HOORAY HEALTH

PANDORA BENEFITS
Crafted Care

BENEFIT GUIDE

2026 Plans for Pandora Jewelry

Affordable Healthcare MADE SIMPLE

Everyone deserves access to quality care that fits their lifestyle. With Hooray Health, getting affordable, everyday care is easier than ever.

AFFORDABLE HEALTHCARE FOR

YOU AND YOUR FAMILY

Pandora Jewelry and Hooray Health have partnered to offer affordable health benefits with layered protection - giving you and your loved ones access to quality care when you need it most.

Whether you're sick, need a prescription, or have an accident - **your Hooray Health benefits have you covered**.

When You're Sick & Need Care	When You Need A Prescription	When You Have An Accident
Get care using telemedicine or visiting an urgent care	**Save on meds – our app finds the best price nearby**	**Don't stress - benefits will cover your medical costs**
✓ 24/7, $0 virtual doctor visits ✓ $25 per visit at an in-network clinic or urgent care ✓ Access to doctors, specialists and hospitals through the First Health Network	✓ Save up to 80% off retail prices and over 500 name-brand medications available ✓ Get access to additional medications for acute and chronic conditions*	✓ Accident benefits starts at $5,000 to help cover eligible injury-related medical costs ✓ No deductible ✓ Go anywhere, or to our in-network providers

The **Hooray Health app** gets you care fast - connect with a telemedicine provider, find nearby providers, check prescription prices, and much more.

Included Benefits

- Doctor office visits
- Hospital visits
- X-rays and labs
- Surgeries

Additional Services

- Discount radiology program
- Virtual behavioral health

Your employer may offer additional coverage options like dental, vision, life insurance, or critical illness protection. To see what's available, check the supplemental benefits on page 21.

*Additional medications are plan specific. Please visit your enrollment website for more details.

Scan the QR code, visit **pandora.myhoorayhealth.com** or call **855-479-4008** to enroll!

USING HOORAY HEALTH PLANS

CARE OPTIONS & COST

Scan the QR Code to watch how to access care with Hooray Health!

WOKE UP WITH A FEVER?

You can choose to call our telemedicine service or visit an urgent care.

CALL A VIRTUAL DOCTOR OR **VISIT AN URGENT CARE**

PAY $0

When using **Hooray Health's** telemedicine doctor

*The $25 per visit fee applies to the number of urgent care visits included in your chosen plan per year.

PAY $25*

Per visit at an in-network urgent care center

Care is only a few steps away:

1. Use the app to find the closest urgent care
2. Call to set an appointment
3. Visit urgent care and show your member ID card

With no insurance, it can cost you up to **$434[1].**

FELL AND BROKE YOUR ARM?

Visit an in-network provider for care.

HOSPITAL VISIT & FOLLOW-UP TREATMENT(S)

PAY $0

Hooray Health's accident benefit covers medical cost up to $5,000, based on your plan.

Care is only a few steps away:

1. Use the app to find a provider
2. Visit provider and check-in by showing your Hooray Health ID card
3. Receive care and get x-rays, casts, and prescription(s), if required.

With no insurance, it can cost you up to **$3,096[2].**

These claim stories are an illustration and represents an individual's experience only and the experiences and opinions herein may be unique to the individual. Individual reimbursement results and coverage vary based on your chosen policy options.

[1]Fairhealthconsumer.org Uninsured/Out-of-Network cost in Zip Code 75248 for CPT Code 99202 Patient visit and 88106 Examination of body fluid.

[2]Gascon Ivey, A. (2023, May 1). How Much Does a Telehealth Visit Cost? GoodRx. Retrieved from https://www.goodrx.com/healthcare-access/telehealth/howmuch-does-telehealth-cost

WHY HOORAY HEALTH

CARE YOU TRUST. PROTECTION YOU NEED.

HOORAY HEALTH

Healthcare can get expensive fast - even for basic visits or small accidents. Hooray Health plans are built to protect your health and your wallet, with simple benefits that help cover the cost of care when you need it most.

