Caring always comes first.

Your Benefit Details

Group Name
Vista Security Group

Plan Type
Univera PPO Signature Deduct 4
Univera PPO Signature Deduct 3 $3000
Univera PPO Signature Deduct 3 $4000
Univera PPO Signature Deduct 3 $4500

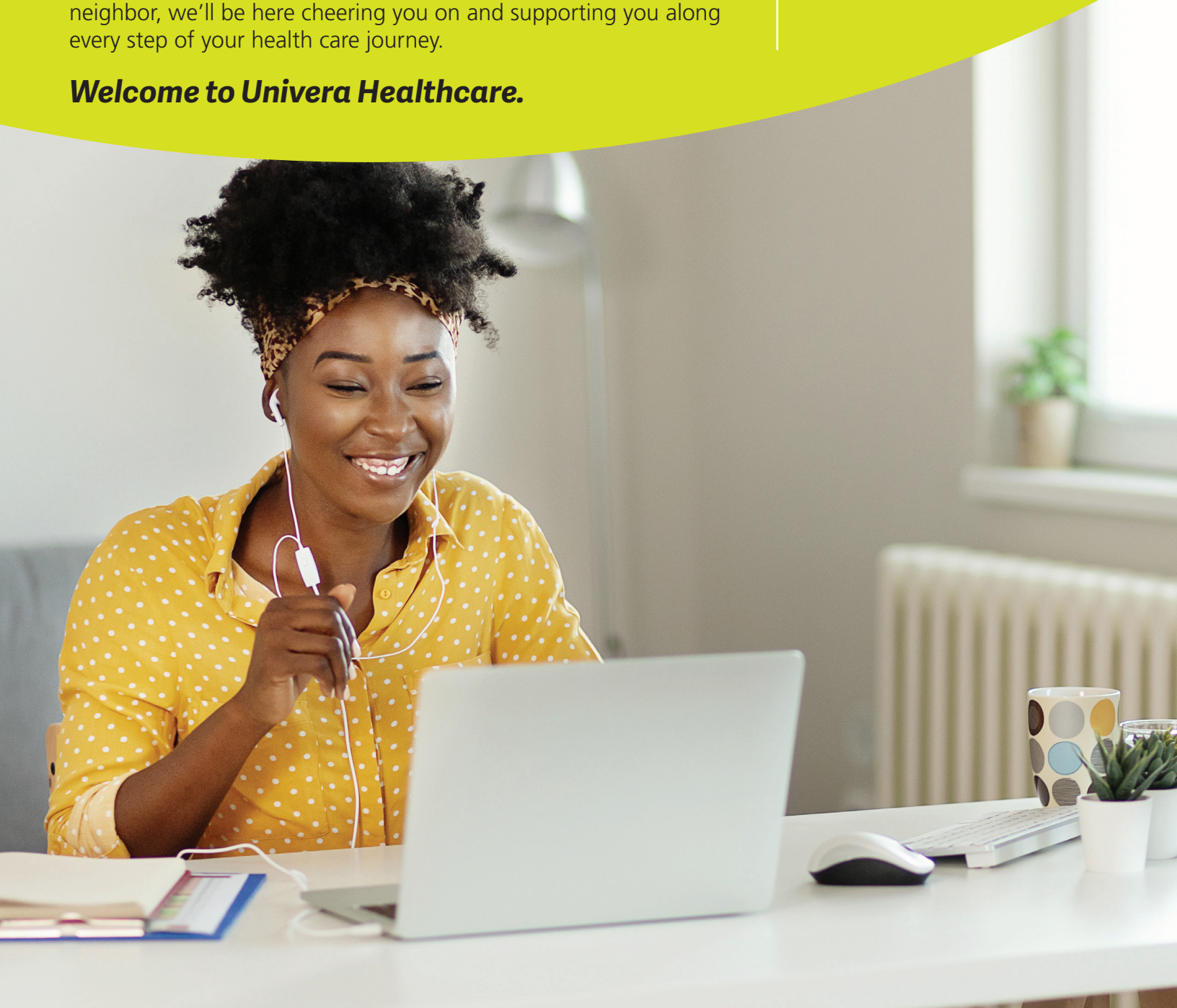
We know what it means to care for Western New York employees.

Because that's who we are, too.

No matter what challenge is thrown our way, Western New York never backs down. Neither do we. And that goes beyond just paying your claims. From our team of doctors, nurses, and health coaches to our social workers, behavioral health specialists, and customer care teams, you can feel confident knowing the entire Univera Healthcare team is behind you. As our member and our neighbor, we'll be here cheering you on and supporting you along every step of your health care journey.

