# Caring always comes first.


## Your Benefit Details

**Group Name**
Vista Security Group

**Plan Type**
Univ PPO Sig Ded 4 (DAH)
Univ PPO Sig Ded 3 3000 (DAG)
Univ PPO Sig Ded 3 4000 (DBG)
Univ PPO Sig Ded 3 4500 (DBH)

# *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.

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## Vista Security Group

## Univ PPO Sig Ded 4 (DAH)

**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 | 07/01/23-06/30/24 |
| Office visit copay (Primary Care Physician) | $20 Copayment Subject to Deductible |
| Office visit copay (Specialist) | $40 Copayment Subject to Deductible |
| Deductible | Single $1,500 / Family $3,000 |
| Out of pocket maximum | Single $4,000 / Family $8,000 |

## Vista Security Group

# General Information

### Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Deductible - Single | $1,500 | $3,000 | |
| Deductible - Family | $3,000 | $6,000 | |
| 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Cost Share - Specialist | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Cost Share - Sick Kids | $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $500 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | $500 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | $500 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per plan year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | $500 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | $500 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

## Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - $0 Copayment<br>Subject to Deductible | 0% Coinsurance<br>Subject to $1,500 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | $20 Copayment<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $20 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | $20 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Specialist - $40 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - $20 Copayment<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - $20 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible | $0 Kids Copay applies to PCP and Specialist |
| Maternity Care | PCP/Specialist - $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP - $20 Copayment<br>Specialist - $40 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| TeleMedicine Program | PCP/Specialist - $0 Copayment<br>Subject to Deductible<br>$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. |
| Chiropractic Care | PCP/Specialist - $20 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Allergy Testing | PCP - $20 Copayment<br>Specialist - $40 Copayment<br>Subject to Deductible<br>$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - $0 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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 calendar 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 | |
| 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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Medical Supplies | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

### Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Covered<br>Subject to Deductible | Covered<br>Subject to $1,500 Deductible | $4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

## Emergency Services

### ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | $200 Copayment<br>Subject to Deductible | $200 Copayment<br>Subject to $1,500 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<br>Subject to Deductible | $200 Copayment<br>Subject to $1,500 Deductible | |

### Urgent Care

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

## Univ PPO Sig Ded 3 3000 (DAG)

**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 | 07/01/23-06/30/24 |
| Office visit copay (Primary Care Physician) | 40% Coinsurance Subject to Deductible |
| Office visit copay (Specialist) | 40% Coinsurance Subject to Deductible |
| Coinsurance | 40% |
| Deductible | Single $3,000 / Family $6,000 |
| Out of pocket maximum | Single $7,000 / Family $14,000 |

## 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. |
| Annual Out of Pocket Maximum - Per Person Cap | $6,650 | N/A | 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 | 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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Days per plan year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Allergy Testing | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 40% Coinsurance<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 50% Coinsurance<br>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<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 50% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

### Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Covered<br>Subject to Deductible | Covered<br>Subject to $3,000 Deductible | $4,000 Reimbursement Per Plan Year<br>Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

## Emergency Services

### ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | 40% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 50% Coinsurance<br>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

## Univ PPO Sig Ded 3 4000 (DBG)

**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 | 07/01/23-06/30/24 |
| Office visit copay (Primary Care Physician) | 20% Coinsurance Subject to Deductible |
| Office visit copay (Specialist) | 20% Coinsurance Subject to Deductible |
| Coinsurance | 20% |
| Deductible | Single $4,000 / Family $8,000 |
| Out of pocket maximum | Single $5,000 / Family $10,000 |

## 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Cost Share - Specialist | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per plan year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Allergy Testing | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

### Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Covered<br>Subject to Deductible | Covered<br>Subject to Deductible | $4,000 Reimbursement Per Plan Year<br>Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

## Emergency Services

### ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 20% Coinsurance<br>Subject to Deductible | |

### Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Urgent Care Center Facility Visit | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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**

**Univ PPO Sig Ded 3 4500 (DBH)**

## 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 | 07/01/23-06/30/24 |
| Office visit copay (Primary Care Physician) | 20% Coinsurance Subject to Deductible |
| Office visit copay (Specialist) | 20% Coinsurance Subject to Deductible |
| Coinsurance | 20% |
| Deductible | Single $4,500 / Family $9,000 |
| Out of pocket maximum | Single $7,000 / Family $14,000 |

## 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. |
| Annual Out of Pocket Maximum - Per Person Cap | $6,650 | N/A | 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% 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per plan year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Allergy Testing | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

### Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Covered<br>Subject to Deductible | Covered<br>Subject to Deductible | $4,000 Reimbursement Per Plan Year<br>Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

## Emergency Services

### ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 20% Coinsurance<br>Subject to Deductible | |

### Urgent Care

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

**FOR INTERNAL USE ONLY**
HIOS ID#
EC

# Commercial Group Health Insurance Application/Change Form

**CONFIDENTIAL**

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

## Section 1: Employer Group & Benefit Information - To be completed with your Group Administrator

Vista Security Group
Employer Name

Association/Chamber Name (if applicable)

**Check Desired Action**
☐ Add ☐ Cancel ☐ Change

Group Administrator's Signature (required) Date

Employee's ID Number

Department Number

### Medical Information

00130586
Medical Group Number (8 digits)

Medical Subgroup Number (E.g. 0001)

Medical Class (E.g. A001)

_____ , _____ , _____
**Medical Effective Date**

**If enrolling in a Medical plan, who do you need coverage for?**
☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

### Dental Information

N/A
Dental Group Number (8 digits)