A simple plan, built with layers of care and cost protections

Hooray Health App

Search for care, talk to a doctor, or check prescription prices - right from your phone

24/7 Telemedicine

$0 Cost
Talk to a board-certified doctor anytime and anywhere

Urgent Care Visits

Pay $25 Per Visit*
Over 4,500 in-network clinic and urgent care locations nationwide

Accident Protection

Benefits up to $5,000
Your plan helps cover the cost when the unexpected happens

Prescription Savings

$0 for many Meds
Save up to 80% off retail prices and over 500 name-brand medications available

Doctors, Specialists & Hospitals

$0 Copay
Find over 1.22 million providers within the First Health Network for additional care

Hospital & Surgery Benefits

$0 Copay
Plan gives set dollar amount for hospital stays and surgeries.

*The $25 per visit fee applies to the number of urgent care visits included in your chosen plan per year.
(1)Coverage details may vary depending on the specific plan options selected by your employer.

Scan the QR code to enroll. Join Hooray Health today and take control of your care. It's simple, smart, and built for you.

Advantage Max Benefit Plan Summary

Hooray Health's **Advantage Max Plans** provide fixed payments you can use towards plan visits and services, with **no preset limit on the number of Urgent Care and Retail Clinic Visits.** In addition to the policy year's fixed payments for illness and sickness, Hooray Health Advantage Max plans also include Accident Medical Expense Benefits.

	MAX $5,000 LITE	MAX $5,000 ENHANCED
ILLNESS AND SICKNESS POLICY YEAR MAXIMUM	$5,000	$5,000
PLUS **ACCIDENT MEDICAL EXPENSE MAXIMUM** (PER ACCIDENT)	$5,000	$5,000
LIFETIME MAXIMUM	N/A	N/A
OUTPATIENT SICK VISIT BENEFITS	**PLAN PAYS PER DAY**	
URGENT CARE/RETAIL CLINIC OFFICE VISITS	Up to Policy Year Max	
Hooray Health Urgent Care / Retail Clinic Network	**Includes Office Visit + In-House lab test, X-Rays, etc.** Member Pays a $25 fee*; Plan pays $275	
Urgent Care or Retail Clinic Office Visits	**First Health Network Provider at discounted rates** or Out-of-Network Provider with no discounts*** ** Plan pays $275	
OUTPATIENT PHYSICIAN OFFICE VISITS	Plan pays $75	Plan pays $75
VIRTUAL PRIMARY CARE & URGENT CARE TELEMEDICINE	$0 consult; 1 per day; Plan pays $5	
VIRTUAL BEHAVIORAL HEALTH TELEMEDICINE[1]	3 visits per year; Plan pays $5	
OUTPATIENT IMAGING/LAB TEST	**PLAN PAYS PER DAY**	
Diagnostic Lab Indemnity Benefit	$50	$50
Diagnostic X-Ray Indemnity Benefit	$50	$50
Diagnostic Exam Indemnity Benefit	$100	$100
OUTPATIENT SURGERY BENEFITS	**PLAN PAYS PER DAY**	
ASC or Hospital Benefit	N/A	$500
Anesthesia Benefit	N/A	$200
INPATIENT BENEFITS	**PLAN PAYS PER DAY**	
Hospital Admission Benefit (1 per year)	$100	$500
In-Hospital Indemnity Benefit	N/A	$500
In-Hospital ICU Confinement Benefit	N/A	$500
Mental Illness Confinement Benefit	N/A	$500
Substance Abuse Confinement Benefit	N/A	$500
In-Hospital Surgery Benefit (Maternity Included) 1 per year	N/A	$500
Anesthesia Benefit (1 per year)	N/A	$200
ACCIDENT BENEFITS (INPATIENT AND OUTPATIENT)	**PLAN PAYS PER ACCIDENT**	
ACCIDENT MEDICAL EXPENSE		
Maximum Benefit Per Accident	up to $5,000	up to $5,000
Annual Deductible	*$0*	
ACCIDENTAL DEATH COVERAGE		
Principal Sum	$1,000	
NON-INSURANCE SERVICES[2]		
Discounted Prescriptions (SimpleScripts Rx)[3]	Included	
Discount Radiology (Green Imaging)[3]	Included	

Footnotes referenced on the last page.

Advantage Max Benefit Plan Summary

Hooray Health's **Advantage Max Plans** provide fixed payments up to the policy maximum amounts which vary based on your unique needs and plan selection. If you reach your policy maximum limit, you still have access to Hooray Health's network of savings, accident coverage, telemedicine and more!