Welcome to Univera Healthcare.

205 Park Club Lane
Buffalo, NY 14221-5239
UniveraHealthcare.com



Vista Security Group

Univera PPO Signature Deduct 4

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	07/01/21-06/30/22
Office visit copay (Primary Care Physician)	$20 copay per visit, subject to deductible
Office visit copay (Specialist)	$40 copay per visit, subject to deductible
Coinsurance	0%
Deductible	In-Network: $1,400 Individual / $2,800 Family
Out of pocket maximum	In-Network: $4,000 Individual / $8,000 Family

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Vista Security Group

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,400	$2,800	
Deductible - Family	$2,800	$5,600	
Coinsurance	0%	40%	
Annual Out of Pocket Maximum - Single	$4,000	$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$8,000	$20,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$6,650	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	$500 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - $0 Copayment Subject to Deductible	0% Coinsurance Subject to $1,400 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$150 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	$20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$20 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP - $20 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 Kids Copay applies to PCP and Specialist
Maternity Care	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Chiropractic Care	PCP/Specialist - $20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $20 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - $20 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$200 Copayment Subject to Deductible	$200 Copayment Subject to $1,400 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$200 Copayment Subject to Deductible	$200 Copayment Subject to $1,400 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$50 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$35/$70 Integrated Rx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Vista Security Group

Univera PPO Signature Deduct 3 $3000

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	07/01/21-06/30/22
Office visit copay (Primary Care Physician)	40% Coinsurance Subject to Deductible
Office visit copay (Specialist)	40% Coinsurance Subject to Deductible
Coinsurance	40%
Deductible	In-Network: $3,000 Individual / $6,000 Family
Out of pocket maximum	In-Network: $7,000 Individual / $14,000 Family

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Vista Security Group

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$3,000	$6,000	
Deductible - Family	$6,000	$12,000	
Coinsurance	40%	50%	
Annual Out of Pocket Maximum - Single	$7,000	$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$14,000	$20,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Cost Share - Specialist	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mental Health Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Substance Use Detoxification	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Skilled Nursing Facility	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 40% Coinsurance Subject to Deductible	40% Coinsurance Subject to $3,000 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Diagnostic X-ray	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Radiation Therapy	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Chemotherapy	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mental Health Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Home Infusion Therapy	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 0% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	50% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Facility	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	40% Coinsurance Subject to Deductible	40% Coinsurance Subject to $3,000 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	40% Coinsurance Subject to Deductible	40% Coinsurance Subject to $3,000 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$35/$70 Integrated Rx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Vista Security Group

Univera PPO Signature Deduct 3 $4000

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	07/01/21-06/30/22
Office visit copay (Primary Care Physician)	20% Coinsurance Subject to Deductible
Office visit copay (Specialist)	20% Coinsurance Subject to Deductible
Coinsurance	20%
Deductible	In-Network: $4,000 Individual / $8,000 Family
Out of pocket maximum	In-Network: $5,000 Individual / $10,000 Family

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

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Vista Security Group

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$4,000	$4,000	
Deductible - Family	$8,000	$8,000	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$5,000	$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$10,000	$20,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$15/50%/50% Integrated Rx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Vista Security Group

Univera PPO Signature Deduct 3 $4500

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	07/01/21-06/30/22
Office visit copay (Primary Care Physician)	20% Coinsurance Subject to Deductible
Office visit copay (Specialist)	20% Coinsurance Subject to Deductible
Coinsurance	20%
Deductible	In-Network: $4,500 Individual / $9,000 Family
Out of pocket maximum	In-Network: $7,000 Individual / $14,000 Family

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

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Vista Security Group

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$4,500	$4,500	
Deductible - Family	$9,000	$9,000	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$7,000	$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$14,000	$20,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$10/$35/$70 Integrated Rx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

univera HEALTHCARE an excellus company

Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply to you
- Additional instructions are included
- This application cannot be processed without this information and a signature

FOR INTERNAL USE ONLY
EC _____

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

00130586 Group Number (8 digits) Medical

_____ Medical Subgroup Number (4 digits)

_____ Medical Class Number (4 digits)

N/A Dental Group Number

N/A Dental Subgroup Number

_____ Department Number

_____ Employee Number

Vista Security Group
Employer Name

Association/Chamber Name (if applicable)

Group Administrator's Signature

Date

Subscriber Status:

☐New Hire - Date of Hire: ___ /___ /____
☐Rehire - Date of Rehire: ___ /___ /____
☐COBRA - Effective Date: ___ /___ /____
☐Retired - Effective Date: ___ /___ /____
☐Canceled - Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Dependent Reached Max Age ☐ Other: _____

