2022

Benefits Guide for Active Employees

Open Enrollment | Oct. 4-22, 2021

San Antonio Water System

UnitedHealthcare®

San Antonio Water System
2800 U.S. HWY 281 North
P.O. Box 2449
San Antonio, TX 78298-2449

October 2021

Dear SAWS Employee:

This Open Enrollment Benefits Guide is designed to provide you with important information regarding the annual open enrollment process and the available medical plans for the 2022 plan year. The open enrollment period for 2022 benefits will be **October 4 - October 22, 2021**. We are pleased to announce that we will continue to offer the PPO Economy (Base Plan) and EPO Plus (Buy-Up Plan) for 2022 with United Healthcare. Express Scripts will also continue to be our pharmacy benefit manager.

More details about our benefits as well as a schedule for voluntary information sessions are included in this benefit guide. All sessions will be held via phone or video conference. The SAWS Benefits staff and a UnitedHealthcare representative will be at each of our enrollment sessions to answer questions that you may have about the 2022 plans. If you have any other questions regarding open enrollment or your benefits, you can contact the **Human Resources Benefits Office at benefitsinquiries@saws.org or 210-233-2025**.

SAWS remains committed to offering you a choice of quality benefit plans to meet your needs and those of your family at competitive costs. SAWS continues to pay the largest share of these costs. This year there will **not** be an increase to premiums and there will no longer be a split in premiums for employees hired after January 1, 2011. However, there will be slight changes in plan designs, which are necessary to keep up with the increased costs of healthcare.

Remember, being smart consumers of health care and working toward a healthy lifestyle can contribute to lower health care costs, which in turn can contribute to keeping our future premium increases to a minimum.

Sincerely,

Your SAWS Benefits Team
San Antonio Water System

SAWS 2022 WebEx & Teleconference Open Enrollment Sessions

All meetings are voluntary

Attend an open enrollment session via Webex or use your phone to listen in.

To attend the WebEx go to saws.webex.com and enter the **access code** listed below that corresponds to the date and time of the session you want to attend. Then enter the **password: *2022***.

To listen to a session using your phone, dial **210-233-2090** and then enter the **access code** listed below that corresponds to the date and time of the session you want to attend. When asked for your attendee ID, enter the # sign.

Date	Time	Access Code
Tuesday Oct. 5	4 p.m.	1460-44-8623
Thursday Oct. 7	9 a.m.	1464-37-1237
Monday Oct. 11	12 p.m.	2484-318-2069
Wednesday Oct. 13	7 a.m.	1467-60-3308
Monday Oct. 18	6 p.m.	1466-18-4725
Wednesday Oct. 20	3 p.m.	1465-80-3291

If you have any questions or need assistance enrolling online, please contact the Benefits team at benefitsinquiries@saws.org or 210-233-2025 and ask for a benefits team member.

Open Enrollment Deadline is Oct. 22, 2021

Note: Benefits are subject to change without notice.

Benefits Program

SAWS offers a generous benefits program that provides quality care. Our goal is to provide you with a comprehensive benefits package that offers affordable choices for you and your family.

Health Care

SAWS medical plan helps you to meet your varying benefit needs for preventive care and maintaining a healthy lifestyle. SAWS' medical plan, administered by UnitedHealthcare Services, Inc. (UHC), offers several plan options for medical coverage as well as programs in Disease Management and Personal Health. UHC also provides interactive online tools and information to help you lose weight, start or maintain an exercise program, and research health issues. For our prescription benefit, we use value based pharmacy management with Express Scripts Inc. (ESI) to keep costs down.

Dental

SAWS offers you and your dependents a comprehensive dental plan through UnitedHealthcare, which includes coverage for preventive, basic and major services as well as orthodontia for children.

Flexible Spending Accounts

Flexible spending accounts allow you to contribute pre-tax funds to pay for eligible out-of-pocket health care expenses up to $2,750, or dependent care expenses (including child care) up to $5,000.

Vision

Our vision plan includes coverage for eye exams, lenses or contacts, frames and a variety of discounts on other eye care products.

2022 Highlights

- **SAWS will continue to offer you the choice of two self-funded medical plans in 2022, PPO Economy and EPO Plus.** Only the PPO Economy Plan has Out-of-Network coverage.
- **Medical premiums will not increase and there will no longer be a split in premiums for employees hired after 1/1/2011.**
- **Primary Care Physician (PCP) and Specialist Visit copays will remain the same.** You will continue to have a choice between Tier 1 providers to save money and Non-Tier 1 providers for both PPO Economy and EPO Plus medical plans. See page 5 for more information.
- **Urgent Care and Emergency Room visit copays will increase.** Urgent Care copays will increase to $75 and Emergency Room copays will increase to $300 for both the PPO Economy and EPO Plus medical plans.
- **EPO Medical Plan deductibles will increase to $1,000 for an individual and $3,000 for a Family.** The individual and family deductibles on the PPO Economy medical plan will remain the same.
- **Out of Pocket Maximums will not change for both the PPO Economy and EPO Medical plans.**
- **Spouse Premium Surcharge remains at $150 per month.** This surcharge only applies to the SAWS medical plan. If your spouse is no longer eligible for their employer's medical plan, please fill out and submit a Spouse Premium Waiver Form as soon as possible to remove the surcharge.
- **Dental premiums will increase by $3-$9 and Vison premiums will increase by $0.55-$1.59, depending on your coverage tier; however, there will be no plan changes.**
- **ALL unused Medical and Dependent Care FSA funds from 2021 will rollover to 2022.** In response to the Global Pandemic, legislation allowed 2020 and 2021 funds to roll over to the next plan years. In 2023, the maximum roll over amount will return to 20% of the Medical FSA maximum contribution limit and no unused Dependent Care FSA amounts will roll over. You **MUST** actively enroll online to continue your Flexible Spending Account elections.
- **Wellness Reward hours for preventative exams will continue.** You will be able to earn up to 12 hours of leave for your participation.
- **Real Appeal Weight Loss Program will continue.** This program is available to eligible employees and their dependents who are 18 years and older. See page 17 for more information.

Table of Contents

This guide is designed to help you make the best benefit selections for you and your family. Information contained in this guide will answer questions regarding the available health, dental, vision, and flexible spending account plans. If you need further information regarding your plans, please contact the Human Resources Benefits Office at 210-233-2025 or join one of the virtual Open Enrollment sessions from your mobile device or computer. SAWS 2022 Open Enrollment is **Oct. 4-22, 2021**. If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices for your prescription drug coverage. Visit pages 30-31 for more details.

What can you do during Open Enrollment?

- Enroll in or change health plans.
- Add or remove dependents from your coverage.
- Add or drop dental or vision coverage.
- Enroll in the medical and/or dependent flexible spending accounts, or change your contribution levels.

2022 Medical Premiums

You and SAWS share in the cost of the medical plan. This year there will not be an increase to premiums even though healthcare costs continue to rise. SAWS has worked diligently to keep premiums down for employees and will absorb the increase to premiums. Your premium amount depends on the plan you select and the family members you choose to enroll. Remember, being a wise consumer of health care can help keep your cost increases to a minimum. Below are the premiums for SAWS medical plans, which also includes your pharmacy coverage. There will no longer be a split in premiums for employees hired after 2011.

2022 MONTHLY MEDICAL PREMIUMS

	PPO Economy (Base Plan)		EPO Plus (Buy Up Plan)	
Tier Selection	SAWS	Employee	SAWS	Employee
Employee Only	$527	$36	$576	$117
Employee + Spouse	$1,065	$115	$1,163	$290
Employee + Child(ren)	$930	$83	$1,018	$229
Employee + Family	$1,576	$167	$1,734	$413

Your premiums are deducted from your paychecks on a pre-tax basis consistent with Section 125 of the IRS code. Your pre-tax premium deductions come out of your pay before federal income and Social Security taxes are withheld, which lowers the actual cost to you and gives you a special tax advantage.

Spouse Premium Surcharge

If your spouse is not covered through your SAWS medical plan, this does not apply to you. However, if you choose to cover your spouse, who is working and has access to medical coverage through their own employer, there is a **$150 monthly surcharge** ($75.00 per pay period) added above and beyond the regular employee medical contribution (premium). If your spouse is not working or does not have access to medical coverage through his/her employer, you must request a waiver for the surcharge. Waiver forms are located on **INSIDER** or contact the HR Benefits Office at 210-233-2025.

Points to Remember About the Surcharge:

- All employees who cover spouses will have a Spouse Premium Surcharge unless a waiver form is turned in for 2022 or was on file for 2021.
- The loss of a spouse's employment and related benefits during the year is a qualifying event that would allow an employee to enroll the spouse and any affected dependents into health care coverage through SAWS within 31 days of the qualifying event and apply for a spouse premium surcharge waiver.

Health Plan Options

UnitedHealthcare will continue as our third party administrator. Our self-funded plans use your premiums and SAWS contributions to pay for the increasing cost of health care. To keep health care costs down and to stay healthy, you will want to take advantage of preventive care, which has no copays and includes things like your annual check-ups and vaccinations (including COVID-19).

	PPO Economy (Base Plan)		EPO Plus (Buy Up Plan)	
Plan Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible[1]	$1,500 Individual	$2,500 Individual	$1,000 Individual	Not Covered
	$4,500 Family	$7,500 Family	$3,000 Family	Not Covered
Coinsurance	20% after deductible	40% after deductible	20% after deductible	Not Covered
Out-of-Pocket[1]	$4,500 Individual	$7,500 Individual	$4,500 Individual	Not Covered
	$11,250 Family	$18,750 Family	$9,000 Family	Not Covered
PCP Office Visit				
Tier 1 Premium Provider	$40	40% after deductible	$25	Not Covered
Non-Tier 1	$50		$40	
Specialist				
Tier 1 Premium Provider	$60	40% after deductible	$40	Not Covered
Non-Tier 1	$70		$60	
Preventive Care	$0	40% after deductible	$0	Not Covered
Virtual Visits	$30	N/A	$15	N/A
Urgent Care	$75	40% after deductible	$75	Not Covered
Emergency Room	$300 per visit co-pay, plus deductible and coinsurance		$300 per visit co-pay, plus deductible and coinsurance Emergency ONLY	
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	Not Covered

[1]**Note:** Out-of-pocket maximums for both the PPO Economy and EPO Plus include medical and prescription copay, deductible, and coinsurance amounts. For all of the coverage details, call 210-233-2025 for a copy of the official plan documents.