MONTHLY RATES	MAX $5,000 LITE	MAX $5,000 ENHANCED
EMPLOYEE ONLY	$74.47	$99.95
EMPLOYEE + SPOUSE	$104.56	$166.94
EMPLOYEE + CHILD(REN)	$110.72	$165.92
FAMILY	$135.45	$228.28

METLIFE DENTAL	MONTHLY RATES
EMPLOYEE ONLY	$35.56
EMPLOYEE + SPOUSE	$69.39
EMPLOYEE + CHILD(REN)	$75.66
FAMILY	$116.93

METLIFE VISION	MONTHLY RATES
EMPLOYEE ONLY	$10.07
EMPLOYEE + SPOUSE	$20.42
EMPLOYEE + CHILD(REN)	$23.21
FAMILY	$35.80

METLIFE SHORT TERM DISABILITY	MONTHLY RATES
EMPLOYEE ONLY	$26.60

Virtual Primary Care

Telemedicine included in Hooray Health Plan

powered by RECURO HEALTH

Top primary care physicians provide personalized care through message-based and video interactions, no matter your location or circumstance. Select a dedicated, board-certified physician who you will see for your annual check-up and any follow-up visits.

Highlights:

- **Comprehensive** An integrated care team of board certified primary care physicians enables care with a personal touch.
- **Convenient** Patient receives a lab kit shipped to their doorstep, self-collect their sample, and mail it to the lab, all from the comfort of their home.
- **Preventive** A proactive approach that includes 1 at-home lab per year, and risk stratification enables early intervention to improve patient experience and outcomes.

Conditions Treated

- Allergic Conditions
- Diabetes
- High Cholesterol
- Hypertension
- GI Tract Issues
- Prediabetes
- Respiratory Illness
- And More

Virtual Urgent Care

Telemedicine included in Hooray Health Plan

Highlights:

- **24/7 Acute Care Access** 24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor.
- **Convenient** Patients can see a board-certified physician wherever they are, whenever they need it.
- **Personalized** Patients receive treatment plans based on their unique needs and can ask follow-up questions to their doctors after the visit, free of charge.

Conditions Treated

- Acne / Rashes
- Allergies
- Cold / Flu / Cough
- Pink Eye
- Ear Problems
- Fever / Headache
- Insect Bites
- And More

855-673-2876 | member.recurohealth.com

Virtual Behavioral Health

Included in Hooray Health Plans

powered by RECURO HEALTH

While experiencing personal or family distress, the assistance of a professional can ensure emotional health.

The Hooray Health app serves as the first step in obtaining comprehensive behavioral health care from therapy and counseling to psychiatry and medication management.*

Conditions Treated

- ADHD/ADD
- Anger Management
- Anxiety
- Bipolar Disorder
- Sleeping Disorder
- Smoking Addiction
- Substance Abuse
- Depression
- Stress
- Eating Disorder
- Grief & Loss
- PTSD
- OCD
- And more

Facts and Figures:

Stress is prevalent in our society and has become a top priority for the U.S. Public Health Services.

48 HOURS

Did you know?

Behavioral health visits are available within 48 hours, far more accessible than other options.

Simply call 855-673-2876 to connect to Virtual Behavioral Health!

Product Details

Psychiatry
Psychiatry and behavioral health medication management.

Integrated Prescription
Prescriptions are immediately sent to the patient's preferred pharmacy for easy pickup.

PGx Testing
Pharmacogenetic testing to personalize the right medication and dosage for each patient, based on their genes.

Health Risk Assessment
Behavioral health-focused risk assessment including depression and anxiety.

Therapy and Counseling
Therapy and Counseling services from social workers and psychologists.

Risk Stratification
Analytics to identify those most at risk of behavioral health challenges to proactively engage and treat.

Integrated Lab Testing
Post-visit lab testing where needed, integrated within the Recuro platform.

Primary Care Coordination
Primary care and behavioral health can be integrated to provide holistic patient care.

Behavioral Health Visits limited to 3 per year including Licensed Counseling, Psych, and Psych Follow-Up. Out of pocket costs for additional visits are $85.00 for Licensed Counseling, $225.00 for Psych Initial Visit, and $95.00 for Psych Follow-Up.