N/A
Dental Subgroup Number (E.g. 0001)

N/A
Dental Class (E.g. A001)

_____ , _____ , _____
**Dental Effective Date**

**If enrolling in a Dental plan, who do you need coverage for?**
☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

**Subscriber Status:** ☐Actively Working ☐Retired ☐Disabled ☐Canceled ☐COBRA

### Medical Plan Selection

☐ Univ PPO Sig Deductible 4 (DAH)
☐ Univ PPO Sig Deductible 3 $3000 (DAG)
☐ Univ PPO Sig Deductible 3 $4000 (DBG)
☐ Univ PPO Sig Deductible 3 $4500 (DBH)
☐

### Dental Plan Selection

☐ Univera Dental Traditions (DI)
☐ Univera Dental Select (DJ)
☐ Univera Access Dental

## Section 2: Subscriber's Information

**Last Name**

**First Name**

**Middle Initial** **Title (e.g., Jr, Sr, III, etc.)**

**Street Address**

**City** **State**

**Zip Code** **Phone**

**Birthdate**: _____ , _____ , _____

**Gender assigned at birth**:
☐Male
☐Female

**Gender identity (optional)**:
☐Transgender Male
☐Transgender Female
☐Prefer to self-describe: _____
☐Prefer not to say
☐Non-binary

**Social Security Number**** _____

**Date of Hire/Rehire**: _____ , _____ , _____

**Retirement Date**: _____ , _____ , _____

_____ ☐Age 65+ ☐Disability
**Subscriber's Medicare Number** (if applicable) ☐End Stage Renal *

_____ , _____ , _____ **Medicare Part A** Effective Date

_____ , _____ , _____ **Medicare Part B** Effective Date

Subscriber's Last Name: _____

## Section 3: Reason for enrollment or change
**To be completed by the Group Administrator** **Not required for cancelations**

**Enrollment Opportunity**: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

**Special Enrollment Opportunity:** ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____
☐Change in employment status ☐A move in or out of the service area
☐Involuntary loss of coverage ☐Former dependent regains eligibility

**Date of Event** ___ , ___ , _____

**COBRA Election - Please indicate the reason for COBRA if applicable:**
☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: _____

**Demographic Change:** ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

## Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

### Subscriber

| Cancel Code: | Medical Cancel Date: | Dental Cancel Date: |
|---|---|---|
| | | |

**Cancel Codes:**
SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
SB06-Employee No Longer Wants Coverage* (subscriber request) SB57-Benefits Terminated – Pandemic
SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

* = Not eligible for COBRA

### Dependent(s)

* = Not eligible for COBRA

| Dependent Name: | Cancel Code: | Medical Cancel Date: | Dental Cancel Date: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Cancel Codes:**
M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

## Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)
☐Other_____

_____ _____ _____ _____
**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender assigned at birth**: ☐Male ☐Female **Birthdate** _____ , _____ , _____
**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ , _____ , _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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)

**↓ Additional Dependent(s) ↓**

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender assigned at birth**: ☐Male ☐Female **Birthdate** _____ , _____ , _____
**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ , _____ , _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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 application form required) ☐Other_____

_____ _____ _____ _____
**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender assigned at birth**: ☐Male ☐Female **Birthdate** _____ , _____ , _____
**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ , _____ , _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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 three dependents need coverage.**

## Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ , ____ , _____ ☐Dental: ____ , ____ , _____
What is the name of the other carrier(s)? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? ☐Medical: ____ , ____ , _____ ☐Dental: ____ , ____ , _____
Policyholder's name _____ ID#(s) _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

## Section 7: 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 acknowledgment 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.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Univera Healthcare plan, you agree to enroll in the dental plan offered to you by your employer.

**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 P.O. Box 211256 Eagan, MN 55121-2656
If you have questions, please contact your Group Administrator. Or, visit us at: UniveraHealthcare.com

## Instructions for completing the Group Health Insurance Application/Change Form

**Section 1: Employer Group & Benefit Information**

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

**Section 2: Subscriber's Information**

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.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

**Gender and gender identity**: Univera Healthcare does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Univera Healthcare will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

**Section 3: Reason for enrollment or change**

Select the box(es) that describe(s) the reason for this enrollment or change 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. You may be required to provide documentation of certain events.

**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?**

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

**Section 5: Information about who you would like coverage for (dependent information)**

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

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- 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 disabled dependent who is over the maximum 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.
* There is additional information needed if eligible for Medicare due to ESRD.
A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

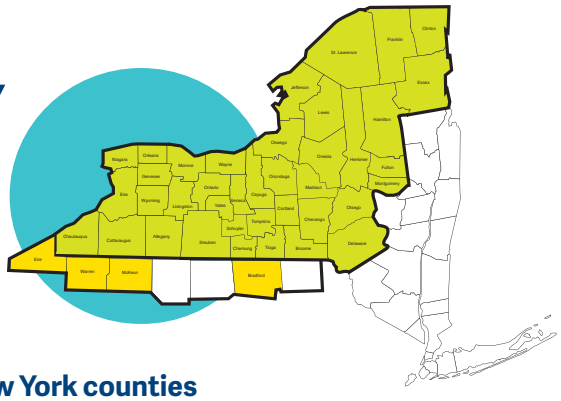
**Section 6: Other coverage information (Required)**

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

**Section 7: Release**

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

# *The Univera Healthcare network means high-quality, easy-to-find coverage.*

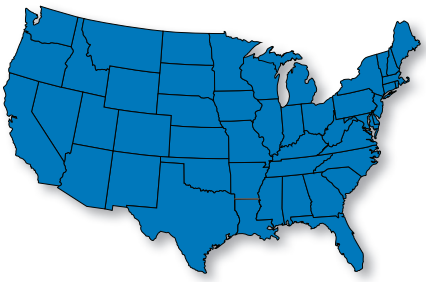


## All Univera Healthcare plans give you access to the largest network in Upstate New York

- The Univera Healthcare 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 select neighboring Pennsylvania counties for extensive access for Southern Tier members

## Plus, peace of mind with nationwide coverage

When members need care outside of our 39-county local network, Univera Healthcare offers access to more than 1.2 million practitioners and 5,600 hospitals 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. If you see the logos below on your card, your plan may also include coverage on a nationwide network.