Stay In-Network

There are several things you can do to help keep costs down. The most important of these is choosing a UnitedHealthcare network provider. A network is a group of doctors, hospitals and other providers and facilities that have a contract with UnitedHealthcare. As part of their contract they have agreed to follow UnitedHealthcare's guidelines and provide health care services at lower prices. It pays to stay in the network — using network providers can reduce out-of-pocket costs, in addition to the overall health plan costs. If you will be having labs done, ask your health care professional where it will be and be sure it is an in-network lab, such as Quest Diagnostics, Clinical Pathology Laboratories, or LabCorp. All of these savings contribute to keeping premium increases to a minimum.

Out-of-network providers do not have a contract with UnitedHealthcare and can bill you above the reasonable and customary rates. Depending on the plan, insurance may cover only a fraction of the cost or none at all. The EPO Plus Plan has **NO** out-of-network coverage, which means you will be responsible for 100% of the cost.

Consumer Tools Save You Money

UnitedHealthcare Pre-Member Website

The UnitedHealthcare Pre-member website is a great Open Enrollment resource to learn about your UnitedHealthcare plans and services. It is simple to use and available to you 24/7 before and during open enrollment. Search for network providers and learn about our online tools and resources. Quickly find information that is most important to you and at your own pace. Visit the UnitedHealthcare Pre-Member Website at https://www.whyuhc.com/saws.

UnitedHealthcare App

UnitedHealthcare App (formerly Health4Me App) is a free smart phone app that provides instant access to all the information you need to manage health care for your family – anytime and anywhere. The more you know about your health care, the better you can manage your health and money. You can also view and share health plan ID cards via email, receive real-time status on account balances, deductibles and out-of-pocket spending, view and manage claims, get health care cost estimates for specific treatments and procedures, find nearby providers, hospitals and quick care facilities, and much more.

myClaims Manager

Understand and track your health care costs and payments and better manage your expenses with myClaims Manager on myuhc.com. You can easily search for claims, track claims, view what was billed, what your health plan paid, what you owe and why. You can also note claims you want to watch or follow up on and add personalized notes. You can pay health care providers online through myuhc.com for any claim that has a "You May Owe" amount using the "Pay Now" feature. (To view "myClaims Manager", login to myuhc.com and select "Claims & Accounts" or log into the UnitedHealthcare App and select "Manage Claims").

myHealthcare Cost Estimator

Using your benefit information, myHealthcare Cost Estimator shows you the estimated cost for a treatment or procedure, and how that cost is impacted by your deductible, co-insurance and out-of-pocket maximum. This means that you'll get an estimate of what you'll be responsible for paying out of your pocket, providing you with useful information for planning and budgeting. Just search for the condition (e.g., back pain) or treatment (e.g., physical therapy) you would like an estimate for, and the cost estimator will show you doctors and locations that offer those services in your area. You'll also be able to learn about your care options, compare estimated costs and see quality and cost efficiency ratings. Most importantly, you'll be able to make an informed decision about what option is best for you.

Consumer Tools Save You Money

UnitedHealth Premium Program (Tier 1 Premium Providers)

To help people make more informed choices about their health care, UnitedHealthcare created the UnitedHealth Premium Program. The Premium Program recognizes doctors who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care. If a doctor does not have a Premium designation, it does not mean he or she provides a lower standard of care. It could mean that the data available to UnitedHealthcare was not sufficient to include the doctor in the program. All doctors who are part of the UnitedHealthcare network must meet credentialing requirements (separate from the Premium program). Visit the UnitedHealthcare website at myuhc.com to help you verify if your provider is in network and part of United Health Premium Program. Or you may call **888-651-7277** and verify with an Advocate4me representative.

Look for the Tier 1 icon or two blue hearts when searching for providers. To identify a Tier 1 or Premium Care Physician during Open Enrollment, go to www.unitedhealthpremium.com.

Naviguard

Naviguard is your ally and champion against out-of-network balance bills. If you receive a balance bill from an Out-of-Network (OON) provider, Naviguard may be able to help. Naviguard advocates for consumers through dedicated, one-on-one support. UnitedHealthcare members who contact Naviguard for balance billing support will be assigned to a personal Advisor who provides support through final resolution, including negotiating a bill reduction with the provider when needed. If you receive a surprise balance bill higher than your co-insurance, co-pay, and deductible amounts, call the number on your health plan ID card. If appropriate, a Naviguard advisor will be assigned to you and will contact you to review your balance bill in detail and discuss next steps. Please visit naviguard.com/bill-toolkit for more information.

Savings When Seeking Health Care Services

When seeking health care services under one of the SAWS self-funded medical plans, you may be able to save significant money when choosing the right place to get care. Below is a list of options that are available to you along with the copays or coinsurance you will pay when remaining in-network.

Where To Get Care	What is it?	Cost
24/7 Virtual Visits	24/7 Virtual Visits connect you with a provider using your smartphone, tablet, or computer. When you need care—anytime, day or night—or when your primary care physician is not available, virtual visits, also known as telehealth, can be a convenient option. From treating flu and fevers to caring for migraines and allergies, you can chat with a provider 24/7.	PPO Economy $30 EPO Plus $15
Convenience Care Clinic	A clinic when you can't see a doctor and your health issue isn't urgent for example, CVS – Minute Clinic. ***Examples are:*** • Vaccinations • Common infections, e.g. strep throat • Minor skin conditions, e.g. poison ivy • Ear aches • Minor injuries • Pregnancy test *Note: Emergency Clinics are **NOT** Convenience Care Clinics*	PPO Economy $40 EPO Plus $25
Primary Care Physician	Go to the doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist if needed. ***Examples are:*** • Checkups • Vaccinations • General health management • Preventive services • Minor skin conditions	Tier 1 Premium Provider PPO Economy $40 EPO Plus $25 Non - Tier 1 PPO Economy $50 EPO Plus $40
Urgent Care	Urgent care is ideal when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that are not life-threatening. ***Examples are:*** • Minor burns • Minor infections • Small cuts that may need stitches • Minor broken bones • Sprains and strains	$75
Emergency Room	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911. ***Examples are:*** • Chest pains • Major burns • Spinal injuries • Sudden weakness • Heavy bleeding • Large open wounds • Severe head injuries • Trouble talking • Major broken bones • Sudden change in vision	PPO Economy $300 Copay + 20% after $1,500 deductible EPO Plus $300 Copay + 20% after $1,000 deductible

There is a $0 copayment on COVID testing-related visits during the National Public Health Emergency period. A testing related visit may occur in a health care provider's office or through a telehealth visit.

UnitedHealthcare Support Services

UnitedHealthcare offers you many additional support services to assist with obtaining the best health care available. For additional information about each program offered, call the number on the back of your ID card. Below are just some of the services available:

Disease Management Programs

Taking care of a long-term health problem or serious illness can be very time consuming, frustrating and expensive. Our disease management programs can help you control your illness, and in the long run may save you some health care dollars by helping you stay as healthy as possible.

Contact UnitedHealthcare Customer Service to enroll in a Disease Management Program to help you manage health issues such as:

- Diabetes
- Asthma
- Coronary Artery Disease
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

Kidney Disease Programs

Our kidney disease programs provide you:

- Nurses you can speak with to help manage your kidney disease.
- Education and counseling.
- Help with finding network dialysis centers and doctors.

Cancer Resource Services

Access to the CRS Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in their specific cancer. Potential benefits include accurate diagnosis, appropriate therapy (neither too little nor too much), higher survival rates and decreased costs. For more information and to participate, visit myoptumhealthcomplexmedical.com. Travel and lodging assistance is not available as part of the Cancer Resource Services program.

Maternity Support Program

A healthy pregnancy is the first step to a healthy baby and mom. The Maternity Support Program supports members before, during and after pregnancy by an experienced maternity nurse who provides assistance, guidance, answers and education.

Congenital Heart Disease Resources Services

Access to the CHD Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in treating congenital heart disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs.

Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility. Participation in this program is voluntary for the enrollee. To help ensure network benefits are received under this program, patients or someone on their behalf should contact CHD Resource Services before receiving care. More information is also available online at myuhc.com.

Autism Spectrum Disorder and Applied Behavior Analysis

Your health plan pays benefits for behavioral services for Autism Spectrum Disorder that are focused on educational/behavioral intervention that is habilitative in nature. This includes Intensive Behavioral Therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis, or ABA).

Types of services may include diagnostic evaluations/assessments, treatment planning, treatment and/or other procedures, medication management, and individual, family and group therapy.

Treatment Decision Support

This program can help you make informed decisions about your health care. It targets specific conditions as well as treatments for those conditions. Participation is completely voluntary and without extra charge. The program offers:

- Access to accurate, objective and relevant health care information.
- Coaching by a nurse through decisions in your treatment and care.
- Information on high quality providers and programs.

Conditions for this program include: back pain, knee and hip replacement, prostate disease and cancer, benign uterine conditions, breast cancer, coronary disease, and bariatric surgery.

Pharmacy Benefits

We know that prescriptions can be expensive, so we utilize value based pharmacy management to keep costs down. Express Scripts Inc. (ESI), the company that manages our prescription benefit, will continue to be our pharmacy benefit manager. ESI has a user-friendly website: express-scripts.com/saws. Through the website you can learn about your plan, what you'll pay for prescriptions, and which pharmacies are in your network. Long-term medications, or maintenance medications, are required to be filled as a 90-day supply. Save money by filling your 90-day supply long-term medications with Express Scripts Home Delivery and Smart90 Exclusive. With these programs, you save on maintenance medications by taking fewer trips to the pharmacy and paying fewer copays. Remember, your diabetic maintenance medications are free! The table below outlines your out of pocket costs.

Pharmacy Benefit	Retail	Home Delivery/ Smart90 Walgreens*
	(30 Day Supply)	(90 Day Supply)
Diabetic Medication**	$0	$0
Other Generic	$10	$25
Preferred Brand	30%, $25 Min / $50 Max	$62.50
Non-preferred Brand	45%, $40 Min / $75 Max	$100
Specialty (Generic and Brand)***	$80	$150

* Maintenance medication and 90-day supply will only be available through home delivery or Walgreens.

** Be sure to get your diabetic supplies at the same time you get your medication. If not, you will be paying for your supplies out of pocket.

*** Specialty drugs must be ordered through Express Scripts specialty pharmacy, Accredo, at 800-803-2523.

Prescription Drug Formulary Change

There are occasional updates to the formulary for the prescription drug plan. So, while the plan benefits are not changing and there are no changes to the copays, you could see changes to your medication costs. You can use the express scripts website or app to search for a medication and see if it is covered.

