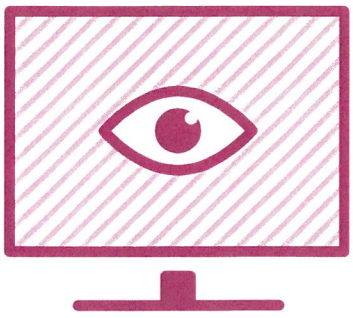
Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

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