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.



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

Please note: MultiPlan, Inc. and its subsidiaries are not insurance companies, do not pay claims and do not guarantee health benefit coverage.

For information about your benefits, please refer to your health plan booklet or contact your Plan Administrator.

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。

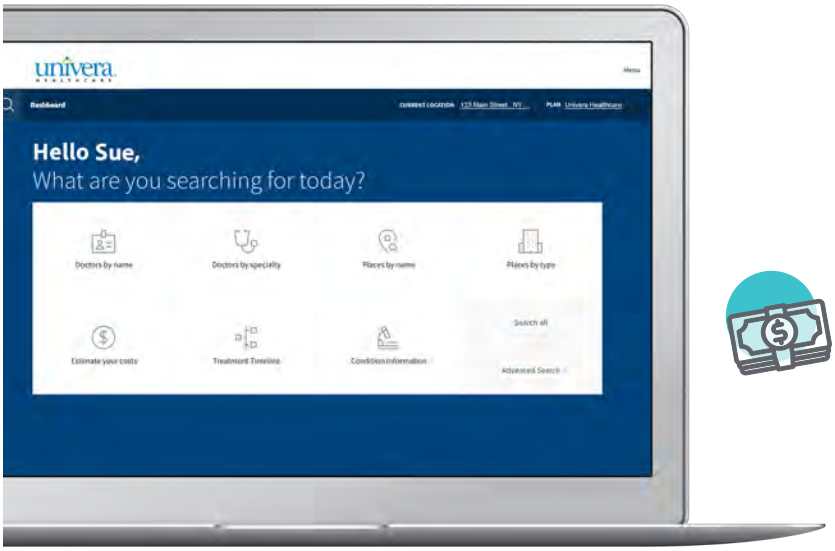
UN-2677

univera HEALTHCARE

# More of what your team needs, all in one place. Now that's convenient.

When it comes to your employees, only the best will do. It's why we're giving them the ability to find care and estimate medical costs in a single online search tool.

Our tool makes it easier for employees and their families to find area doctors and estimate out-of-pocket medical costs before they get a bill — which is especially important for employees with high deductible plans.




**All results are personalized to employees' plans, spending, and deductibles when they log in.**

## Find a Doctor

- Search doctors, specialists, urgent care, hospitals, and more in our local and national networks*
- Filter results by specialty, languages spoken, if accepting new patients, provider tier, and more
- See side-by-side comparisons and create a PDF of results to save, share, or print

## Estimate Medical Costs

- Log in for average estimated out-of-pocket medical costs based on your year-to-date spending and deductible
- Research estimated medical costs across more than 1,600 treatment categories and 400+ procedures
- Filter results by cost, treatments provided, location, and more
- Access treatment timelines to understand the entire process, stages of care, and cost breakdown throughout

Health care just got a whole lot more transparent.
Learn more at **UniveraHealthcare.com**

Download on the App Store | GET IT ON Google Play

*If the PHCS and MultiPlan logo is present on the back of the Member Card, your plan also provides access to a national primary preferred provider organization (PPO) as a complement to Univera Healthcare's regional network. Network coverage may vary based on plan. Estimate Medical Costs tool may not be available to all plans.



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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.

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16838-22M

univera HEALTHCARE

Understanding your

# *High Deductible Health Plan*

A high deductible health plan or "HDHP" is designed to help keep premium costs low for you and your family. You'll have coverage for things like:

- Choice of doctors and hospitals
- No-cost telemedicine*
- Doctor visits
- Prescription drug
- Maternity and newborn care
- Hospitalization
- Urgent care visits
- Laboratory coverage
- Free preventive care
- Specialty care

## Let's start with the basics:

Preventive care can help you avoid getting sick and improve your health. With a HDHP, preventive services such as routine physicals, screenings and vaccinations are covered in full.** The deductible does not apply to preventive services; they are covered in full from day one.

For services other than preventive care, you are responsible for paying out of your pocket until you meet your **deductible**. The deductible amount will vary based on your plan, so make sure you know what that amount is. Once you reach your deductible, you will pay a percentage of cost, called coinsurance. **Coinsurance** is your share of the costs of a covered health care service, calculated as a percent. You will have to pay a percentage of that service and the health insurance company will pay the rest.

## *The diagram illustrates how this works:****

### Preventive Services


**Insurance company provides full coverage**

### Other Services

Until deductible amount is reached


**You pay a deductible up to a certain amount**

After deductible amount is reached


**Once the deductible amount is reached, you pay a percentage called coinsurance**

You can use a tax-free account, called a Health Savings Account (HSA), to help pay for your portion of the costs. Talk to your HR or benefits representative about the account options that might be available to you.

Health insurance company pays  You pay

*Subject to the deductible where applicable.