Pharmacy Benefits

Rx Mail Order or Home Delivery

You can receive up to a 90-day supply of long-term medication delivered directly to you for one home delivery copayment. A long-term medication is one that is taken to treat an ongoing condition such as high blood pressure, high cholesterol, or diabetes. To enroll in the Home Delivery Program, visit express-scripts.com, sign in, then choose which of your current maintenance medications you'd like to receive through home delivery. Or you can call Express Scripts at the toll-free number on your ID card or **844-553-9111.**

Smart90 Walgreens Exclusive

Your prescription program provides savings through the Smart90 Walgreens Exclusive Program. In order to take advantage of these savings you must get a 90-day or three-month supply of your long-term medication. You will be required to fill this prescription either through mail order or a Walgreens pharmacy. Look up medications that qualify on express-scripts.com/saws. Call your nearest Walgreens and ask for instructions about how to transfer your prescription from your current pharmacy or how to get a new prescription from your doctor.

SaveonSP

SaveonSP helps you save money on certain medications. If you take an eligible prescription that falls under the specialty drug category, you will receive a letter to enroll and reduce your copay amount to zero for the specialty drug prescription. Due to manufacturer program limits and renewal requirements, you are responsible for keeping track of the money you receive and spend, so make sure you take down the manufacturer's phone number if you have questions. Don't miss out on these savings. View a list of medications that qualify for this benefit on **INSIDER** or saws.org/openenrollment.

InsideRX Pets

InsideRX Pets is a free prescription savings program to provide pet owners discounts on brand and generic human medications prescribed for pets at 40,000 participating retail pharmacies. Prescriptions include those that treat chronic conditions such as diabetes, anxiety, arthritis, or heart disease. If you would like more information and to view a list of medications and participating pharmacies, go to insiderxpets.com. Express Scripts is a free program that is not payed for by your premiums.

Dental Plan

Part of keeping healthy and happy is taking care of your smile. SAWS continues to offer a self-funded dental plan in 2022 for you and your family. UnitedHealthcare will continue as our third-party administrator. Dental premiums will increase by $3-$9, depending on your tier selection; however, there will be no changes to the plan.

Plan Features	Non-Ortho		Ortho	
	Network	Non-Network	Network	Non-Network
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$1,500 per person per Calendar Year	$1,500 per person per Calendar Year	$1,500 per person Lifetime	$1,500 per Person Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In-Network)	No (Out-of-Network)
Annual deductible applies to orthodontic services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	

Covered Services *	Network Plan Pays**	Non-Network Pays***	Benefit Guidelines
Diagnostic Services			See Exclusions and Limitations section for all Preventive & Diagnostic services benefit guidelines located on INSIDER or contact your HR Benefits Office for a copy.
Periodic Oral Evaluation	100%	100%	
Radiographs	100%	100%	
	100%	100%	
Preventive Services			
Prophylaxis (Cleaning)	100%	100%	
Fluoride Treatment (Preventive)	100%	100%	
Sealants and Space Maintainers	100%	100%	
Basic Services			
Restorations (Amalgams or Composite)*	80%	80%	
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	80%	80%	
	80%	80%	
Major Services			
Inlays/Onlays/Crowns	50%	50%	
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service esti-

**The network percentage of benefits is based on the discounted fees

***The non-network percentage of benefits is based on the usual and

2022 DENTAL MONTHLY PREMIUMS

Tier Selection	SAWS	Employee
Employee Only	$15.62	$16.00
Employee + Spouse	$30.72	$31.00
Employee + Child(ren)	$37.08	$37.00
Employee + Family	$41.34	$42.00

Vision Plan

Vision coverage remains the same for 2022, however premiums are increasing by $0.55-$1.59 depending on your coverage tier. Healthy eyes and clear vision are an important part of your overall health and quality of life. UnitedHealthcare will help you care for your sight while saving you money. Your vision plan also offers discounts on Contact Lenses, Lasik Eye Surgery, Hearing Aids, and more. For additional information, visit myuhcvision.com.

Plan Features	In-Network	Non-Network
Comprehensive Vision Exam	$10 copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$10 copay for each	See Below for Reimbursement amounts
Frequencies - Based on last date of service	Exam once every 12 months	Exam once every 12 months
	Lenses once every 12 months	Lenses once every 12 months
	Frames once every 24 months	Frames once every 24 months
Pair Of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay)	Up to $45
Contact Lenses		
Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today. A complete list can be found by visiting our website www.myuhcvision.com.	Up to 6 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay)	Up to $150
Non-selection contacts You receive an allowance which is applied toward the fitting/ evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $150 (material copay is waived)	Up to $150
Medically necessary contact lenses	Covered in full after applicable copay	Up to $210

2022 VISION MONTHLY PREMIUMS

Coverage Tiers	Employee
Employee Only	$7.35
Employee + Spouse	$13.49
Employee + Child(ren)	$14.14
Employee + Family	$21.36

You do not need to enroll in medical coverage to elect vision coverage.

Flexible Spending Accounts

A flexible spending account (FSA) lets you set aside money to help pay for health and dependent care expenses. You don't pay taxes on the money you contribute, which save you money. You must sign up each year. If you choose to continue your flexible spending account, you will have to actively enroll through Infor Lawson Employee Self–Service.

2022 CONTRIBUTION LIMITS

FSA	Minimum	Maximum
Health Care	$240	$2,750
Dependent Care	$240	$5,000

*2022 Contribution Limits subject to change by IRS Rules.

Health Care FSA vs. Dependent Care FSA

Health Care FSA

Use it for eligible health care expenses like medical, pharmacy, dental and vision services and supplies incurred by the following persons:

- You and your spouse.
- All dependents you claim on your tax return.
- Your child under age 27 at the end of the tax year.
- Any person you could have claimed as a dependent on your return except that:

1. The person filed a joint return;
2. The person had a gross income of $4,300 or more;
3. Or, you or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return

Dependent Care FSA

Use it for eligible dependent care expenses like day care, elder care services and programs for your dependents under the age of thirteen or dependent adults who require dependent daycare services.

To view account activity, balances and to submit claim forms for either your Health Care or Dependent Care FSA, go to myuhc.com. For eligible Health Care FSA items you can visit the **INSIDER** or fsastore.com.

You will be allowed to roll over all of your unused funds to the next calendar year from your Medical Flexible Spending Account. All Dependent Care FSA funds will also be rolled over to the next year.

Flexible Spending Accounts

How does your Medical FSA work?

If you decide to set aside money in an FSA to save taxes on eligible health expenses, money is taken out of each paycheck before federal and Social Security taxes are taken out. The money is then placed into your FSA. You can use this money to pay co-pays, deductibles, coinsurance, prescription costs and other eligible medical expenses listed by the Internal Revenue Service. A list of eligible expenses can be found on **INSIDER** in the benefits area of the Human Resources page.

You have three options on how to use the money to pay your out-of-pocket expenses.

1. You can use your FSA card at the point of service to pay for eligible expenses.
2. You can pay your out-of-pocket expenses up front and request reimbursement from your FSA account. This will allow you to decide when to use your FSA money, but it will require paperwork and time for each individual transaction you request for reimbursement.
3. You can skip the paperwork and stamps and choose UnitedHealthcare's automatic payment feature. This feature will allow UnitedHealthcare to automatically send you a check for the amount you paid up front, out-of-pocket. UnitedHealthcare will know only the amounts submitted through the medical claims. To choose this option you must:
   - Login to myuhc.com.
   - Click on **claims and accounts.**
   - Select **plan balances.**
   - Select **manage automatic payment settings.**

How your Dependent Care FSA Works

If you decide to set aside money in your Dependent Care FSA, you can use this money to be reimbursed for eligible dependent day care expenses. Covered dependents include children under 13, a disabled spouse and/or a disabled dependent. Dependent Care FSA money is also taken out of each paycheck before taxes. However, you may not be reimbursed for a dependent care expense until your FSA account has accumulated the total amount you are requesting from your paycheck deductions. Your FSA card cannot be used for dependent care reimbursement.

What expenses can be reimbursed or paid for with my health FSA?

The IRS decides which expenses can be paid from an FSA, which include, but not limited to, deductibles, copayments and medication. The IRS can modify the list at any time. Check **INSIDER** for the list of IRS expenses that are eligible for reimbursement under your FSA.

As of January 1, 2020, certain over-the-counter medical products have been reinstated as eligible expenses for HSAs and FSAs without a prescription. These products also include certain menstrual care products.

PLEASE NOTE: **If you choose to continue your flexible spending account, you will have to actively enroll through Infor Lawson Employee Self-Service. For 2022, your unused 2021 FSA balance will roll over to 2022.**

SAWS Well@Work Wellness Programs

NOTICE REGARDING WELLNESS PROGRAM

The San Antonio Water System Well@Work Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

As part of the wellness program you will be encouraged to participate in a biometric screening and to complete a health risk assessment (HRA). The biometric screening will include a blood test for total cholesterol, HDL, and blood glucose, and the HRA will ask a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). **These programs, and all Wellness Programs are voluntary.** You are not required to participate in biometrics or complete the HRA. However, employees who choose to participate in biometric screenings will receive an incentive of 4 hours of wellness time off for participating.

Participation in other wellness activities such as Well Connected, Fitness Center utilization, and other wellness challenges may also result in opportunities for additional incentives. SAWS is committed to helping you achieve your best health. If you think you might be unable to meet a standard for a reward or incentive under the wellness program, and would like the opportunity to earn the same reward by different means, contact Una Cuffy at 233-3417 to discuss.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used by United Healthcare (UHC), to offer you services through UHC administered programs, such as Real Appeal, Health Coaching services or other available health and wellness programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally-identifiable health information.

Although United Healthcare may provide San Antonio Water System *aggregate* information it collects to design programs based on identified health risks, your personal information will never be disclosed either publicly or to San Antonio Water System, except as necessary to respond to a request *from you* for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally-identifiable health information are: representatives of United Healthcare (the plan's third party administrator), Quest Diagnostics (who will administer the on-site biometrics) or subcontractors of United Healthcare and Quest Diagnostics engaged to provide you services under the wellness program.

In addition, all individually-identifiable medical information obtained through the wellness program will be maintained by the third-party administrators listed above and held separately from any personnel and employment records held by San Antonio Water System. Where required by law, any records stored electronically will be encrypted. For more information about the Medical Plan's privacy practices under the Health Insurance Portability and Accountability Act of 1996, please see the HIPAA Privacy Notice available on the SAWS Website. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Una Cuffy at 233-3417.

SAWS Well@Work Wellness Programs

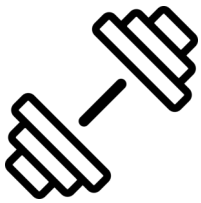
Take part in our Wellness programs that have been updated to allow you to participate virtually. Our Virtual Diabetes Prevention Program, Well Connected and Virtual Health Coaching are great ways to stay healthy as your work from home. We know that maintaining a consistent health and wellness routine may be difficult, but we are up for the challenge! Our Wellness team is determined in providing you with creative ways to take charge of your health and can't wait to see you at a virtual wellness event soon.