Section 2: Your Information

This section should be completed by the Subscriber

Last Name First Name MI _____ Social Security #**

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

Street Address City State Zip

_____ Phone

_____ Email

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Medicare Number (if applicable)

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced Marital Status Event Date ___/___/_____

Section 3: Subscriber Medical Plan Selection

____ Univera PPO Signature Deductible 4 (DAH)
____ Univera PPO Signature Deductible 3 $3000 (DAG)
____ Univera PPO Signature Deductible 3 $4000 (DBG)
____ Univera PPO Signature Deductible 3 $4500 (DBH)

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child(ren)
☐Self & Spouse ☐Family

Effective Date: ___/___/_____

Section 4: Subscriber Dental Plan Selection

Please select plan if applicable:

☒ Not applicable

If enrolling in a Dental plan, who do you need coverage for?

☒ Not applicable

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage ☐COBRA
☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance
☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage
☐Address Change ☐Last Name Change ☐A move in or out of service area
☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other _____

Date of Event ___/___/_____

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber
☐Medical Coverage ☐Dental Coverage ☐Both Cancelation Effective Date ___/___/_____
☐Dependent(s) (List each dependent below in section 7)
☐Medical Coverage ☐Dental Coverage ☐Both Cancelation Effective Date ___/___/_____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage
☐Coverage through spouse ☐Loss of eligibility through employer or discontinuation of employer coverage
☐Other _____

Section 7: Information about who you would like coverage for

☐Spouse ☐Dependent Child ☐Disabled Dependent Child *Separate form required
☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**
Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**
Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal
_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: M ☐ F ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #**

Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No

If yes, are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage cancel? __/__/__

Policyholder's name _____ ID# _____

Effective Date: ___/___/____

Who did the insurance cover? ☐Self Only ☐Self & Child (ren)
☐Self & Spouse ☐Family

Section 9: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

PREFERRED PROVIDER ORGANIZATION (PPO)

I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature_____

Date_____

Please return to PO Box 21146, Eagan, MN 55121
If you have questions, please contact your Group Administrator.
Or, visit us at: UniveraHealthcare.com

Instructions for completing the Group Health Insurance Application

Section 1
This section should be completed by a Group Benefits Administrator.

Section 2
This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 3
Column A – This column is populated with the plan name your group has selected.
Column B – Select who you want to cover on this medical plan.

Section 4
Column A – Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.
Column B – Select who you want to cover on this dental plan.

Section 5
Select the box that describes what you need to do regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you must also check coverage type and persons to be covered, and Dependent Information section.

You may be required to provide documentation of certain events.

Section 6
If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

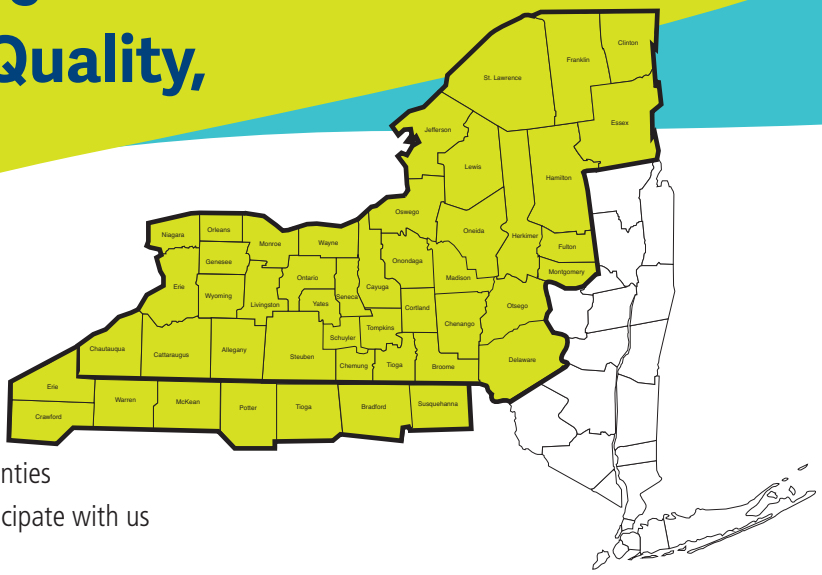
Section 7
Please include information about all the people who you would like coverage for.
Use an additional application if more than five people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.
Qualified guidelines for coverage include:

- A legal spouse (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 8
Please include accurate information in this section. This could affect the processing of your application and/or claims.