**In accordance with the PPACA preventive care regulations, full coverage (no cost share) will be applied for those services meeting the requirements as outlined in Grade A and B. Recommendations of the United States Preventive Services Task Force.

***Note: for illustrative purposes only - plan options vary

univera® HEALTHCARE

## For example:

Let's say your deductible is **$2,000.**

You go to your doctor for low back pain. You pay **$100** for the visit.

You still have to pay **$1900** more to reach your deductible.

Your doctor orders an MRI of your lower back. You pay **$1,000** for the MRI.

You still have to pay **$900** more to reach your deductible.

After a series of visits to your doctor and a chiropractor, you have **$0** left to reach your deductible. Now you will pay a percentage of cost, **called coinsurance**.

If your coinsurance is **20%**, and the next time you visit your doctor your bill is **$100**, then **you'll pay $20 and we will pay $80.**

To help you with your costs, there is an **out-of-pocket maximum** which is an annual limit on the amount of money that you would have to pay for health care services, not including your monthly premiums. Remember, preventive care is covered in full and is not subject to the deductible.

***To determine your deductible, out-of-pocket maximum and coinsurance amounts, check your Summary of Benefits and Coverage (SBC), your online member account at Member.UniveraHealthcare.com, or your monthly health statements.***

## How much will you pay?

A lot goes into that. First, is how much your provider charges for a service. At Univera Healthcare, we've negotiated with providers so our members pay less than if you went to your doctor uninsured.

### There are a few other things you can do to help figure out how much you're going to pay when you need care:

**1**

Use our **Estimate Medical Costs tool** at UniveraHealthcare.com/EstimateCosts. This tool provides an estimate of what a procedure might cost among different providers. For personalized results based on your benefits, use the tool while logged in to your member account.

**2**

**Call your doctor or specialist** ahead of time and ask how much the anticipated service will cost.

**3**

Log into your member account at **Member.UniveraHealthcare.com** to check your benefits or call our Customer Care Advocates at the number listed on the back of your member card.


UN-2913 / 14109-20M

# Prescription home delivery

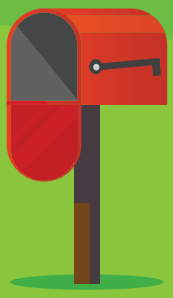
## Signing up is as easy as 1, 2, 3...


## Consider home delivery if you:

- Want some of your life back? Get a 90-day supply all at once.
- Take the same medication(s) every month.
- Need help managing your family's prescriptions.

## Home delivery of prescriptions is safe and confidential:

- Insulated packaging protects your medications from the sun, rain and cold.
- Discreet packaging does not reveal contents.
- Delivery straight to your mailbox.



Automatic refill option. Free standard shipping. Express delivery available. Pharmacists available to answer questions. **Call today!**

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UN-2518 / 12217-18CC

# 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

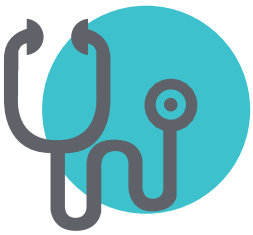
**Ask a Nurse Today!**
**Call 1-800-348-9786**
**(TTY/TDD 1-800-662-1220)**

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.

13849-19
NurseCallLine 9/2019

# 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***

**$$$**



UN-2851 / 14121-20M

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# Member Care Management

*Because a little extra care can go a long way.*

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From everyday questions to long-term guidance through complex medical conditions, the Univera Healthcare Member Care Management team is here to lend a hand. Need help keeping track of prescription refills? No problem. Need to find a support group or information about a diagnosis? We know just where to look. We can even help you learn how to better care for a family member. Just give us a call. Our team is ready to give you the extra support you need at no additional cost.

## *Four Big Ways We Help You Manage Your Health*

### Dedicated Team

**Coordinated care when you need it most.**

A care manager works with a multi-disciplined team of health care professionals to deliver specialized, expert guidance and one-on-one support.

### Complex Condition Management

**Personalized support to get you through.**

After a thorough assessment gives us a clear picture of your unique situation and needs, we provide outreach and support to help you better manage and understand your condition.

### Chronic Condition Management

**Ongoing expertise and specialized care.**

We identify the barriers preventing you from achieving your health goals and help you overcome them. We also provide support like education on recommended tests and screenings so you can feel confident managing your illness.

### Mental and Behavioral Health Management

**Proven approaches with real results.**

Substance abuse and mental illness are treatable diseases. And we'll provide you with the education, support, and community resources you need to get the upper hand on them.

"When you consider health insurance, you might think 'emergency coverage, medical bills, payments, and paperwork.' As a Univera Healthcare member, you get so much more. We care about you — the person — which is why we're here with quick answers, important connections, proven methods, and ongoing care planning when you need it."

— Joanne Richards, Member Care Management Team

## *FAQs About Member Care Management*

### 1 What health conditions qualify for Member Care Management?

If you're a Univera Healthcare member, chances are you can benefit from Member Care Management on some level. It could be as simple as assistance with finding resources for a family member or as complex as creating an ongoing care plan for a chronic illness. **Whatever the situation, we provide this service as part of your membership, at no extra cost to you.**

### 2 How does it work?

We engage with you to provide support across all aspects of your health. That means we may reach out to help with things like care coordination for a chronic condition, or you can also contact us with questions about doctors, care, coverage, and more. Either way, we'll pull together the right team to help you move forward.

### 3 How much does it cost?

It's free to members. Our Member Care Management services are included at no additional cost to you. By helping you schedule and remember appointments, source prescriptions, and stay on top of your health, they can often even save you money.