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Network: PDP Plus

Dental	In-Network[1] % of Negotiated Fee	Out-of-Network[2] 90% of R&C Fee**
Coverage Type		
Type A: Preventive (cleanings, exams, X-rays)	80%	80%
Type B: Basic Restorative (fillings, extractions)	60%	60%
Type C: Major Restorative (bridges, dentures)	50%	50%
Deductible†		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit		
Per Person	$750	$750

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

[2] Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

†Applies to Type B and C Services.

*** Orthodontia excluded for adults. Available for dependent children up to age 19.

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category but is not a complete description of the Plan.

Plan Type	How Many/How Often
Type A — Preventive	
Oral Examinations	Two times in 12 months
Examinations – Problem Focused	Combined with Examinations Limit
Prophylaxis (cleanings)	Two times in 12 months
Sealants	One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday
Topical Fluoride Applications	One fluoride treatment in 12 months for dependent children up to his/her 14th birthday
Full Mouth X-Rays	Full mouth X-rays; one per 60 months
Bitewing X-Rays	Bitewings X-rays; one set in 12 months for adults and children
Labs & Other Tests	
Periapical X-Rays	
Other X-Rays	
Type B — Basic Restorative	
Fillings	One replacement per surface in 24 months

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Endodontics	Root canal treatment limited to once per tooth per lifetime
Periodontics	• Periodontal scaling and root planing once per quadrant, every 60 months • Periodontal surgery once per quadrant, every 60 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Emergency Palliative Treatment	
General Anesthesia	
Resin Composite Fillings (includes coverage for composite fillings on molars)	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
Apexification & Recalcification	
Periodontics – Non-Surgical	
Oral Surgery: Simple Extractions	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	
General Services	
Type C — Major Restorative	
Consultations	One in 12 months
Prefabricated Crowns	One per tooth in 10 calendar years
Crown Buildups / Post Core	One per tooth in 10 calendar years
Repairs	One in 12 months
Recementations	One in 12 months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 10 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Dentures – Rebases / Relines	One in 36 months
Denture Adjustments	One in 12 months
Fixed Bridges	One in 10 calendar years
Inlays / Onlays /Crowns	One replacement per tooth in 10 calendar years
Implant Services	One per tooth position in 10 calendar years
Implant Repairs	One per tooth in 10 calendar years
Implant Supported Prosthetic	One per tooth in 10 calendar years
Tissue Conditioning	One in 36 months
Occlusal Adjustments	One in 12 months
Harmful Habit Appliances	
Occlusal Guards / Bruxism Appliances	

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Exclusions **This plan does not cover the following services, treatments and supplies:**

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Adjustments of a denture made within 6 months after installation by the same dentist who installed it.
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance.
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at or call to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern. Please review the enclosed plan benefits to learn more.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit or call to have a list faxed or mailed to you.

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

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†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Vision Plan Summary

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision provider and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists, and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[1]

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.[1]

Laser vision correction: [2] Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every **12** months
• Eye health exam, dilation, prescription, and refraction for glasses: Covered in full after a $10 copay.	
• Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice.	
Frame	Once every **24** months
• Allowance: **$130** after **$25** eyewear copay. $150 on featured frames	
• Costco, Walmart, and Sam's Club: **$70** allowance. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart, and Sam's Club.	
Standard corrective lenses	Once every **12** months
• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$25** eyewear copay.	
Standard lens enhancements[1]	Once every **12** months
• Standard Polycarbonate (child up to age 18) **and Ultraviolet (UV) coating**: Covered in full.	
• Progressive Standard, Progressive Premium/Custom, Standard Polycarbonate (adult), Scratch-resistant coatings, Solid or Gradient Tints, Anti-reflective, Photochromic: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at metlife.com/mybenefits.	
Contact lenses (instead of eyeglasses)	Once every **12** months
• Contact fitting and evaluation: Standard or Premium fit covered in full	
• Elective lenses: $**130** allowance	
• Necessary lenses: Covered in full after eyewear copay.	