Well Connected

Take 10-15 minutes out of your work day every other week to recharge and connect with your coworkers while we share some healthy tips to help you stay active and well! Each session will feature different wellness topics and some will include live demonstrations.

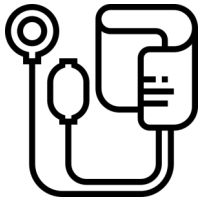
SAWS Fitness Centers

Once the Fitness Center reopens it will be available for SAWS employees to use at their convenience, 24 hours a day, 7 days a week. The facility is equipped with recumbent and spin bikes, treadmills, elliptical machines, row machines, dual pulley weight system, dumbbells, curl and straight bars, kettle bells, medicine balls, lockers and showers. Additional Fitness locations are available at Eastside OC, Wurzbach Pump Station, Clouse WRC, Northeast OC, H2Oaks, Medio Creek, Agua Vista and Environmental Laboratory with limited equipment.



Self-Measured Blood Pressure Program

Take an active part in managing your blood pressure by joining this program and receiving a free Blood Pressure monitor. With the support of UnitedHealthcare Health Coach, Lauren Zuniga, employees commit to completing a series of steps to learn how to use the cuff and track their blood pressure at home.



SAWS Well@Work Wellness Programs

Health Challenges

Health challenges are designed to increase your awareness of different aspects of your health. From weight loss to exercise to nutrition, these challenges encourage you to enhance your overall well-being.

Virtual Diabetes Prevention Program

Presented by the YMCA, this 16-week course will give employees who are at high risk for developing diabetes the tools and resources to halt pre-diabetes in its tracks. The program includes a one year membership at YMCA at no cost. For more information about the YMCA Diabetes Prevention Program and for registration information, email YIntegratedWellness@ymcasatx.org.

Health and Fitness Tools

SAWS provides several tools to help you monitor and achieve your goals like blood pressure monitors, scales, and desk treadmills available at various locations. Contact our onsite Wellness Coordinator at 210-233-3127 for more information regarding special events and other available tools.

On-site and Virtual Health Coaching

UnitedHealthcare coaching is an opportunity to work one-on-one with a health mentor who helps motivate individuals to cultivate positive health choices. Health coaches educate and support participants to achieve their health goals through lifestyle and behavior change modifications. Areas of focus include, but are not limited to: weight management, critical health risk management, stress management, diabetes management, cardio risk reduction, nutrition counseling and overall lifestyle improvement. Health coaching sessions can be completed in person or virtually.

Biometric Screenings

A good way to minimize health risks and pursue a healthier lifestyle is to find out more about yourself. The SAWS Well@Work Program can help you get that valuable information through the annual biometric screening.

Each year, a team from Optum Biometrics Solutions administers biometric screenings as part of our UnitedHealthcare plan at no additional cost to you.

During the screening event, you will learn more about your health risks to help prevent the onset of illness and disease. The screenings target blood pressure, cholesterol, glucose and body composition. Participants will receive immediate results and feedback.

Fasting is not required for the screenings, but you will get more accurate results if you do. The cholesterol, HDL and glucose screenings will be conducted with a simple finger prick.

The biometric screenings are voluntary, confidential, and free to employees enrolled in SAWS medical plans. Active full-time employees who are not enrolled in SAWS medical plan may also participate by going to their Primary Care Physician for an annual physical, which should be at no cost to the employee as provided for under the Affordable Care Act. All biometric screening and physician forms must be completed and submitted to the Wellness Team to be eligible for **four hours of leave** to be used in 2022.

Wellness Reward Hours

In an effort to increase your relationship with a Primary Care Physician (PCP) and increase participation in annual preventive exams, you can receive **four hours of leave in each of the two categories for a total of eight hours of wellness leave** each calendar year.

Category 1: Annual Physical Exam

You will be able to earn four wellness reward hours by visiting a PCP for an annual physical exam, which is covered at no cost to you under the medical plan with an in-network provider. By establishing a relationship with a PCP, you will have a doctor to visit if an illness arises. Also when getting an annual physical, the PCP may be able to diagnose illnesses and chronic diseases early on, which may prevent and treat complications that may arise if it goes unmanaged. The PCP will also be able to advise of any additional testing that may be needed based on family history. If you used your annual physical in place of the biometric screening to earn four hours of leave contact the Wellness Coordinator at 210-233-3127 to determine an alternate means of earning your **four wellness reward hours**.

Category 2: Preventive Exams

You may earn **four wellness reward hours** by completing one of the following preventative exams.

- Well women's exam
- Mammography (ages 40 and above)
- Colonoscopy (ages 50 and above)
- One dental cleaning

The deadline to submit your Wellness Rewards form is November 30, 2022.

UnitedHealthcare Wellness Services

Better health starts with making the health care choices that are right for you. UnitedHealthcare helps provide members with the programs, resources and ongoing support they need to become empowered, confident health care consumers.

RALLY®

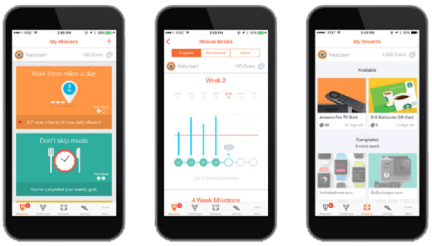
What is Rally?

Rally is an interactive Web and mobile experience that you can use to develop personalized, achievable lifestyle changes and rewards you for accomplishing those goals. You'll earn Rally coins for completing simple and healthy actions.

Rally Marketplace lets you swap your Rally® coins for discount offers on a wide selection of name-brand items. Just browse the Marketplace, exchange your coins for the discount offers you like, then purchase desired items at the new, discounted price.

Personalized health survey

Start with the quick health survey and get your Rally Age, a measure to help you assess your overall health. Rally will then recommend missions for you: activities designed to help improve diet, fitness and mood. Start easy, and level up when your are ready.



After you complete your health survey, you can also:

- Track your personalized missions — you may easily track your progress by self-reporting or using a wearable fitness device.
- Make healthy connections through challenges, community interactions and coaching.
- Register your eligible spouse or dependent on Rally for some family competition.
- Access personal health records.

Get started at myuhc.com

Real Appeal

Start living a healthier life with Real Appeal®, an online weight loss program proven to help you achieve lifelong results at no additional cost as part of your health plan benefits.

Your Weight Loss. Your Schedule

No matter your reasons for wanting to lose weight, Real Appeal® can help you reach your goals through small, achievable steps that result in lasting change. Even if you're short on free time — adding a few healthy moments each week can make all the difference.

What You Need to Enroll

- Insurance information.
- Height and weight.
- Health history.
- Preferred day and time for online weekly group session.

Sign up at saws.RealAppeal.com

Tailored to your lifestyle and schedule

Online coaching - Tailored guidance that fits your unique schedule and lifestyle.

Motivating support sessions—30-minute group sessions you can attend whether you are at home or on the go.

Tools for success—24/7 online resources, plus a Success Kit delivered to your door.

Real Appeal Outcomes

222 SAWS participants lost 1,996 pounds!

* Real Appeal is available at no additional cost to eligible employees, spouses, dependents 18 and older and pre-65 retirees with a Body Mass Index (BMI) of 23 or higher on our UnitedHealthcare plan. If you choose UnitedHealthcare for your benefits, you can enroll once you are active in the new plan.

Other Benefits Provided by SAWS

In addition to offering medical, pharmacy, dental, and vision benefits SAWS also provides you and your family with other valuable benefits. SAWS pays for your life, accidental death & dismemberment, and long term disability insurance as well as provides an employee assistance program. You can also purchase additional life insurance for your family members. SAWS also contributes to your future with two retirement plans. If you'd like to save more for your retirement, SAWS offers an additional voluntary 457 retirement plan now with a ROTH option.

Group Term Life and Accidental Death & Dismemberment Insurance

SAWS provides your family with financial security if you should die prematurely with a group term life insurance policy and Accidental Death & Dismemberment (AD&D) insurance. AD&D insurance may also provide an additional amount in the event that the death or dismemberment is a result of an accident. To provide you with this protection, SAWS purchases group term life insurance and AD&D equal to one times your annual salary, at no cost to you. This coverage is through The Standard Life Insurance Company. You may also purchase additional life insurance, up to five times your salary, in addition to coverage for a spouse and dependents. Premiums are based on age and whether you are a smoker or non-smoker and may require evidence of insurability, which includes completing a health questionnaire online with Standard. More information is located on **INSIDER** in HR Benefits section or contact HR at 210-233-2025.

TheStandard®

HealthAdvocate℠

Other Benefits Provided by SAWS

Long Term Disability

Long term disability insurance helps provide financial protection for you through monthly benefits in the event of a covered disability. SAWS has purchased this coverage for you through The Standard Insurance Company. If you become disabled, there is a 90-day waiting period before the benefit starts. All sick leave must be exhausted to participate in LTD. This monthly benefit pays 60 percent of your monthly pre-disability earnings, up to a maximum of $6,000 per month. This amount would be reduced by any additional work earnings, workers' compensation, state disability, etc. More information is located on **INSIDER** in the HR Benefits section or contact HR at 210-233-2025.

The Life Services Toolkit

The Standard provides group life insurance and has partnered with HealthAdvocate to offer you and your beneficiary free or discounted services to help make important life decisions that can make a difference now and in the future. Just go to standard.com/mytoolkit and type in "assurance" as the username.

Services include:

- Personalized Legal Center .
- Financial Fitness Center.
- Health and wellness.
- Funeral planning.
- Grief support.

Deer Oaks Employee Assistance Program

SAWS knows that you have a lot going on and we want you to know that when you need help, we've got a confidential program available for you. The Deer Oaks Employee Assistance Program (EAP) is a free service provided to you and your dependents by SAWS. This program offers a wide variety of counseling, referral and consultation services, which are all designed to assist you and your family in resolving work/life issues in order to live happier, healthier, more balanced lives. These services are completely confidential and can be accessed by calling the toll-free helpline, at 866-327-2400. You can also access the Deer Oaks website at deeroakseap.com for more information (Username/Password: SAWS) or the HR Benefits page on **INSIDER.**

DEER OAKS
EAP Services

Retirement Benefits Provided by SAWS

SAWS cares about your financial future and has two retirement plans as well as a voluntary 457 retirement plan option. Participation in the Principal Retirement and Texas Municipal Retirement Systems (TMRS) require a mandatory 3 percent contribution. SAWS provides matching contributions into your accounts. Once you achieve vesting in these plans, you earn ownership of the matching contributions. Empower Retirement is SAWS' voluntary 457 retirement plan administrator and offers a Pre and Post Tax retirement savings plan.