### 4 Will I have to explain my situation to a new person every time I talk to Member Care Management?

No. The first time you call, we'll put you in touch with the right person to handle your needs on an ongoing basis. After that, you'll usually speak to your dedicated care manager who will help coordinate with any other specialty clinicians. No bouncing around trying to find the right person to help.

---

At Univera Healthcare, we truly care about the people and community we serve. Which is why we go beyond simply covering medical bills to provide the extra guidance and support our members need to live healthier, happier lives. Give us a call to see how we can help.

**Member Care Management**

1-877-222-1240 (TTY: 1-800-662-1220)
8 a.m. to 5 p.m. ET
Case.Management@UniveraHealthcare.com

**Opt out of Member Care Management at any time by calling 1-877-222-1240**



UN-2471 / 15753-21M

## Meet Your Member Care Management Team

### Registered Nurses

Your dedicated registered nurse will typically be your main point of contact on the Member Care Management team — providing you with the care planning, education, and emotional support you need to achieve your health goals.

### Registered Dieticians

Want to start eating better? Our registered dieticians are food and nutrition experts who can tell you exactly what you need to eat to support your health.

### Behavioral Health Specialists

When you're dealing with addiction or mental illness, it can feel like you've got nobody in your corner. But that's not true. Get the counseling and direction you need from our behavioral health specialists.

### Social Workers

Being the primary caregiver for a family member can be extremely challenging to handle on your own. Our social workers are here to give you the skills, tools, support, and confidence to get issues resolved.

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# Simpler health plan? Check.

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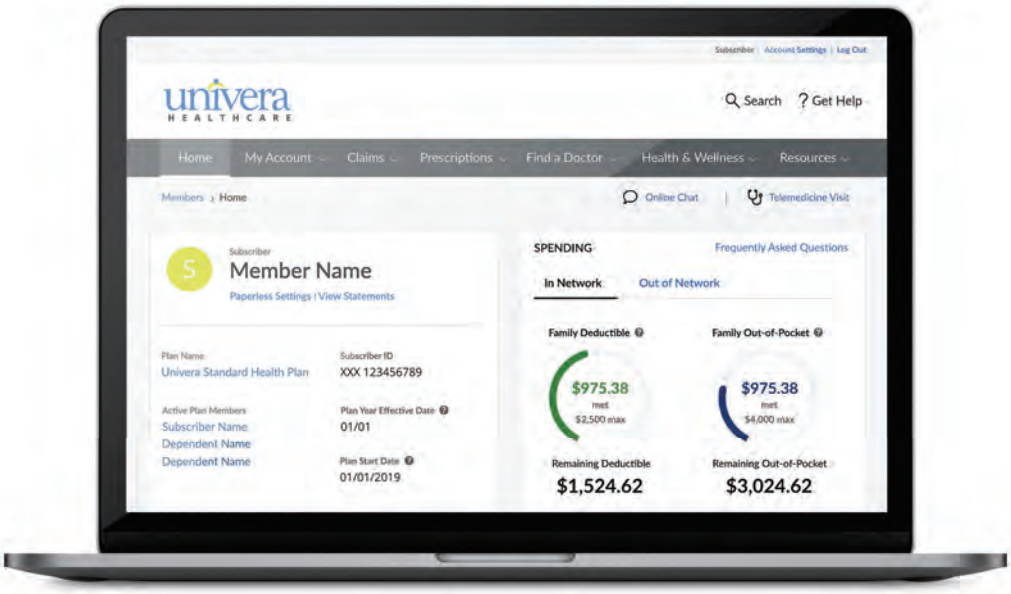
You know that feeling when you check the last thing off your to-do list? We do, too. That's why we've made it easier to save time, save money, and get things done by creating your Univera Healthcare online member account. Sign up today and keep tabs on your plan from any device.

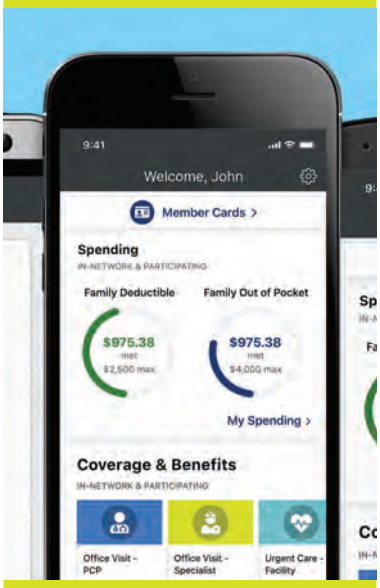



1. **My Account**
   Create an online account to access your member card, view a summary of benefits and coverage, claims, go paperless, and more.
2. **Find a Doctor/Dentist**
   Locate a provider in our extensive 39 county regional network.*
3. **Spending**
   Get a breakdown of your health care spending.
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.*

## Visit UniveraHealthcare.com to register today.

**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

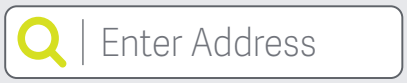
*If the PHCS and MultiPlan logo is present on the back of your Member Card, your plan also provides access to a national primary preferred provider organization (PPO) as a complement to Univera Healthcare's regional network.

# *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.

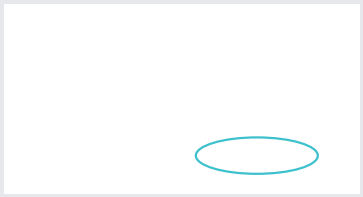
**1 In Your Browser, Type UniveraHealthcare.com/login**

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**

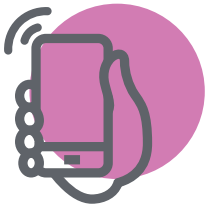
You'll also choose a pair of security questions in case you forget either of these.