The Univera Healthcare Network Means High Quality, Easy to Find Coverage

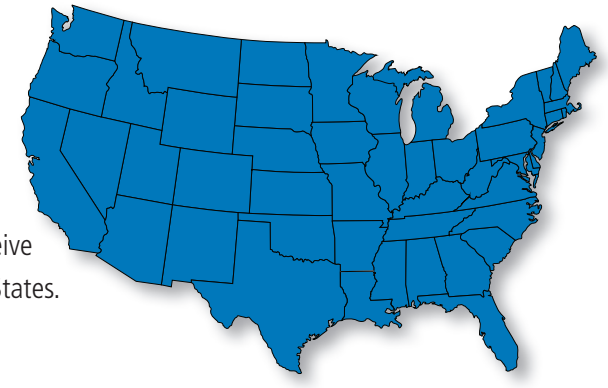


Univera Healthcare offers the largest network in Upstate New York:

- The Univera PPO network covers 39 Upstate New York counties
- More than 98% of all providers within these counties participate with us
- Includes all major hospitals and strategic physician groups
- Offers competitively negotiated rates for increased savings and value
- More direct contract relationships with providers in 8 Pennsylvania counties for unparalleled access for Southern Tier members

Peace of Mind with Nationwide Coverage

When members need care outside of our 39 county local network, Univera Healthcare offers access to more than 876,000 practitioners and 5,000 acute care facilities through the PHCS/MultiPlan system. Using PHCS/Multiplan, members get the same in-network benefit when they receive care from a PHCS/MultiPlan participating provider throughout the United States.



PHCS MultiPlan Complementary Network

Navigating our Nationwide Network

We know it can be stressful to locate a new provider. Whether you live outside of our local area, are traveling for work or vacation, or are looking for a doctor your college-age child can rely on while at school, our dedicated Network Navigator is available to assist you in finding participating providers and facilities, answer claims questions, and help resolve questions or issues that may arise. For personalized, one-on-one assistance with network access outside of the Western New York region please contact Patricia Brooker at patricia.brooker@univerahealthcare.com.

univera® HEALTHCARE an excellus company

UN-2677 / 12872-18M

24/7 Nurse Call Line

The support you need whenever you need it.

You can contact a nurse by phone anytime - 24 hours a day, seven days a week - with general health questions. Nurses can provide support on the phone or through follow-up educational mailings. If you need ongoing support, you may be referred to a member care manager so you will have the support that best fits your needs.

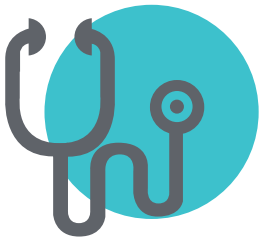
- 24/7 nurse line availability to all individuals who call in to the program
- Decision making support and education when you need it most
- Assistance with finding providers
- Nutritional information
- Information regarding medications and diagnoses
- Referrals, as appropriate, into the larger Member Care Management program for enhanced care management by a dedicated care manager
- Welcome mailing sent to all newly eligible for the program

Ask a Nurse Today!
Call 1-800-348-9786
(TTY/TDD 1-800-662-1220)

The 24/7 nurse line is a service provided to our members to support their relationship with their health care providers. The information provided is intended to help educate members, not to replace the advice of a medical professional. If you are experiencing severe symptoms such as sharp pains, fever, loss of bodily function control, vomiting or any other immediate medical concern, dial 911 or contact a physician directly.

Know Where to Get Care

You have options when choosing where to go for medical care. Here are some tips to help you make the right choice for where to go the next time you need care.



Primary Care Physician

Your doctor should be your **first choice** for routine medical care or minor illnesses or injuries that are not an emergency. You may have an office visit copay depending on your plan.

Tip: If you can't make it to their office, you might be able to schedule a remote visit with your doctor through phone or video connection, known as telehealth. Check with your primary care physician to see if they offer this option.

Cost

$

Telemedicine

If your doctor isn't available for minor medical or behavioral health needs, telemedicine may be an option for you. Telemedicine gives you fast and convenient access to a doctor 24/7/365 wherever you are through your phone, tablet, or computer. Register today at Member.UniveraHealthcare.com

Medical Telemedicine for:
Allergies • Asthma • Cold & Flu • Constipation • Diarrhea Fever • Joint Aches • Nausea • Pink Eye • Rashes
And more

Behavioral Health Telemedicine for:
• Addictions • Anxiety Bipolar disorders • Depression Eating disorders • Grief and loss • LGBTQ support • Panic disorders • Stress
And more

Cost

$

Urgent Care

If your medical issue is not life threatening and your doctor isn't available, you can visit an urgent care center and get the care you need.

