Bullhook Community Health Center Inc

Policy #: 413779
Effective Date: January 1, 2016

Plan Design Summary

Ameritas
fulfilling life.

Eye Exam, Lenses, Frames

	VSP Choice + Affiliates	Out of Network
Annual Eye Exam	**Covered in full**	**Up to $45**
Single Vision Lenses	**Covered in full**	**Up to $30**
Bifocal Lenses	**Covered in full**	**Up to $50**
Trifocal Lenses	**Covered in full**	**Up to $65**
Lenticular Lenses	**Covered in full**	**Up to $100**
Frames	**Up to $130**	**Up to $70**
Contact Lenses: Medically Necessary	**Covered in full**	**Up to $210**
Contact Lenses: Elective (in lieu of Glasses)	**Up to $130**	**Up to $105**

Deductible, Frequencies

	Deductible	Frequency
Annual Eye Exam	**$15**	**Once every 12 months**
Material - Spectacles	**$25**	**Once every 12 months**
Material - Frames	**$25**	**Once every 24 months**

Monthly Rates

Employee	**$10.70**
Employee +1 Dependent	**$15.90**
Employee +2 or More Dependents	**$26.90**

VSP Choice Network Doctor: VSP will pay the cost of a comprehensive eye examination and prescribed materials purchased (frames, lenses, or contacts), up to the plan allowance. Up to a 20% savings on lens extras such as scratch resistant and anti-reflective coatings, tints, blended and progressive lenses. A 20% discount is applied to the amount over the $130 frame allowance. There is a 20% discount off additional pairs of prescription glasses and sunglasses.

Non-Network Doctor: VSP will pay the cost of an eye examination and prescribed materials purchased (frames, lenses, or contacts) based upon a schedule of benefits. Although over 90% of VSP patients typically receive services from member doctors, services may be secured from any licensed optometrist, ophthalmologist, and/or dispensing optician. Bills for services from non-member doctors may be submitted to VSP for reimbursement. Services obtained through non-member doctors are subject to the same deductibles and limitations as services through VSP member doctors.

Laser Vision Surgery: Discounts vary by location, but will average 15% off the contracted laser center's usual and customary charges. Additionally, if the laser center is offering a temporary price reduction, VSP members will receive 5% off the promotional price.

How to access benefits: If you need to locate a VSP participating doctor, call Vision Service Plan at (800) 877-7195 or visit VSP's web site at www.vsp.com.

Your Agent's information: **Nickolas Prinzing (406) 252-4104**

Benefits stated above are subject to the terms of the applicable master policy. Should they differ, benefits and terms stated in the Master Policy will prevail. Any change to this flier is prohibited

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Dental Summary	Premier		
Benefits Based on 75th Usual & Customary	1st Year	2nd Year	3rd Year
Type 1 - Preventive Procedures *Fluoride Treatments (under age 19), X-Rays, Cleanings, Periodic Exams*			
Benefit Year Deductible	$0	$0	$0
Plan Benefit	100%	100%	100%
Type 2 - Basic Procedures *Simple Extractions, Fillings, Root Canals, Non-Surgical Periodontics*			
Benefit Year Deductible	$50	$50	$50
Plan Benefit	80%	80%	80%
Type 3 - Major Procedures *Removal of Impacted Teeth, Bridges, Crowns(including crowns on implants), Dentures, Partials, Surgical Periodontics*			
Benefit Year Deductible	Not	$50	$50
Plan Benefit	Covered	50%	50%
Benefit Year Maximum Type 1, 2, and 3	$1,000	$1,500	$2,000
Orthodontia (under age 19)			
Lifetime Deductible			$50
Plan Benefit	Not	Not	50%
Lifetime Benefits	Covered	Covered	$1,000

Monthly Rates

Employee	$30.80
Employee +1 Dependent	$60.96
Employee +2 or More Dependents	$90.75

Dental Summary	Pediatric Dental AV 70*		
Benefits Based on 75th Usual & Customary	1st Year	2nd Year	3rd Year
Type 1 - Preventive Procedures *Fluoride Treatments (under age 19), X-Rays, Cleanings, Periodic Exams*			
Benefit Year Deductible	$75	$75	$75
In-Network Plan Benefit	100%	100%	100%
Type 2 - Basic Procedures *Simple Extractions, Fillings, Removal of Impacted Teeth*			
Benefit Year Deductible	$75	$75	$75
In-Network Plan Benefit	55%	55%	55%
Type 3 - Major Procedures *Root Canals, Bridges, Crowns (including crowns on implants), Dentures, Partials*			
Benefit Year Deductible	$75	$75	$75
In-Network Plan Benefit	35%	35%	35%
Benefit Year Maximum Type 1, 2, and 3	NA	NA	NA
Out of Pocket Maximum – per child	$350	$350	$350
Multi-Child Out of Pocket Maximum	$700	$700	$700
Medically Necessary Orthodontia (under age 19)			
Lifetime Deductible			$0
Plan Benefit	Not	Not	50%
Lifetime Benefits	Covered	Covered	NA-Combined with Dental

* This plan has been certified by the federal government and meets requirements for pediatric dental EHB under the Affordable Care Act.

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Pediatric Dental Essential Health Benefits (EHB)

Pediatric Dental Essential Health Benefits (EHB)
Pediatric dental EHB are one of ten benefit categories that must be offered to small employers by the Affordable Care Act and are subject to consumer protections, including no annual or lifetime limits and established member out of pocket maximum. Pediatric coverage is limited to persons under age 19.

Better Benefit
If a member under the pediatric dental age receives a service eligible for payment under either the traditional family benefits or the pediatric dental benefits, we will review the claim under the parameters of both benefit coverages and consider the better benefit for payment by us.

Out of Pocket Maximum
The most a member will pay for pediatric dental benefits before this plan begins to pay 100% of covered services. Expenses accumulated toward this limit do not include premium, charges in excess of the allowed amount, payments for procedures performed out-of-network or for non-covered services, including services not fully reimbursed due to contractual limitations such as frequency limitation or alternative benefit provision.

Multi-Child Out of Pocket Maximum
The most a family will pay for pediatric dental benefit before this plan begins to pay 100% of covered services. When the combined expenses accumulated for covered services meets the multi-child out of pocket maximum, all remaining out of pocket maximums for that family will be waived. Once any one individual meets their individual out of pocket maximum we will pay 100% of covered services for that individual.

Medically Necessary Orthodontia
For orthodontia, medically necessary relates to serious medical conditions, such as cleft lip or cleft palate (as defined by state). Pretreatment estimates are strongly encouraged before beginning any orthodontic treatment.

Member Savings

Plan members may receive additional savings that can reduce out of pocket expenses:

- Save up to 15% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide (savings does not include contact lenses or vision care materials)
- Save on prescription medications through any Walmart or Sam's Club pharmacy (membership at Sam's Club not required)

With our dental plans, you can receive care from any dentist you choose. However, with one of our dental network providers, your out-of-pocket costs will almost always be less. That's because these providers agree to charge a discounted network fee for each covered procedure.

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