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 UniveraHealthcare.com today for anytime, anywhere access to your health plan.

* Network coverage may vary based on your plan. Estimate Medical Costs tool may not be available to all plans.



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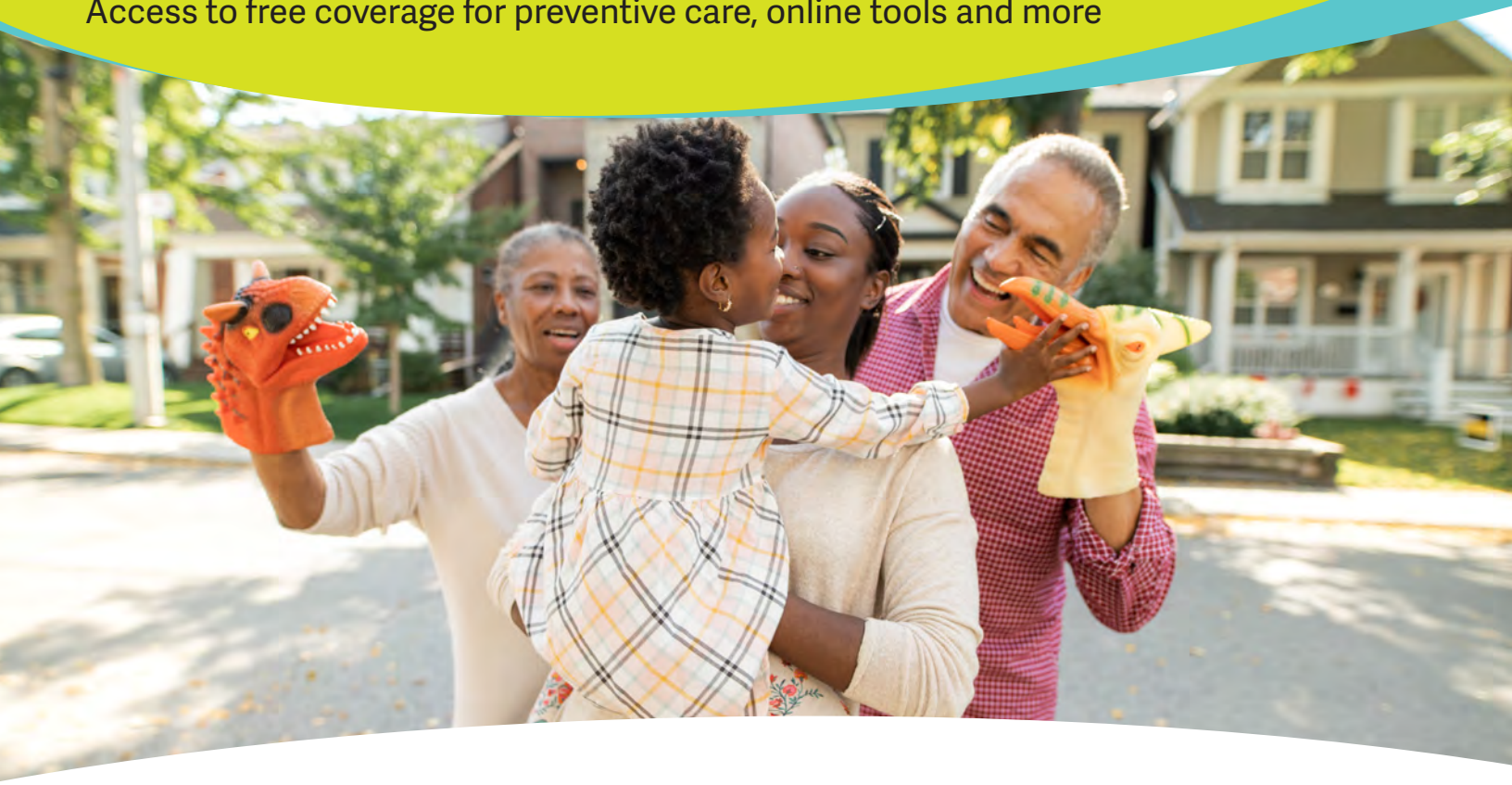
UN-2424/14009-20M

univera® HEALTHCARE

# Free preventive services with your HDHP

Access to free coverage for preventive care, online tools and more



Did you know that most preventive health screenings and immunizations are covered at no cost to you? Download the Univera Healthcare mobile app and create your online member account to see what else your plan includes.

**Preventive care keeps you healthy. And it's covered.***

- **Annual Routine Checkup**
- **Annual OB/GYN Visit**
- **Cholesterol Screening**
- **Colorectal Cancer Screening**
- **Diabetes (Type 2) Screening**
- **Immunizations**
- **Mammography Screening**
- **Well-Child Visit**

See the full list of preventive care services available to you at **UniveraHealthcare.com/PreventiveCare**

Download on the App Store | GET IT ON Google Play

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

univera HEALTHCARE

*A well visit or preventive service can sometimes turn into a "sick visit," in which out-of-pocket expenses for deductible, copay and/or coinsurance may apply. There may also be other services performed in conjunction with the above preventive care services that might be subject to deductible, copay and/or coinsurance. Covered services do not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.



UN-3032/14857-20M

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.