Minor cuts, bruises or burns
Muscle strains • sprains
Cold and flu treatment

Cost

$$

Emergency Room

You should only go to the emergency room if you have a serious or potentially life-threatening medical condition. Call 911 for assistance. Do not try to drive yourself there.

Cost

$$$

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.
Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.
注意 ：如果您说中文 ，我们可为您提供免费的语言协助 。请参见随附的文件以获取我们的联系方式

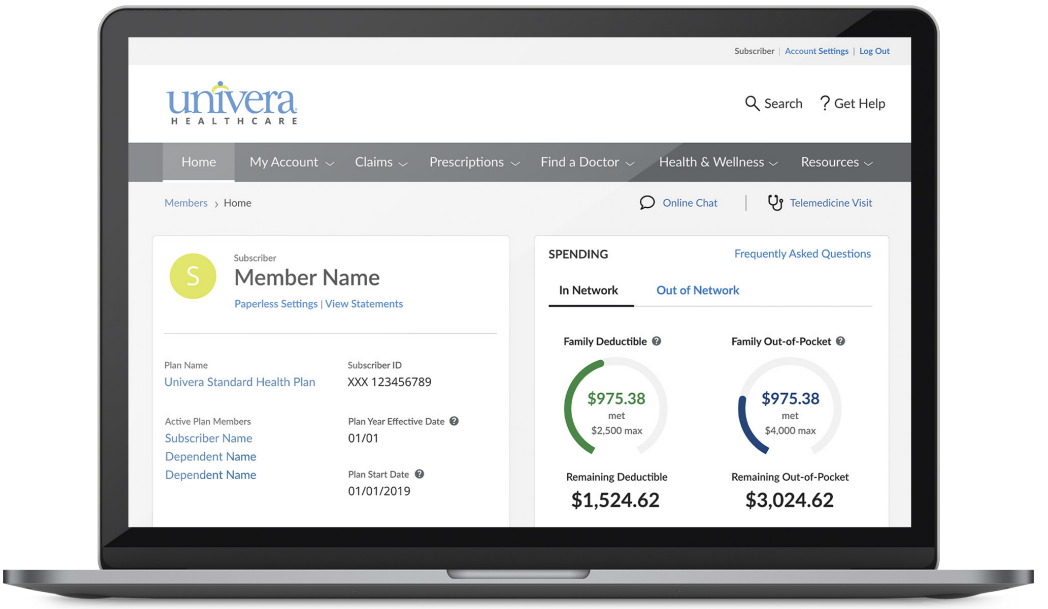
UN-2851 / 14121-20M

univera® HEALTHCARE

Simpler health plan? Check.

univera HEALTHCARE

You know that feeling when you check the last thing off your to-do list? We do, too. That's why we've made it easier to save time, save money, and get things done by creating your Univera Healthcare online member account. Sign up today and keep tabs on your plan from any device.



1 My Account

Create an online account to access your member card, view a summary of benefits and coverage, claims, go paperless, and more.

2 Find a Doctor/Dentist

Locate a provider in our extensive 39 county regional network.*

3 Spending

Get a breakdown of your health care spending.

4 Coverage & Benefits

View a summary of your plan details.

5 Claims

View and submit claims.

6 Get Rewards

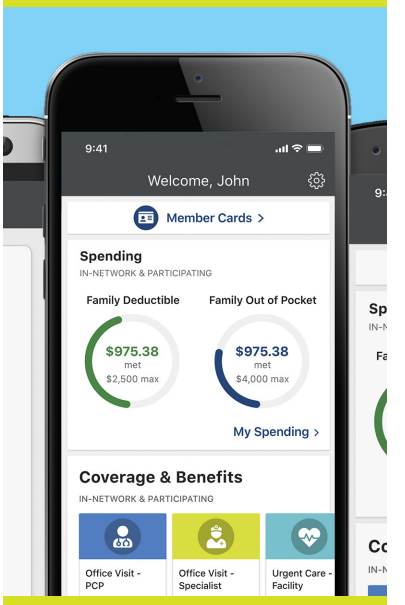
Enjoy quick access to spending and rewards programs.

7 Estimate Medical Costs

Research and get a personalized estimate of out-of-pocket medical costs for over 1,600 treatments and over 400 procedures.

Download the Univera Healthcare App.

Take your health plan with you for on-the-go access 24/7.



View your member card.

•

Track deductibles and out-of-pocket spending.

•

Find a provider or medical facility.

•

Access your benefits and claims information.

Download on the App Store

GET IT ON Google Play

Visit Member.UniveraHealthcare.com to register today.