SAWS Retirement Plan

The SAWS Retirement Plan with Principal Retirement has two features, a Defined Benefit (DB) feature and a Defined Contribution (DC) feature. Employees hired before June 1, 2014 participate in the DB feature and employees hired or rehired on or after June 1, 2014 participate in the DC feature.

Defined Benefit Feature

The DB feature is a traditional pension plan, where both SAWS and employees contribute, and these contributions are invested by professionals. Mandatory employee contributions of 3 percent of compensation began after Dec. 31, 2014. Employees reach retirement eligibility after 20 years of service at any age or age 60 with five years of service.

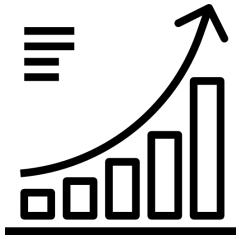
Upon retirement, employees may earn a monthly lifetime retirement benefit based on age, years of service and highest average salary. Only employees hired before June 1, 2014 are eligible to participate in the DB feature. Employees become 100 percent vested in this benefit after five years of service.

Defined Contribution Feature

The DC feature also includes SAWS and employee contributions, but employees elect how these contributions are to be invested. Upon retirement, the amount of benefit is dependent on the amounts contributed, the investment earnings or losses and plan expenses.

Employees make mandatory contributions of 3 percent of their salary and SAWS contributes 4 percent. Employees hired or rehired on or after June 1, 2014 participate in the DC feature of the plan. Employees become 100 percent vested after one year of service.

A copy of the San Antonio Water System Retirement Plan can be found on **INSIDER** in the HR benefits section under retirement.



Retirement Benefits Provided by SAWS

SAWS participates in the Texas Municipal Retirement System (TMRS). You contribute 3 percent of your salary, and SAWS matches your deposits and interest at retirement at one times your contribution (3 percent). The only way to receive SAWS matching funds is to retire from TMRS. You will become vested after five years of service. Eligibility requirements for retirement is five years of service at age 60 or 20 years of service at any age. For more information, including retirement benefit estimates, visit the TMRS website at tmrs.com or call 800-924-8677.

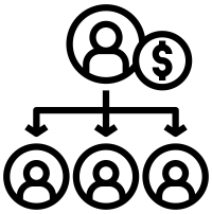
457 Deferred Compensation

SAWS offers a voluntary 457 Deferred Compensation Plan administered by Empower Retirement for you to save and supplement TMRS, Principal and Social Security retirement benefits. You can now contribute pre or post (Roth) tax dollars to save for your future. For more information, call or go online or contact an Empower representative. A representative from Empower is available every month at SAWS to assist you with enrollment and answer any questions you may have. You can also call the number below for information and advice. To enroll and transfer funds online go to empowermyretirement.com or call 800-701-8255.

Other Important Benefit Information

Beneficiaries

Are your beneficiaries up-to-date? Open Enrollment is a great time to check your current beneficiaries and make any updates if needed. To update your beneficiaries with TMRS, Principal Retirement or Empower Retirement, you can contact them by phone or go online to make changes. Their contact information is located at the back of this Benefits Guide. You may also find these beneficiary forms along with The Standard life insurance beneficiary form on **INSIDER** in the HR benefits section.



Address Changes

Have you moved? Update your address to ensure you receive important benefits information, such as your 2022 Benefits Enrollment confirmation, retirement statements, ID cards and much more. To update, complete an employee change form and TMRS address form found on **INSIDER** and submit to the Benefits Department at BenefitsInquiries@saws.org or drop off your forms at the Benefits drop box located at the entrance of Headquarters Tower II.

Completing Your Open Enrollment

The 2022 Open Enrollment will be a **passive enrollment.** You do not need to enroll online unless you want to make changes to your current benefits. If you do not submit a 2022 online enrollment, you will continue in the same plan(s) as 2021. However, if you want to participate in a Flexible Spending Account for 2022, you will need to actively enroll in 2022 benefits through Infor Lawson Employee Self-Service.

Important to Remember:

- **Enrollment** — 2022 Open Enrollment will be electronic through Infor Lawson Employee Self-Service.
- **Password Expired** — If you have not logged on to the Employee Self-Service in the past six months, please contact the I.S. Help Desk at 210-233-2007 for assistance.
- **Adding a Dependent** — The online Employee Self-Service system will allow you to add any dependent that has previously been included in the validation process. If you have a new dependent you would like to add, please contact Human Resources prior to enrolling in the 2022 plans, and provide the required documentation for dependent validation.
- **Changing Coverage** — Open enrollment is the only time you can change your coverage unless you have a qualifying life event or HIPAA special enrollment and request the change within 31 days.
- **Waiving Coverage** — if you decline or drop medical coverage, you must provide proof of other insurance and must select the waiver option under the benefits selection during the enrollment process.

Benefits Eligibility

You are eligible to enroll in the active employee plans if you are a regular full-time employee who is scheduled to work at least 30 hours per week.

Dependent Eligibility

Your eligible dependents may also participate in the plan:

- Your spouse, an individual to whom you are legally married.
- You or your spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian; or an unmarried child age 26 or over who is or becomes disabled and dependent upon you. A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order, the court or administrative order.
- To be eligible for coverage under the plan, a dependent must reside within the United States.

Note: Dependents may not enroll in the plan unless you are also enrolled. If you, your spouse, or dependent are employed by SAWS and covered under the plan, you must each be enrolled as a participant and not be covered as a dependent of the other person. In addition, if you and your spouse are both covered under the plan, only one parent may enroll your child as a dependent.

Completing Your Open Enrollment

Qualifying Life Events

You can only add or remove eligible dependents during open enrollment or during a qualifying life event. Dependents can be added or removed from your benefits as a result of the following events: your marriage, your divorce, birth of a child, death, loss or gain of other coverage. Changes must be made within 31 days of the event. A more detailed listing of eligible family status changes is provided in Section 2 of the Plan Document.

Coverage for a spouse or dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage and provide a properly completed enrollment form. Coverage for dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources with the appropriate documentation within 31 days of the birth, adoption or placement.

Dependent Verification

If you plan on adding a new dependent to your medical coverage who is not currently enrolled in one of the SAWS benefit plans, you will need to complete a dependent validation.

To complete a dependent validation, please submit to Human Resources the documents listed below:

Type of Eligible Dependent	Required Documentation
Spouse	• Copy of marriage license or declaration and registration of informal marriage. • Copy of Social Security card. • Date of birth.
Dependent Child	• Copy of birth certificate or verification of birth facts (naming you or your spouse as the child's parent), or • Copy of adoption agreement, or • Copy of qualified medical child support order, or • Copy of court custody or guardianship documents. *AND* • Copy of Social Security card.

Reminder: Adding Your Newborn to Your Benefit Plans

Newborns can be added **within 31 days** of their birth or during open enrollment. Employees must provide the benefits office with a birth certificate or a Verification of Birth Facts issued by the hospital. In addition, employees must provide the newborn's Social Security number and complete an enrollment form. A copy of the Social Security card must also be submitted when you receive it.

Planning for Retirement

Future Premium Cost Sharing

One of the biggest expenses you can anticipate in retirement will be health care costs. Employer-sponsored retiree health plans can play an important role in contributing to retirement security for those pre-65 retirees who are too young to qualify for Medicare. SAWS is committed to providing health care coverage to employees and eligible retirees at an affordable cost and to paying the largest share of the cost of that coverage.

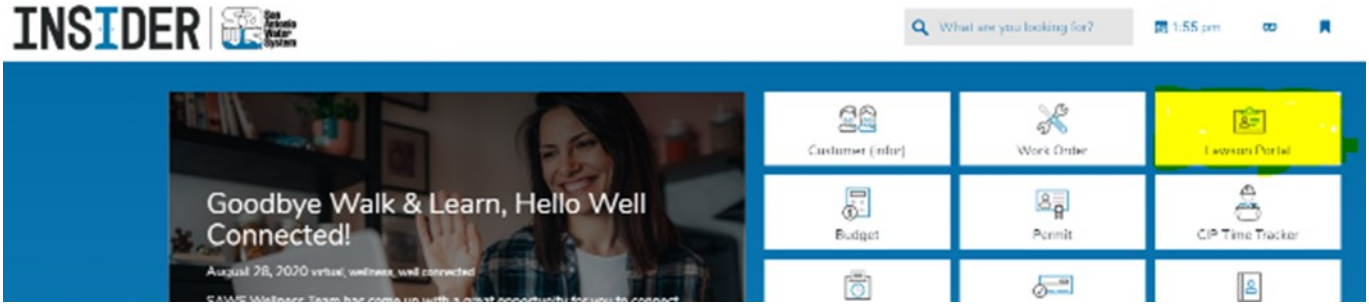
SAWS shares the cost of health care with retirees by paying approximately two/thirds of the cost of health care and retirees pay one-third of the cost.

If you are eligible for medical coverage through SAWS at retirement, your retiree premiums will be based on your years of service, your hire date, retirement date and Medicare eligibility.

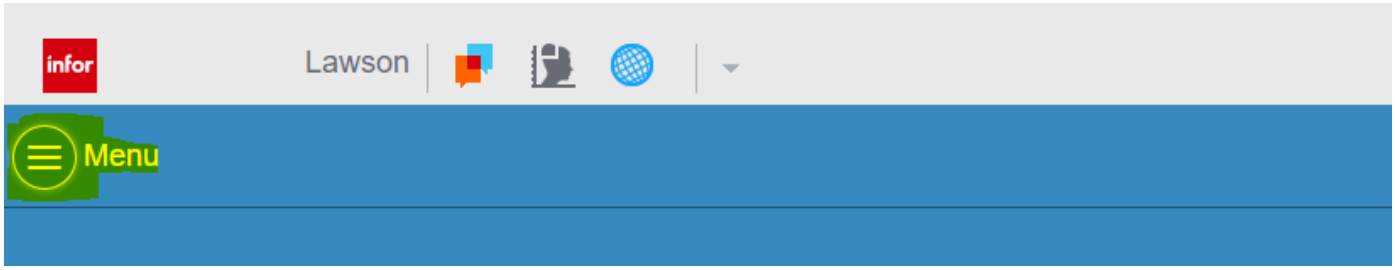
How to Access Open Enrollment

If you are making changes to your 2022 benefits or enrolling in the Medical or Dependent Flexible Spending Accounts, you must enroll online through Lawson Employee Self-Service.