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 visits with MDLIVE may be covered in the following ways:*

| Plan Type | Telemedicine Cost Share |
|---|---|
| **Copay** | Covered in full |
| **Hybrid/Deductible Non-HSA** | If your doctor's visits are subject to deductible, a telemedicine visit will be covered in full after deductible |
| | If your doctor's visits are a copay with no deductible, a telemedicine visit will be covered in full |
| **Deductible HSA** | Covered in full after deductible |
| ***Note:** This is not a contract. It is intended to highlight the coverage for most plan options. Please refer to your contract for your plan's benefits.* | |

*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 $180. This means a member who as not met their deductible will not pay more than $180.

***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** - UNIVERA to 635483 (Message and data rates may apply.)
**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 and privacy policy, please visit www.mdlive.com/terms-of-use and www.mdlive.com/privacy-policy. MDLIVE is an independent company, offering telehealth services in the Univera Healthcare service area.

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-2675 / 16698-22M REV10/22

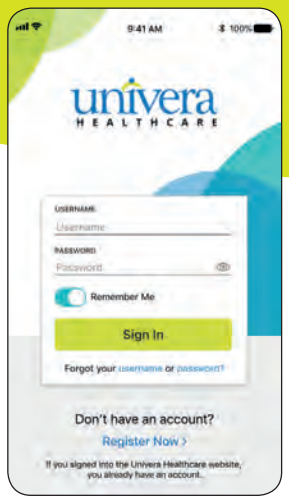
univera HEALTHCARE

Get ready for better care – anywhere

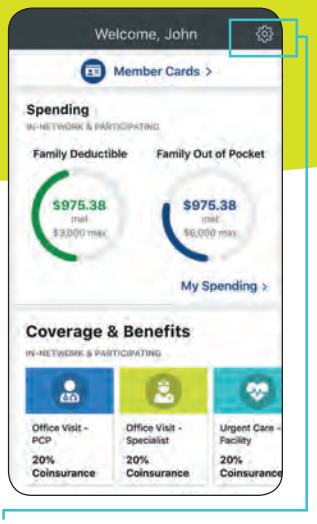
# *Your Wellframe® Quick Start Guide*

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.

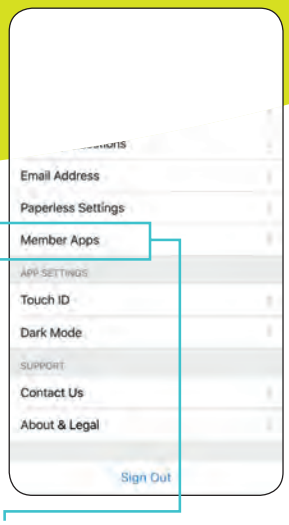
## Here's all you have to do:



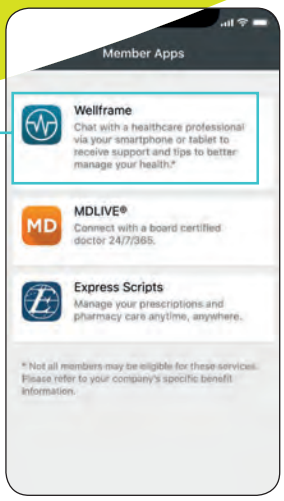

1 Download the Univera Healthcare app and register your online account.



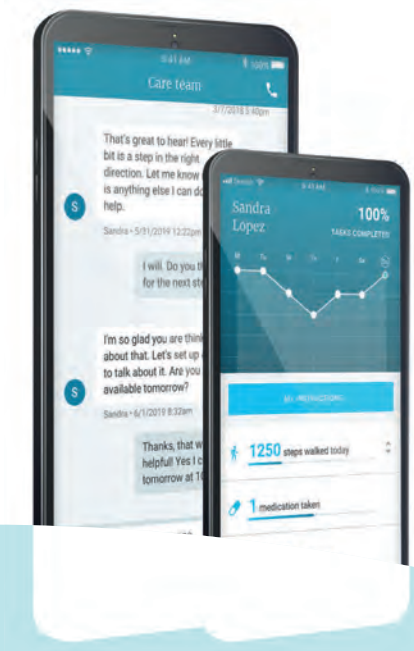

2 Open your Univera Healthcare app and click the settings icon on the top right.




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


UN-2818

univera HEALTHCARE

# The best time to learn about surgery is before you need it.

## Welvie My Surgery® prepares you ahead of time to help you achieve better outcomes.

Univera Healthcare is happy to offer this surgery decision program to you, through our partnership with Welvie.

About 15 million Americans have surgery every year[1]. So the odds are good that you and your doctor will be talking about surgery at some point in your life. And one of the keys to success is good preparation.

**Luckily, you have help. You have Welvie®.**

Your health plan gives you access to Welvie My Surgery — a self-guided online program that walks you through the entire surgery journey in six steps. And it is available to you at no added cost.

Using videos, Q&As and more, My Surgery teaches you how to decide on, prepare for and recover from surgery. Because the more you know, the better your chance for a successful result.

For example, it is estimated that around 20% of patients will have complications after surgery[2]. Many of them are preventable, and Welvie shows you how to avoid them.

**The best time to learn about surgery is before you need it.**

You may not need surgery right now. But when you do, Welvie will make sure you will be ready.

[1] "Strong for Surgery," American College of Surgeons.
[2] "The Hidden Pandemic: the Cost of Postoperative Complications," Springer Link, November, 2021

### A $25 GIFT CARD IS WAITING FOR YOU.

$25

You will get a $25 Amazon gift card for completing Steps 1-3 of the Welvie My Surgery program and a short survey.

The gift card is available to you and any covered family members once every 365 days.