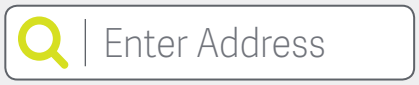
*If the PHCS and MultiPlan logo is present on the back of your Member Card, your plan also provides access to a national primary preferred provider organization (PPO) as a complement to Univera Healthcare's regional network.

Get care that's always there in 5 easy steps.

If you have a few minutes, you have plenty of time to create your online member account. Make sure you're getting the most value out of your health plan with a breakdown of how you're using your benefits, the ability to see and submit claims, go paperless, and more.

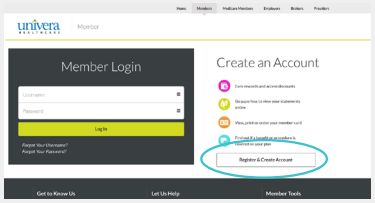
1 In Your Browser, Type Member.UniveraHealthcare.com

This will take you directly to the registration screen.



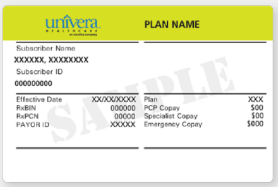
2 Create a New Account

Select the Register & Create Account button on the right side of the screen.



3 Complete the Form

You'll need your Subscriber ID, so be sure you have your Member Card handy.



4 Choose a Username and Password

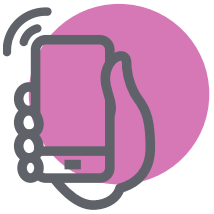
You'll also choose a pair of security questions in case you forget either of these.

Username* |

Password* |

5 Verify Your Email Address

We'll send you an email to verify your new account. Sign in and you're ready to go!



Don't forget to download the app

Log in to see more features, tools, and resources online.

- View a Summary of Benefits and Coverage
- Find a Doctor or Dentist
- Track Deductible and Out-of-Pocket Spending
- View and Submit Claims
- Estimate Medical Costs
- View Online Member Cards
- Download Statements and Forms

Create your account at Member.UniveraHealthcare.com today for anytime, anywhere access to your health plan.

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意 ： 如果您说中文 ， 我们可为您提供免费的语言协助 。请参见随附的文件以获取我们的联系方式

UN-2424

univera HEALTHCARE

Telemedicine for
Medical and Behavioral Health Care

univera HEALTHCARE

The Comfort of Care Available Anytime, Anywhere

If your doctor isn't available, telemedicine may be an option for you. Telemedicine gives you fast access to medical and behavioral health care 24/7/365, from the comfort of your home, desk, or hotel room. **All you need to do is activate it through your online member account and download the MDLIVE app.**

Rest assured, our health care professionals deliver the same quality of care you receive from your own doctor, via your phone, tablet, or computer.

When Do You Use Telemedicine?

- Instead of going to urgent care or the emergency room for minor and non-life-threatening conditions
- Whenever your primary care doctor is not available
- If you live in a rural area and don't have access to nearby care
- When you're traveling for work or on vacation

Here Are Some Common Conditions Treated With Telemedicine:

Adults

- Allergies
- Cold and Flu
- Ear Infections
- Fever
- Headache
- Joint Aches and Pains
- Nausea and Vomiting
- Pink Eye
- Rashes
- Sinus Infections
- Sunburn
- Urinary Tract Infections*

Children

- Cold and Flu
- Constipation
- Earache*
- Fever*
- Nausea and Vomiting
- Pink Eye

*MDLIVE does not provide support for urinary tract Infections in males; does not provide support for earache conditions for children under 12 years old; does not provide support for fever-related conditions for children under 3 years old.

Telemedicine Covers Behavioral Health, Too

In addition to anytime, anywhere access to medical doctors, you can also consult with a psychiatrist or choose from a variety of licensed therapists from the privacy of your own home. You can even schedule recurring appointments to establish an ongoing relationship with one therapist.

Interested but not sure counseling is right for you? Take the first step with a free, no-commitment online assessment at **MDLIVE.com/BH-Assessments**. Here are some conditions people rely on behavioral health telemedicine for:

- Addiction
- Bipolar Disorders
- Depression
- Eating Disorders
- Grief and Loss
- LGBTQ Support
- Panic Disorders
- Stress
- Trauma and PTSD

Telemedicine Is Covered Just Like a Trip to the Doctor

If your doctor's office visit is...	Then your medical and behavioral health telemedicine program benefit cost share is...
Covered with a copay	Covered in full.
Covered with copay/deductible	Covered in full once deductible is met.*
Covered deductible/covered in full	Covered in full once deductible is met.*
Covered with deductible/ coinsurance	Covered in full once deductible is met.*
Covered with coinsurance only	Covered in full once deductible is met.*

*If you haven't met your deductible, you will pay the allowable charge of $40. The $40 allowable charge does not apply to Behavioral Health services. The allowable costs for the Behavioral Health services vary but do not exceed $150. This means a member who as not met their deductible will not pay more than $150.