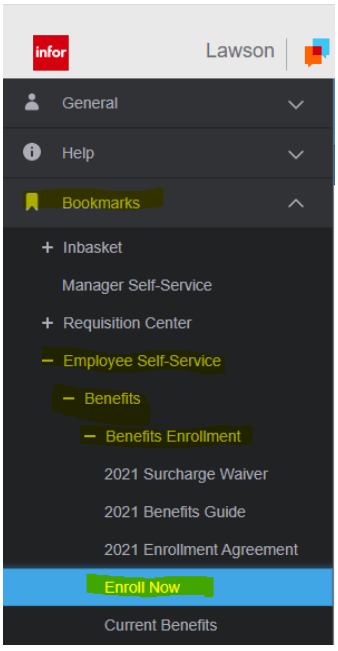
1. While on the INSIDER, find and click on the Lawson Portal Icon.



2. Lawson will open in a new tab. Click on the Menu on the left side of your screen.

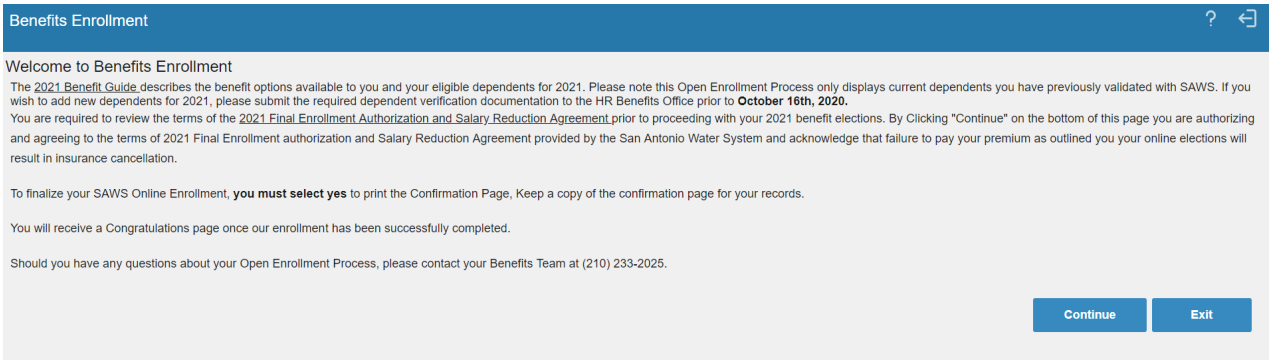


3. Clicking on the Menu will open up your Bookmarks. Click on Bookmarks, then hover over Employee Self-Service -> Benefits -> Benefits Enrollment, and click on Enroll Now.



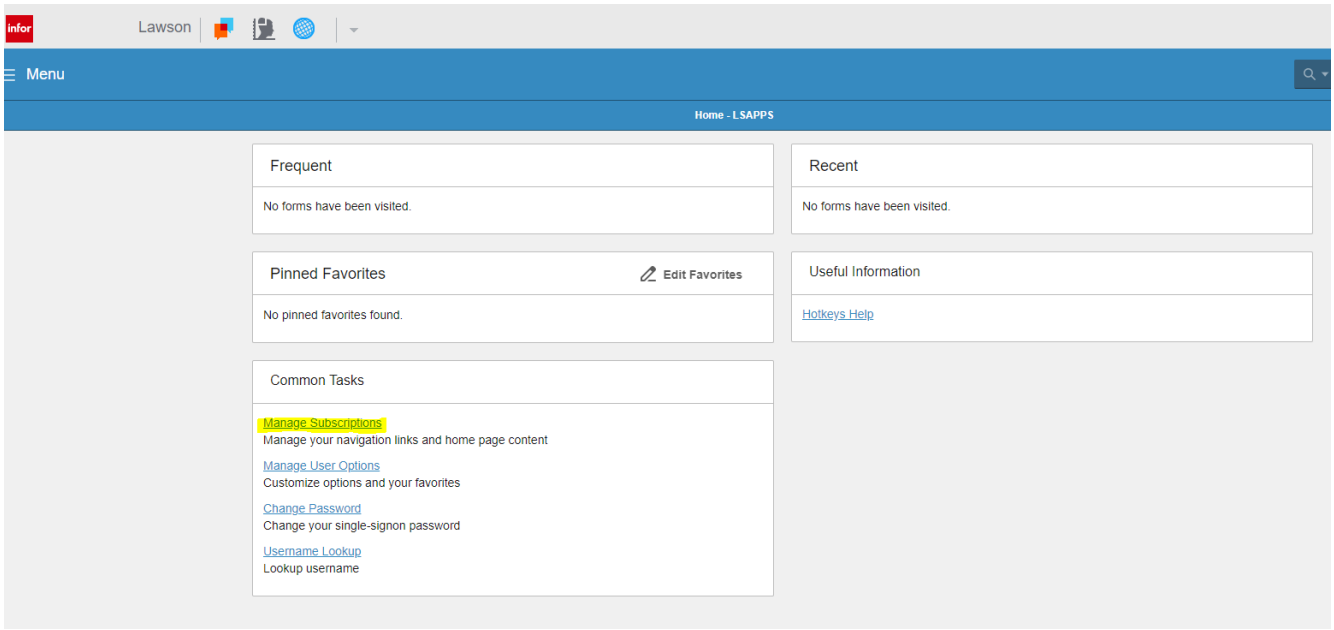
How to Access Open Enrollment

4. Clicking on Enroll Now will open a new window for you to begin the benefits enrollment process.

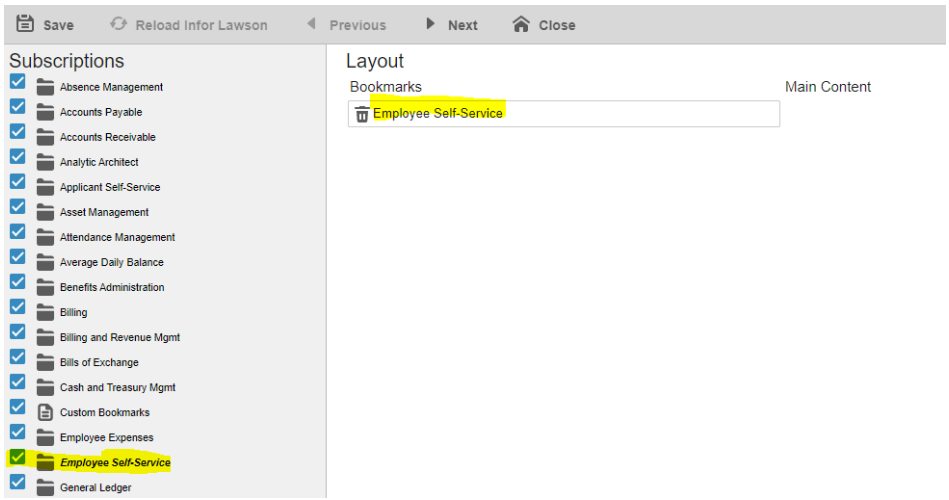


Don't see Employee Self-Service under your bookmarks?

