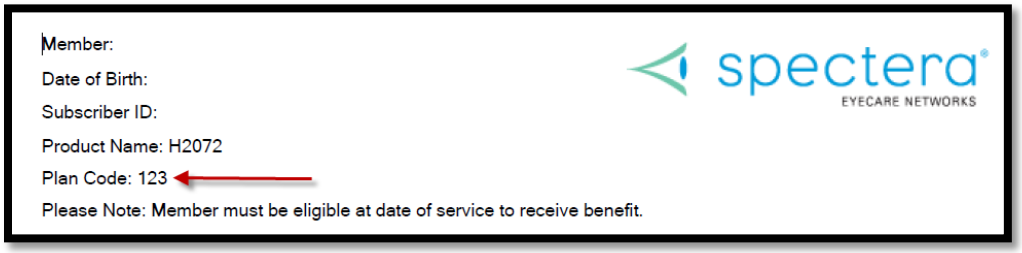
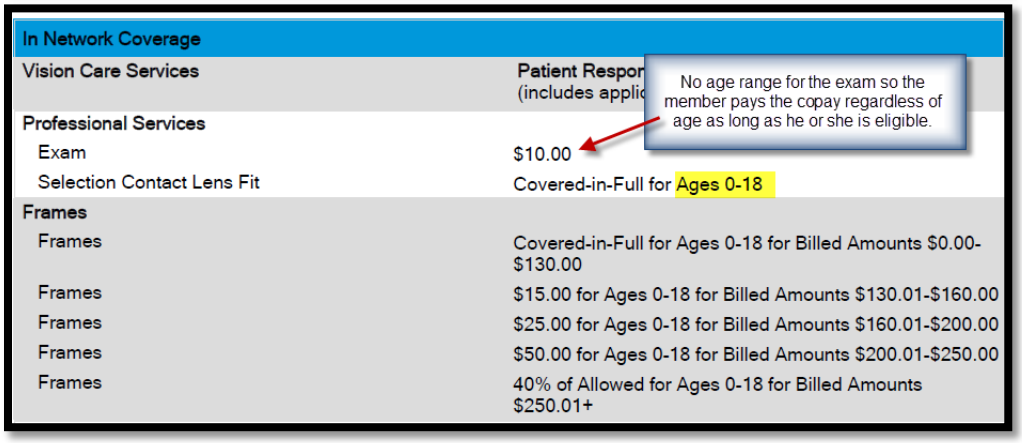
Tell Me More About Essential Health Benefit plans (EHB)

Essential Health Benefit plans, or EHB plans, are medical plans that always have a member out-of-pocket maximum*, and may or may not* have a deductible. Vision is just one component of an EHB plan. EHB plans (also referred to as ACA/Obamacare plans) require coverage of Dental, Vision, Rx and more for pediatric members. As a result, any out-of-pocket costs roll up to the medical out-of-pocket maximum and deductible when applicable.

How do you identify an EHB plan and how do you determine if there is a deductible that gets applied first?

- The easiest way to determine if a plan is an EHB plan is to look at the plan code listed on the benefit summary. When reviewing member benefits at spectera.com, look at the plan code on the top of the page. If the plan code is 3 or 4 characters long, the plan is an EHB plan. Once you identify the member has an EHB plan, you will want to determine if it is a plan *with or without* a deductible.
- The easiest way to determine if a plan has a deductible is, again, the plan code.
    - If the plan code starts with a D (i.e. – D99), you can assume that some portion of the member's benefit is dependent on a deductible. If you determine that the member has a deductible, you can reference the plan material given to you to determine where the deductible is required; either on the exam, materials, or both.
    - The member would receive the benefits listed on the benefit summary as long as:
        - The member is eligible for benefits,
        - The member's age falls within the stated range,
        - And the deductible for the service/material has been met.