Don't wait until you need it. There are four easy ways to activate telemedicine today.

WEB - Register/Log in at UniveraHealthcare.com/Member
APP - Download the MDLIVE app
TEXT - Text UNIVERA to 635483
VOICE - Call 1-866-914-8426

Did You Know?

70%

of doctor's office visits could be handled over the phone.[1]

20.3 *days*

is the average wait time between scheduling an appointment and seeing a primary care doctor.[2]

90%

of emergency room visits can potentially be prevented with telemedicine.[3]

[1] "New medical cost savings program: Telemedicine means great discounts." R. Schultz, January 9, 2010.

[2] Based on MDLIVE data, 2016.

[3] Based on New York State Department of Health data, 2016.

MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/terms-of-use. MDLIVE is an independent company, offering telehealth services in the Univera Healthcare service area.

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注意：如果您说中文，我们可为您提供免费的语言协助。请参见随附的文件以获取我们的联系方式。

UN-2675 / 13936-20M

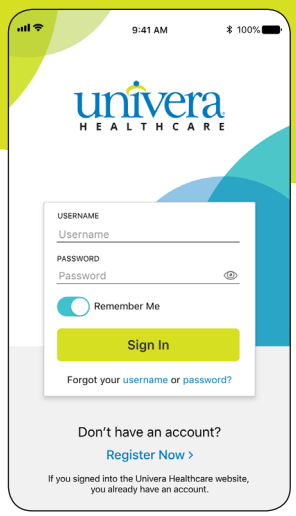
univera HEALTHCARE

Get ready for better care – anywhere

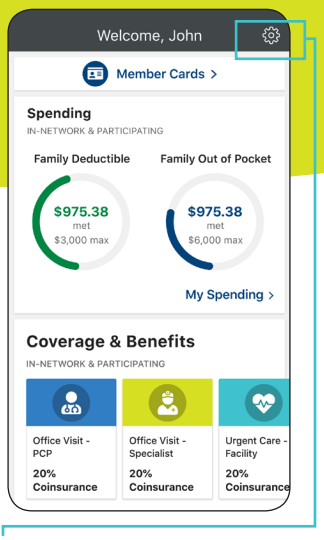
Your Wellframe® Quick Start Guide

Free to all Univera Healthcare members, the Wellframe® app gives you instant access to our dedicated team of nurses, dietitians, and other health care professionals to help you get healthier on your schedule.

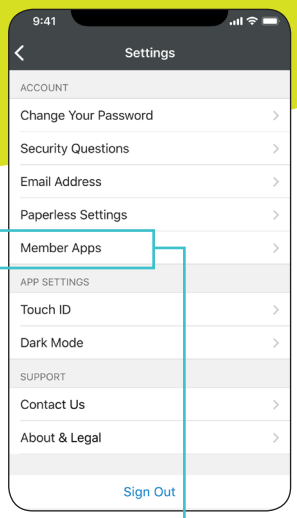
Here's all you have to do:



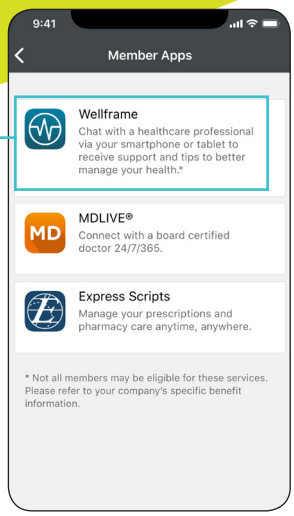
1 Download the Univera Healthcare app and register your online account.



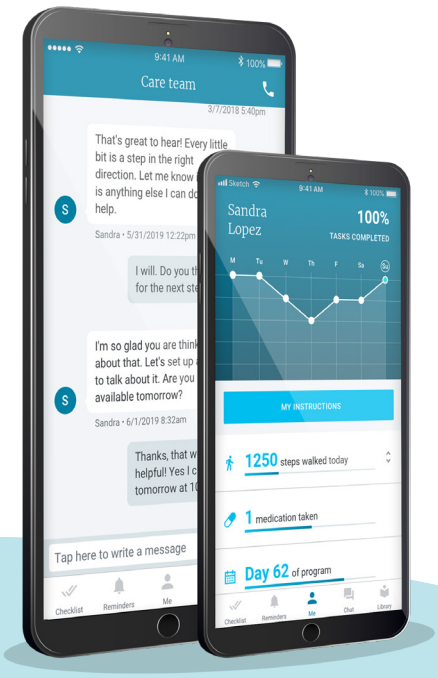
2 Open your Univera Healthcare app and click the settings icon on the top right.