1. Once in Lawson, click Manage Subscriptions.

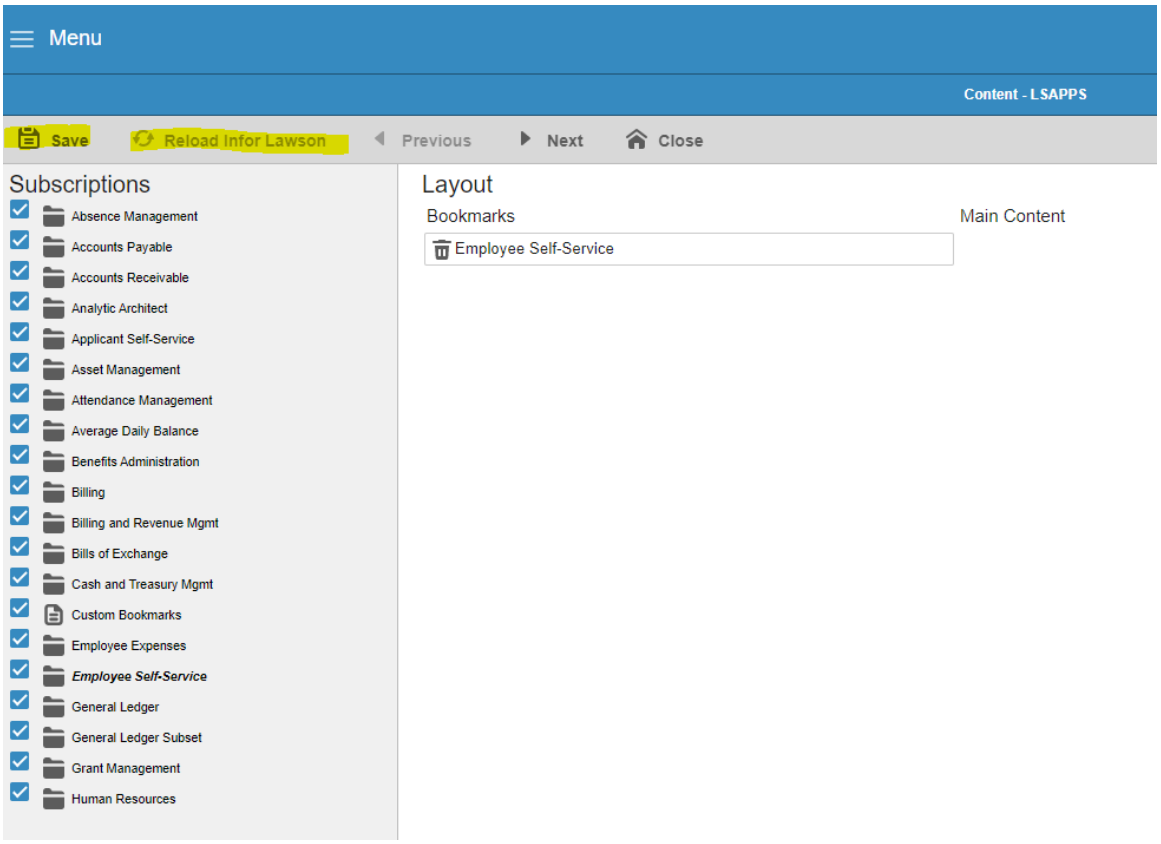


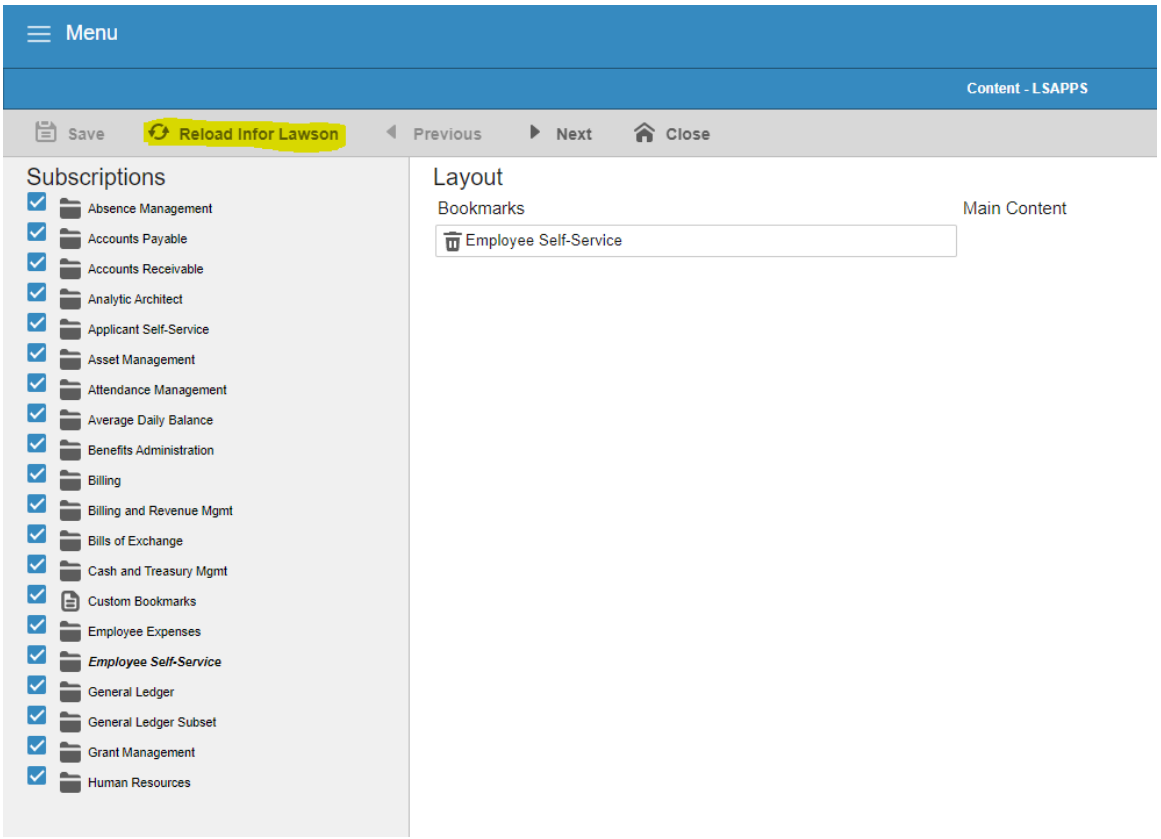
2. Ensure that Employee Self-Service is checked and click and drag over to Bookmarks.



How to Access Open Enrollment

3. Select the Save icon, then Reload Infor Lawson. Return to Step 2 to begin the benefits enrollment process.





Required Notices

Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms

Under the law, insurance companies and group health plans must provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary will help consumers better understand the coverage they have and allow them to easily compare different coverage options. It summarizes the key features of the plan and coverage limitations and exceptions. For a copy of the SBC of the SAWS medical plans, visit the **INSIDER** Human Resources benefits page or contact the HR Benefits Office at 210-233-2025 for a copy.

Under the Patient Protection and Affordable Care Act (Health Reform), consumers will also have a resource to help them understand some of the most common but confusing jargon used in health insurance. Employees can access the Uniform Glossary of Terms online at the **INSIDER** Human Resources benefits page or contact the HR Benefits Office at 210-233-2025 for a copy.

Governing Plan

This guide is intended to provide summary information about the benefit plans offered to the employees of San Antonio Water System. Complete plan details are included in the Plan Documents available on the **INSIDER** Human Resources benefits page and at **myuhc.com**, or contact the Human Resources Benefits Office at 210 -233-2025 for a copy. In the event of any discrepancy between this document and the official Plan Document, the Plan Document shall govern.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, is a Federal law that requires employers to offer qualified beneficiaries the opportunity to continue medical coverage, vision coverage, dental coverage, and/or participation in the SAWS Health Care Flexible Spending Account at their own cost in the case of certain qualifying events.

COBRA Notice Requirements. Each employee or qualified beneficiary is required to notify the Human Resources Benefits Office within 60 days of a divorce, legal separation, a child no longer meeting the definition of dependent, or entitlement to Medicare benefits. UnitedHealthcare, the SAWS COBRA administrator, will then notify all qualified beneficiaries of their rights to enroll in COBRA coverage. Notice to a qualified beneficiary who is the spouse or former spouse of the covered employee is considered proper notification to all other qualified beneficiaries residing with the spouse or former spouse at the time the notification is made.

HIPAA Privacy Policy

The Health Insurance Portability and Accountability Act (HIPAA) details the rules San Antonio Water System will follow to safeguard the confidentiality of medical information obtained through the course of enrollment and administration of our health plans. For detailed information, visit **hhs.gov/ocr/privacy** or the **INSIDER** Human Resources benefits page.

Patient Protection and Affordable Care Act (PPACA) - Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Required Notices

Women's Health and Cancer Rights Act of 1998 (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including Copayments and any annual deductible) are the same as are required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Medicare Part D Creditable Coverage Notice

Entities that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether the drug coverage they have is creditable or non-creditable. SAWS has determined that the prescription drug coverage offered by SAWS through Express Scripts is, on the average for all plan participants, expected to pay out as much as, or more than, what the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage under Medicare.

For a copy of the SAWS Creditable Disclosure Notice please see pages 30 and 31 of this benefit guide or contact the HR Benefits Office at 210-233-2025 for a copy.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator.

For information on notification or prior authorization, contact your issuer.

HIPPA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage.) However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request

enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your SAWS Human Resources Benefits Office at 210-233-2025.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Texas, contact your State Medicaid or CHIP office (see below) to find out if premium assistance is available. If you live in a state other than Texas, please see the U.S. Department of Labor's current CHIPRA model notice for a list of states which provide premium assistance.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877-KIDS-NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA (3272)**.

CHIP | TEXAS Health and Human Services

TEXAS – Medicaid
gethipptexas.com
800-440-0493

To see if any other states other than Texas or the states listed on the current CHIPRA model notice have added a premiums assistance program since July 31, 2021, or for more information on special enrollment rights contact either:

U.S. Department of Labor Employee Benefits Security Administration **dol.gov/agencies/ebsa** 866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **cms.hhs.gov** 877-267-2323, Menu Option 4, Ext. 61565

SAWS Active Employees and Dependents
Important Notice from the San Antonio Water System
About Your 2022 Prescription Drug Coverage and Medicare Prescription Drug Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with San Antonio Water System ("SAWS") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plan offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a stand-alone Medicare Prescription Drug Plan (commonly referred to as a Medicare Part D Plan) or a Medicare Advantage Plan that includes prescription drug coverage (commonly referred to as an MAPD Plan). All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. SAWS has determined that the prescription drug coverage offered by SAWS through Express Scripts is, on the average for all plan participants, expected to pay out as much as, or more than, what the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage under Medicare. Because your existing coverage from SAWS is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare Drug Plan?

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

When you become eligible for Medicare and have enrolled in Medicare Part A and/or Part B, you have the following options concerning prescription drug coverage:

1. You may stay in the SAWS Group Health Plan, which includes SAWS prescription drug coverage, and not enroll in Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare open enrollment period; or (2) if you lose your coverage under the SAWS Group Health Plan.
2. You may stay in the SAWS Group Health Plan, including SAWS prescription drug coverage, and also enroll in Medicare Part D prescription drug coverage at this time. Your current coverage under the SAWS Plan, which pays for other health benefits as well as prescription drugs, will not change if you choose to enroll in Medicare Part D prescription drug coverage. The SAWS Group Health Plan will pay prescription drug benefits as the primary payer, and thus the value of your Medicare Part D prescription drug coverage will be greatly reduced.
3. You may reject coverage under the SAWS Group Health Plan and choose coverage under a Medicare Part D Plan for prescription drug coverage. If you reject coverage under the SAWS Plan, you will be able to receive coverage at a later date, as long as you are still a SAWS employee in a benefits-eligible position, and you re-enroll during an open enrollment period or are eligible for special enrollment in the SAWS plan. If you reject coverage under the SAWS Plan and cease to be a SAWS employee in a benefits-eligible position, you will not be able to regain coverage under the SAWS Plan.

SAWS does not charge a separate premium for its prescription drug plan. You will pay the same premium to participate in the SAWS Group Health Plan whether or not you elect to receive prescription drug coverage through a Medicare Part D Plan.

Although SAWS cannot state that in all cases the SAWS prescription drug coverage will be more advantageous than the Medicare prescription drug coverage, in most cases you will have better and less expensive prescription drug coverage under the SAWS prescription drug coverage.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with SAWS and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact our office for further information at (210) 233-2025. NOTE: You may receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook (available at http://www.medicare.gov/publications/pubs/pdf/10050.pdf). You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2021
Name of Entity/Sender:	San Antonio Water System
Contact—Person/Office:	Patty Goldspink/Human Resources
Address:	2800 U.S. Hwy 281 North
	San Antonio, TX 78212
Phone Number:	(210) 233-2025