We're here to help

Find a Vision provider at
www.metlife.com/vision

Download a claim form at
www.metlife.com/mybenefits

For general questions go to
www.metlife.com/mybenefits
or call 1-855-MET-EYE1
(1-855-638-3931)

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

- Eye exam: up to **$45**
- Frames: up to **$70**
- Contact lenses:
  - Elective up to **$105**
  - Necessary up to **$210**
- Single vision lenses: up to **$30**
- Lined bifocal lenses: up to **$50**
- Lined trifocal lenses: up to **$65**
- Lenticular lenses: up to **$100**
- Progressive lenses: up to **$50**

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments:

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

Medications

- Prescription and non-prescription medication

1 All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart or Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

2 Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Savings from enrolling in a MetLife Vision Plan will depend on various factors, including plan premiums, number of visits to an eye care professional by your family per year and the cost of services and materials received. Be sure to review the Schedule of Benefits for your plan's specific benefits and other important details.

Vision insurance is provided by Metropolitan Life Insurance Company, New York, NY (MetLife). Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Short Term Disability

Metropolitan Life Insurance Company

Explore the coverage that helps you protect your income and your lifestyle.

What is Short Term Disability insurance?

Short Term Disability (STD) insurance can help you replace a portion of your income during the initial weeks of a Disability.

How is "Disability" defined under the Plan?

Generally, you are considered disabled and eligible for short term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation.

For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance/Summary Plan Description provided by your Employer or contact your MetLife benefits administrator with any questions.

What is the benefit amount?

Short Term Disability:

The Short Term Disability benefit replaces a portion of your predisability earnings, less the income that was actually paid to you for the same Disability from other sources[1] (e.g., state disability benefits, no-fault auto laws, sick pay, vacation pay etc.).

The Benefit amount is **50%** of your predisability weekly earnings subject to the plan's maximum weekly benefit of **$200.**

When do benefits begin and how long do they continue?

Short Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait, while disabled, before you are eligible to receive a benefit. The elimination period is as follows:

For Injury: 7 days.

For Sickness (includes pregnancy): 7 days.

Benefits continue for as long as you are disabled up to a maximum duration of **25** weeks of Disability.

Your plan’s maximum benefit period and any specific limitations are described in the Certificate of Insurance/Summary Plan Description provided by your Employer.

Additional Disability Plan Benefits:

Coverage with Your Best Interests in Mind...

When you are ill or injured for a short period, MetLife believes you need more than a supplement to your income. That's why we offer return-to-work services, and financial incentives.

Services to Help You Get Back to Work Can Include:

Nurse Consultant or Case Manager Services:
Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis:
Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accommodations:
Adjustments (e.g., redesign of work station tools) that enable you to return to work.

Retraining:
Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives:
Allow you to receive Disability benefits or partial benefits while attempting to return to work

Answers to Some Important Questions...

Q. Can I still receive benefits if I return to work part time?

A. Yes. As long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Your plan offers financial and Rehabilitation incentives designed to help you to return to work when appropriate, even on a part-time basis when you participate in an approved Rehabilitation Program. While disabled, you may receive up to 100% of your predisability earnings when combining benefits, Rehabilitation Incentives and other income sources such as Social Security Disability Benefits and State Disability Benefits, and part-time earnings.

With the Rehabilitation Incentive you can get a 10% increase in your weekly benefit.
Following the 4th weekly benefit payment, the Family Care Incentive provides reimbursement up to $100 per week for eligible expenses, such as child care.
You may be eligible for the Moving Expense Incentive if you incur expenses in order to move to a new residence recommended as part of the Rehabilitation Program. Expenses must be approved in advance.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability which results from or is caused or contributed to by:

- Elective treatment or procedures, such as cosmetic surgery, reversal of sterilization, liposuction, visual correction surgery or in vitro fertilization, embryo transfer procedure, artificial insemination, or other specific procedures. However, pregnancies and complications from any of these procedures will be treated as a sickness.
- War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

Additionally, no payment will be made for a Disability caused or contributed to by any injury or sickness for which you are entitled to benefits under Workers' Compensation or a similar law.

Other limitations or exclusions to your coverage may apply. Please review your Certificate of Insurance for specific details or contact your benefits administrator with any questions.

The "Plan Benefits" provides only a brief overview of the STD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan

documents, the legal plan documents will govern.

Short Term Disability ("STD") coverage is provided under a group insurance policy (Form GPNP99) issued to your employer by MetLife. This STD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your STD contributions cease (if applicable) or upon termination of the group contract by your employer. Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details. State variations may apply.