3 Click Member Apps from the settings menu.



4 Click Wellframe® and enter code "UNIVERA" to download.



Health care experts and support at your fingertips

Once you download Wellframe®, you're ready to:

- Connect with and text our dedicated team of health care professionals at any time
- Create a personalized health plan and track progress
- Receive daily tips, reminders, and videos
- Join programs within the app for additional support

Download on the App Store

GET IT ON Google Play

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UN-2818

univera HEALTHCARE

Get up to $500 with Wellness Your Way

With Wellness Your Way you can receive up to $500* annually to be used on programs and services to help keep you and your family healthy.

Whether saving time through healthy food home delivery services, taking advantage of the 24/7 convenience of online fitness classes, or simply signing the kids up for sports and healthy activities – you can use your Wellness Your Way rewards in whatever way best fits your family's needs and lifestyle.

Claiming your rewards is easy

Wellness Your Way provides each family with up to $500* annually as a reward, just for being members. There's no complicated activity tracking or reimbursement forms to send in. Simply register online and your Wellness Your Way debit card will be sent in the mail.

1. Log in/Register at UniveraHealthcare.com
2. Go to the Rewards & Incentive area under Health and Wellness
3. Click the Wellness Your Way tab to request your debit card which is to be used for wellness related purchases
4. Your rewards card is in the mail!

Use your rewards for any wellness activities you see fit!

Your Wellness Your Way card can be used wherever MasterCard is accepted*, including online merchants. This gives you the flexibility of choosing the healthy programs that are right for you.

Use your Wellness Your Way rewards on things like:

- Gym memberships
- Exercise equipment
- Kids sports & activities
- Community Supported Agriculture (CSA)
- Weight management programs
- Meal kit delivery services
- Smoking cessation programs
- And much more!

For more information visit **UniveraHealthcare.com**

* Wellness Your Way program payment is $500 per family contract, $250 per single contract. For an individual policy, the subscriber will receive a debit card for $250. The $500 reward applies to family policies where there is a subscriber and a spouse covered by the contract. Both subscriber and spouse are eligible for the $250 reward, which is issued in one $500 debit card in the subscriber's name.

Wellness Your Way MasterCard rewards cards will arrive in active status and are ready to use. When making a transaction, always select "credit" at the point of purchase. Cards will not work at ATMs or gas stations.

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univera HEALTHCARE an excellus company

UN-2652/12961-19M

Seeing the dentist is key to **good health**

Earn up to **$300** with **Dental Rewards**

Good dental habits are not only an important part of oral health, but to overall health as well. Recent studies show that regular dental care can significantly improve an individual's oral health and reduce future medical treatments.

Claiming rewards is easy

Dental Rewards is a unique program to the market. We offer families an annual reward of $300* for getting dental exams and cleanings. Members simply provide us with proof that they received the services and their rewards amount will be mailed to them. It's that easy.

For more information, please contact your Account Services Representative.

univera® HEALTHCARE
an excellus company

*Dental Rewards payment is $100 for the subscriber. An additional $100 can be claimed for up to two additional members, for a total of $300 per contact.

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UN-2573/12471-18M

univera HEALTHCARE
an excellus company

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at: https://www.univerahealthcare.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO UNIVERA HEALTHCARE ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)

NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*

NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range _____ to _____

- AND, IF APPLICABLE –

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing
____ Sexually transmitted diseases
____ Substance use disorder
____ Abortion
____ Mental health *(excluding psychotherapy notes)*

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

Return form to:

Univera Healthcare
P.O. Box 211256
Eagan, MN 55121

or Fax: 315-671-7079

PLEASE KEEP A COPY FOR YOUR RECORDS

Notice of Nondiscrimination

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The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

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Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

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Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

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نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

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B-5495

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
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B-5495

Health plan terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

Primary Care Physician (PCP)—A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

Referral—Instructions provided by a PCP for specialty care. Most plans do not require referrals.

In-network coverage—The coverage available when you receive services from a provider who participates in your health plan.

Out-of-network coverage—The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

Out-of-area—Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

Copay—A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount—The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance—A cost-sharing method that requires you pay a percentage of the allowed amount for certain medical services.

Deductible—A set dollar amount you pay for covered services you receive before your insurer will make a payment.

Out-of-pocket maximum—The maximum amount of copays, deductible and coinsurance payments that you will pay for health services each calendar year.

*Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.

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