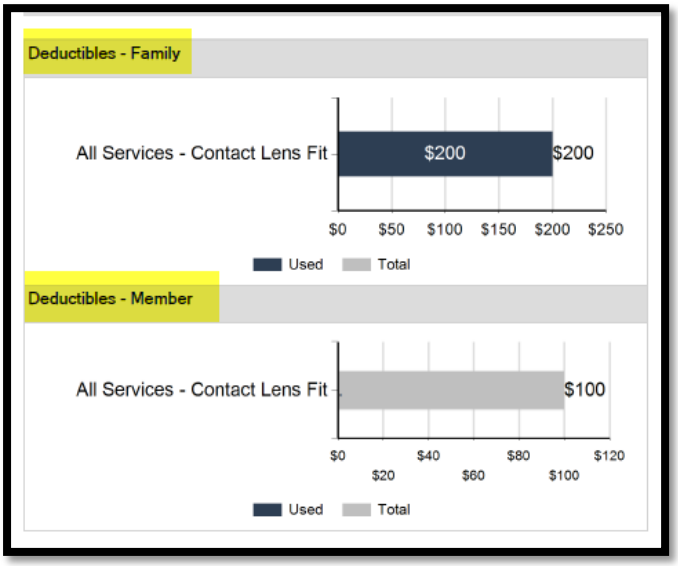


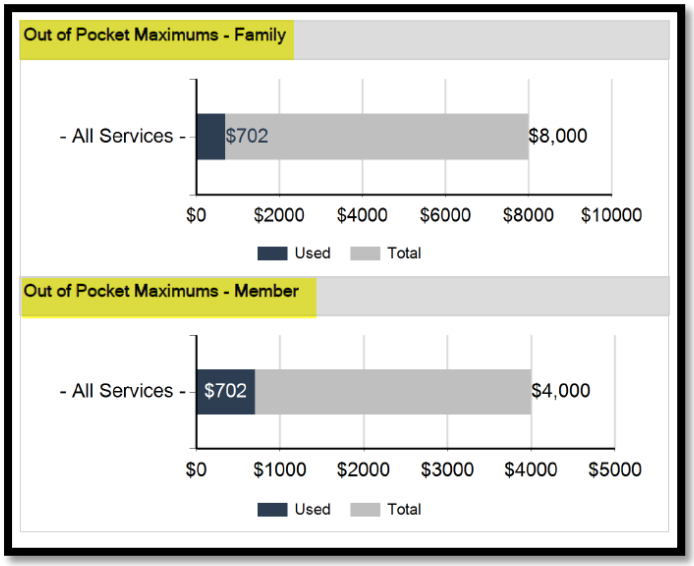
spectera
EYECARE NETWORKS

What is a deductible and what is an out-of-pocket maximum?

A deductible is the specified amount of money that the member must pay before the insurance coverage is enabled. The deductible is visible on the second or third page of the member's benefit summary, and will look like the example below. First, notice that it shows "All Services – Contact Lens Fit". This means that both the exam and materials are subject to the deductible for this plan. For example, you may see "All Materials – Contact Lens Fit" which would mean only the materials are subject to the deductible.

Please Note: The contact lens fit is always covered for ACA plans regardless of whether the deductible applies.





- Since both Member and Family are shown in the examples below, this plan requires the member to hit their individual deductible *or* the family deductible before the benefits listed on the sheet will be available.
    - If the deductible **hasn't** been met, the member would pay the eligible expenses, typically your contracted rate, 100% out-of-pocket, based on the eligible coverage. Any out-of-pocket cost will accumulate toward the deductible/out-of-pocket max.
    - If the deductible **has** been met, then the plan details on the benefit summary provided to you will be applied. (e.g. $xx copay toward exam or for coinsurance, xx% of allowed for bifocal, etc.)

- Out-of-pocket maximums, like deductibles, include the member's Medical, Rx, Vision, and Dental claims. Once the member hits the out-of-pocket maximum, then the member gets 100% coverage on all plan components.
    - For example, if a member had coinsurance of 50%, that would be ignored and the member would get their service covered in full.
    - Items that are not part of the coverage would continue to be charged at 100% of the billed charges since there is no benefit towards that option. For example, because platinum progressives are not part of the plan coverage, the full cost of these lenses would be the member out-of-pocket cost.

Note: If only the 'Deductible – Member' chart is listed, then the member only has to meet the individual deductible shown. If the family deductible has been met, then the individual deductible doesn't have to be met. The plan coverage is available when either individual or family is met.

spectera® EYECARE NETWORKS

FREQUENTLY ASKED QUESTIONS

Why does an adult – or someone over 18 – show coverage if they aren't even eligible?

A member's EHB eligibility is based on the adult subscriber's eligibility with one of UnitedHealthcare's medical plans. As a result, we note that the coverage is only available up to a certain age.

Why do EHB plans have a different contact lens formulary?

The formulary for EHB plans (contact lens formulary for medical plans, available at spectera.com) was developed to meet the needs of the pediatric population. The contact lens formulary for Medical plans is only for pediatric benefits. This formulary is only used if the member has EHB coverage listed on their benefit summary.

We offer the Medical plan formulary because the lenses on this formulary are traditionally better suited for wearers under the age of 19. EHB plans only cover contact lenses that are on the formulary. If the member selects a contact lens that is not on the formulary, then the contact lens purchase is 100% out-of-pocket for the member. There is no allowance that can be applied.

NOTE: If the benefit is not EHB then please refer to contact lens formulary listed for vision plans.

How do I read the plan grid?

The plan grid provided to you is a secondary source for you when working with EHB plans. These documents will have a "Y" or "N" to identify what part of the member's benefit the deductible applies to. If there is a "Y", then the deductible must be met prior to the benefit kicking in. If the deductible hasn't been met then the member will pay based on the eligible expenses for the item and the out-of-pocket cost will then accumulate towards the deductible/OOPM.