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-651-7277 or visit whyuhc.com/saws. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500** Individual / **$4,500** Family Out-of-Network: **$2,500** Individual / **$7,500** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. You must begin a new deductible each calendar year.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,500** Individual / **$11,250** Family Out-of-Network: **$7,500** Individual / **$18,750** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-888-651-7277** for a list of network providers.	You pay the least if you use a Tier 1 Premium provider in the Network. You pay more if you use a Non-Tier 1 provider in the Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1 Premium Provider: $40 copay per visit, deductible does not apply. Non-Tier 1: $50 copay per visit, deductible does not apply.	40% coinsurance, after deductible	Virtual visits - $30 copay per visit by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Tier 1 Premium Provider: $60 copay per visit, deductible does not apply. Non-Tier 1: $70 copay per visit, deductible does not apply.	40% coinsurance, after deductible	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	40% coinsurance, after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance, after deductible	Preauthorization is required out-of-network for certain services or benefit reduces to 35% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required out-of-network or benefit reduces to 35% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay Mail-Order: $25 copay Diabetic medications: $0 for 30 day supply/retail or 90 day supply/ mail order	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	Provider means pharmacy for purposes of this section. *Retail*: Up to a 30 day supply. Retail 90 supply only available at Walgreens pharmacy (mail-order copay applies). *Mail-Order*: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by Express Scripts, Inc. Certain drugs may have a pre-authorization requirement or may have a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount and applicable copay. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prior approval is required for all specialty drugs and must be ordered from Accredo, ESI's specialty pharmacy. No coverage for prescription drugs with UnitedHealthcare.
	Tier 2 – Your Mid-Range Cost Option (Preferred Brands)	Retail: 30% coinsurance ($25 Min/$50 Max)/30 day supply Mail-Order: $62.50 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
	Tier 3 – Your Mid-Range Cost Option (Non-Preferred Brands)	Retail: 45% coinsurance ($40 Min/ $75 Max)/30 day supply Mail-Order: $100 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
	Tier 4 – Your Highest Cost Option	Retail: $80 copay/30 day supply Mail-Order: $150 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required out-of-network for certain services or benefit reduces to 35% of allowed amount.
	Physician/surgeon fees	20% coinsurance, after deductible	40% coinsurance, after deductible	None
If you need immediate medical attention	Emergency room care	$300 copay per visit, then 20% coinsurance, after deductible	$300 copay per visit, then *20% coinsurance, after deductible	*Network deductible applies
	Emergency medical transportation	20% coinsurance, after deductible	*20% coinsurance, after deductible	*Network deductible applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Urgent care	$75 copay per visit, deductible does not apply.	40% coinsurance, after deductible	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	40% coinsurance, after deductible	$100 per occurrence deductible applies out-of-network prior to the overall deductible. Preauthorization is required out-of-network or benefit reduces to 35% of allowed amount.
	Physician/surgeon fees	20% coinsurance, after deductible	40% coinsurance, after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply.	40% coinsurance, after deductible	Preauthorization is required out-of-network for certain services or benefit reduces to 35% of allowed amount.
	Inpatient services	20% coinsurance, after deductible	40% coinsurance, after deductible	$100 per occurrence deductible applies out-of-network prior to the overall deductible. Preauthorization is required out-of-network or benefit reduces to 35% of allowed amount.
If you are pregnant	Office visits	Copay for Initial Visit then No Charge	40% coinsurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance, after deductible	40% coinsurance, after deductible	
	Childbirth/delivery facility services	20% coinsurance, after deductible	40% coinsurance, after deductible	$100 per occurrence deductible applies out-of-network prior to the overall deductible. Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 35% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	40% coinsurance, after deductible	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 35% of allowed amount.
	Rehabilitation services	$70 copay per visit, deductible does not apply.	40% coinsurance, after deductible	Outpatient rehabilitation services are unlimited per calendar year. Preauthorization required out-of-network for certain services or benefit reduces to 35% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Habilitative services	$70 copay per visit, deductible does not apply.	40% coinsurance, after deductible	Services are provided under Rehabilitation Services above. Preauthorization required out-of-network for certain services or benefit reduces to 35% of allowed amount.
	Skilled nursing care	20% coinsurance, after deductible	40% coinsurance, after deductible	$100 hospital per occurrence deductible applies out-of-network prior to the overall deductible. Skilled Nursing is limited to 60 days per calendar year. Inpatient rehabilitation - Unlimited. Preauthorization is required out-of-network or benefit reduces to 35% of allowed amount.
	Durable medical equipment	20% coinsurance, after deductible	40% coinsurance, after deductible	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 35% of allowed amount.
	Hospice services	20% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 35% of allowed amount.
If your child needs dental or eye care	Children's eye exam (refraction)	Not Covered	Not Covered	No coverage for Children's eye exams (refraction).
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult/Child, unless related to an accident)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (covered only for treatment of morbid obesity)
- Chiropractic (Manipulative care) – 35 visits per calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-651-7277.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-651-7277.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-651-7277.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-651-7277.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$40
Coinsurance	$2,232
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,772**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-651-7277.or visit whyuhc.com/saws. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual / **$3,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. You must begin a new deductible each calendar year.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,500** Individual / **$9,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-888-651-7277** for a list of network providers.	You pay the least if you use a Tier 1 Premium provider in Network. You pay more if you use a Non-Tier 1 provider in the Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1 Premium Provider: $25 copay per visit, deductible does not apply. Non-Tier 1: $40 copay per visit, deductible does not apply.	Not Covered	Virtual visits - $15 copay per visit by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Tier 1 Premium Provider: $40 copay per visit, deductible does not apply. Non-Tier 1: $60 copay per visit, deductible does not apply.	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay Mail-Order: $25 copay Diabetic medications: $0 for 30 day supply/retail or 90 day supply/ mail order	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	Provider means pharmacy for purposes of this section. *Retail*: Up to a 30 day supply. Retail 90 day supply only available at Walgreens Pharmacy (mail-order copay applies). *Mail-Order*: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by Express Scripts, Inc. Certain drugs may have a pre-authorization requirement or may have a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount and applicable copay. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prior approval is required for all specialty drugs and must be ordered through Accredo, ESI specialty pharmacy. No coverage for prescription drugs with UnitedHealthcare.
	Tier 2 – Your Mid-Range Cost Option (Preferred Brands)	Retail: 30% coinsurance ($25 Min/ $50 Max)/30 day supply Mail-Order: $62.50 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
	Tier 3 – Your Mid-Range Cost Option (Non-Preferred Brands)	Retail: 45% coinsurance ($40 Min/$75 Max)/30 day supply Mail-Order: $100 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
	Tier 4 – Your Highest Cost Option	Retail: $80 copay/30 day supply Mail-Order: $150 copay/90 day supply	Must pay full price and directly submit claims to Express Scripts for reimbursement of eligible amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance, after deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay per visit, then 20% coinsurance, after deductible	$300 copay per visit, then *20% coinsurance, after deductible	*Network deductible applies
	Emergency medical transportation	20% coinsurance, after deductible	*20% coinsurance, after deductible	*Network deductible applies
	Urgent care	$75 copay per visit, deductible does not apply.	Not Covered	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance, after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay per visit, deductible does not apply.	Not Covered	None
	Inpatient services	20% coinsurance, after deductible	Not Covered	None
If you are pregnant	Office visits	Copay for Initial Visit then No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance, after deductible	Not Covered	
	Childbirth/delivery facility services	20% coinsurance, after deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$60 copay per visit, deductible does not apply.	Not Covered	Outpatient rehabilitation services are unlimited per calendar year.
	Habilitative services	$60 copay per visit, deductible does not apply.	Not Covered	Services are provided under Rehabilitation Services above.
	Skilled nursing care	20% coinsurance, after deductible	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance, after deductible	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	20% coinsurance, after deductible	Not Covered	None
If your child needs dental or eye care	Children's eye exam (refraction)	Not Covered	Not Covered	No coverage for Children's eye exams (refraction).
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult/Child, unless related to an accident)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (covered only for treatment of morbid obesity)
- Chiropractic (Manipulative care) – 35 visits per calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/saws.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-651-7277.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-651-7277.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$25
Coinsurance	$2,335
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$540
Coinsurance	$252
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,792**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

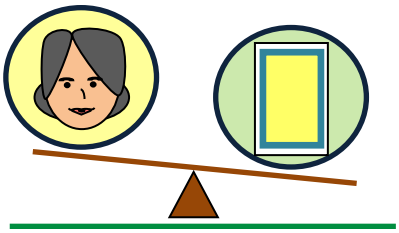
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

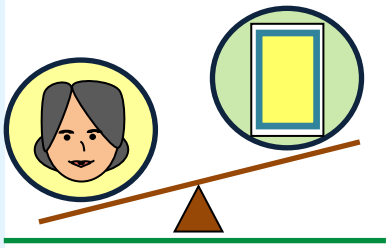
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

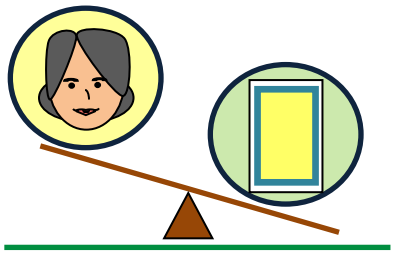
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

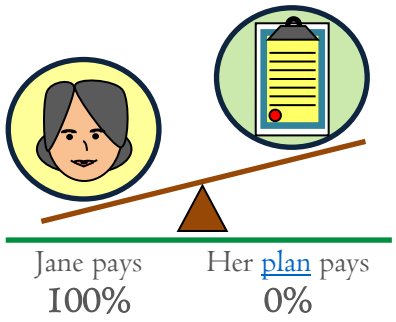
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

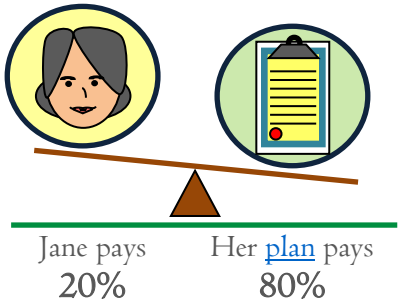
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

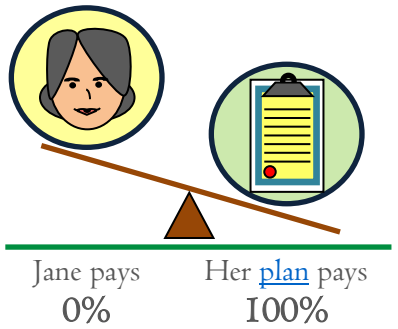
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Important Contact Information

Organization	Phone	Website/Email Address
SAWS Human Resources - Benefits Office	210-233-2025	**INSIDER/intranet/departments/HR**
Interim Benefits Manager – Patty Goldspink	210-233-3306	benefitsinquiries@saws.org
Sr. Benefits Analyst – Mary Jo Vargas	210-233-3445	benefitsinquiries@saws.org
Benefits Analyst – Andrea Muniz	210-233-3389	benefitsinquiries@saws.org
Manager, Employee Services & Wellness—Una Cuffy	210-233-3417	Una.Cuffy@saws.org
UnitedHealthcare		
Customer Service	888-651-7277	myuhc.com
Mental Health Providers	888-651-7277	myuhc.com
Dental	888-651-7277	myuhc.com
Vision	888-651-7277	myuhcvision.com
Flexible Spending Accounts	888-651-7277	myuhc.com
SAWS Onsite Service Account Manager	210-233-3066	Abi.Luis@saws.org
SAWS Onsite Wellness Coordinator	210-233-3127	Lauren_Zuniga@uhc.com
Express Scripts - Pharmacy Benefit Manager	844-553-9111	express-scripts.com
Accredo - Specialty Pharmacy	800-803-2523	
Group # SAWATER		
Deer Oaks Employee Assistance Program	866-327-2400	deeroakseap.com
Texas Municipal Retirement System (TMRS)	800-924-8677	tmrs.com
Standard Life Insurance - Group # 753337	800-291-2171	standard.com
SAWS Retirement Plan - Principal	800-547-7754	principal.com
Hired Prior 6/1/2014 Defined Benefit #519560	Hired After 6/1/2014 Defined Contribution #461192	
Empower Retirement, 457(b) Plan # 100026-01	800-701-8255	Empowermyretirement.com

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San Antonio Water System