[1] Under certain circumstances, MetLife may estimate the amount of income you may receive from other sources.

Discount Radiology*

Included in Hooray Health Plan

Green Imaging

SAVE UP TO 70% ON YOUR X-RAY, MRI, CT, ULTRASOUND, MAMMOGRAM

or other medical imaging procedure.*

When you need diagnostic imaging for your medical needs, trust **Green Imaging** to provide you with high-quality facilities, great service, and transparent & affordable rates.

No surprise bills. One flat rate from Green Imaging will include both the exam fee and the radiologist fee, with no additional cost to you. **Call Green Imaging to save today!**

Cardiac diagnostic imaging services:

- CT Coronary Angography (CTCA)
- Coronary Artery Calcium Scoring
- Cardiac MRI

CALL 844-968-4647 AND BOOK YOUR APPOINTMENT

*Discount program is offered by Hooray Health, not employer and offered to everyone regardless of hours worked or who their employer is.

ADDITIONAL COVERAGE OPTIONS

SUPPLEMENTAL PLANS

Your employer cares about your health and well-being—not just while you're at work, but in all areas of life. That's why they're offering access to additional benefits beyond your Hooray Health coverage.

These optional plans are made available through trusted providers and give you extra support where it matters most—your health, your finances, and your peace of mind.

Choose the coverage that fits your needs and feel confident knowing you're supported—at work, at home, and everywhere in between.

Dental

Affordable dental plans, with no waiting periods and special group pricing. Great for families and includes yearly coverage limits.

Vision

Vision plans use the VSP Choice Network, giving you access to over 86,000 eye doctors across the U.S.

Short-Term Disability

(STD) insurance can help you replace a portion of your income during the initial weeks of a Disability.

ENROLL TODAY!

Scan the QR code, visit **pandora.myhoorayhealth.com** or call **855-479-4008** to enroll!

Footnotes and Disclaimers

IMPORTANT: This is a fixed indemnity policy, NOT comprehensive health insurance. (More details on the Enrollment Site)

*Visits to Urgent Cares in the Hooray Health network cost $300. You will pay $25 for a sick visit because the insurance plan's Sickness Urgent Care Benefit will pay the remaining $275 due. If you go to an out-of-network urgent care, you will still receive the $275 Sickness Urgent Care benefit, but you may have to pay more than $25 out of pocket.

**First Health Network contracted providers can be found at hoorayhealth.com/FHN. Discounted rates will be applied after services are rendered at physician's office through the Third Party Administrator. Member will be responsible for any payment balance above the plan payment of $275. Please see plan policy for details.

***Out-of-Network provider visits are paid $275 per the plan policy. Member will be responsible for any payment balance above the plan payment of $275. Please see plan policy for details.

(1) Behavioral Health Visits limited to 3 per year including Licensed Counseling, Psych, and Psych Follow-Up. Out of pocket costs for additional visits are $85.00 for Licensed Counseling, $225.00 for Psych Initial Visit, and $95.00 for Psych Follow-Up.

(2) The services described are not insurance and are not provided by Zurich American Insurance Company.

(3) Program is offered by Hooray Health, not employer. Discount programs are not offered by the employer, but is offered by Hooray Health to everyone regardless of hours worked or who their employer is. Distribution of materials that identify discount program should not be interpreted as employer sponsorship or endorsement of discount program.

The Accident and Hospital Indemnity benefits are not dependent upon the use of the Hooray Health Network, the First Health Network, or any network. The Insurance benefits described above are underwritten by Zurich American Insurance Company, 1299 Zurich Way, Schaumburg, IL 60196, 1-800-987-3373. This document provides a general description of certain provisions and features of this insurance program and does not revise or amend the applicable policies. In the event of a discrepancy between this document and your certificate of insurance or the group policy, the terms of the group policy shall apply. All benefits are subject to the terms and conditions of the group policy. Please refer to your Certificate of Insurance for a detailed description of the insurance coverage, including the exclusions, limitations, reductions and termination. Coverage may not be available in all states or certain terms, conditions and exclusions may be different where required by state law. This insurance provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative, it is intended to help supplement Comprehensive coverage. This insurance does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.