### It is easy to get started with Welvie.

Go to **welvie.com** and select *Register*.
Need help? Call Welvie at 1-877-542-7803 (TTY 711). We can be reached Monday through Friday, 8 a.m. to 7 p.m., Eastern time.

welvie℠
MY SURGERY℠

# Six Steps to Better Decisions

## Step 1

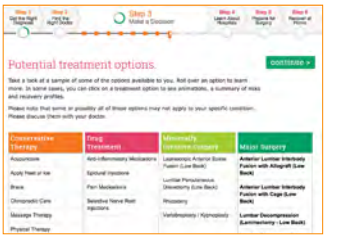
**Starting your surgery decision off on the right foot.**
Welvie's interactive exercises help you explain your symptoms so you can make the most of your doctor's visit and get the right diagnosis.


## Step 2

**How to talk to your doctor. (And listen, too.)**
Welvie shows you how to ask all the essential questions before you have to make an all-important choice about who will provide your medical care.


## Step 3

**Is surgery the only answer?**
Welvie can help you discover if alternative treatments might be available. You will learn how to work with your doctor to discover the best solution for you.

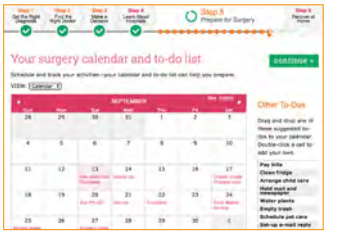



## Step 4

**Selecting a hospital is your call.**
Welvie guides you in selecting the right kind of hospital (they are not all the same). And reminds you of some key things to ask the doctors and nurses on your surgical team.


## Step 5

**OK. Now let's get this surgery over with.**
When the decision to have surgery has been made, Welvie helps you build your pre-op to-do list. Knowing you have planned, you can relax a bit.




## Step 6

**Time to go home. And get well.**
Let the healing happen. Welvie gives you tips to help reduce the chance of complications and speed your recovery, even before you leave the hospital.


Welvie is an independent company that provides a surgery decision program to Univera Healthcare members.

UN-3279 (1/2023)

univera HEALTHCARE

## 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, HIV/AIDs 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: 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

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

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.

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.

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请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

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.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

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.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

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.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495

# 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, please contact your Account Services Representative at 1-833-396-9355.

* 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.

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。

univera HEALTHCARE

UN-2652 • 7-2020/14272-20M

# 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 at 1-833-396-9355.**

univera® HEALTHCARE

*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.

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-2573/14223-20M

univera
HEALTHCARE

**PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM**

***Please Note: COPIES OF ALL BILL/RECEIPTS FOR a Dental Cleaning or Exam MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARED TO BE CONSIDERED. if you do not have a valid bill or receipt for a Dental Cleaning or Exam, please contact the provider of service to obtain prior to submitting for your reward reimbursement.***

***NOTE: Please submit one rewards request per Univera Dental Reward form. Individual reward requests need to be submitted for each eligible dependent according to your contract. To be eligible for this reward benefit services must be for either a dental cleaning or exam.***

***If you have eligibility, benefit or form related questions, please contact your Account Services Representattives at 1-833-396-9355.***

# Univera Dental Rewards

*Mail completed form and all required information to :*

**Univera Healthcare**
**P.O. Box 211256**
**Eagan, MN 55121-2656**

## SECTION 1
## INFORMATION REQUIRED FOR REWARD

**1-**FULL NAME AND DATE OF BIRTH OF THE PERSON RECEIVING SERVICES

**2-**NAME AND ADDRESS OF THE DENTAL PROVIDER PROVIDING THE SERVICE

**3-**DATE SERVICE IS RENDERED

**4-**CHARGE FOR SERVICE RENDERED

**5-**ALL CLAIMS MUST BE SUBMITTED WITHIN 120 DAYS AFTER CLEANING AND EXAM IN ORDER TO BE CONSIDERED FOR REWARD PAYMENT.

## SECTION 2
## SUBSCRIBER INFORMATION

*Please enter all information exactly as shown of your ID card.*

| SUBSCRIBER'S LAST NAME | SUBSCRIBER'S FIRST NAME | SUBSCRIBER IDENTIFICATION NUMBER | |
|---|---|---|---|
| | | | |
| **ADDRESS NUMBER AND STREET** | **CITY** | **STATE** | **ZIP CODE** |
| | | | |

## SECTION 3
## SERVICE INFORMATION

*Please complete all sections below for each individual service rendered. If you need more than three sections, please complete a separate form. NOTE. Please select only the amount you are eligible for based on your contract benefits.* ***If you don't know your benefit, contact your benefit administrator or call the telephone number listed on your identification card.***

| PATIENT'S FULL NAME | MEMBER'S DATE OF BIRTH | RELATIONSHIP TO SUBSCRIBER | DATE(S) OF SERVICE | FOR INTERNAL USE ONLY SERVICE INFORMATION | REWARD AMOUNT |
|---|---|---|---|---|---|
| LAST NAME:<br>FIRST NAME: | ___/___/___<br>*mm dd yyyy* | ☐ SELF<br>☐ SPOUSE<br>☐ CHILD | FROM: ___/___/___ | ☑ DENTAL CLEANING AND EXAM<br>*D0120*<br>*Dx. Z7189*<br>For Internal Use Only | $25<br>$50<br>**X** $100 |

PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM

## SECTION 4
## SIGNATURE AND DATE

*Unsigned forms will be returned*

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S).

**SUBSCRIBER SIGNATURE:** _____ **DATE:** _____

# *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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