2022

Benefits Guide for Retirees

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 Pre-65 Retiree/Medicare Advantage Plan Participant:

This Open Enrollment Benefits Guide is designed to provide you with important information regarding the annual open enrollment process and available medical plans for the 2022 plan year. The open enrollment period for 2022 benefits will be **October 4 - October 22, 2021**. Enrollment will once again be **passive**, meaning Pre-65 retirees and Medicare retirees who do not wish to make any benefit election changes for 2022 do not have to re-enroll; your current plan elections will roll over into the new plan year.

If you are a **Medicare retiree**, you will still have the options of the Medicare Advantage PPO Economy and PPO Plus plans, which will have **decreased premiums** in 2022. If you have a spouse or dependent who is on a Pre-65 Retiree plan, you do not need to submit an enrollment form for them if you do not wish to make any changes.

For Pre-65 retirees, we will continue to offer the PPO Economy and the EPO Plus self-funded medical plans, and Express Scripts will continue to be our pharmacy benefits manager. Although SAWS met its cost share goal in 2021, where retirees pay one-third of the cost of health care and SAWS pays two-thirds of that cost, premiums will be **increasing** for both plans due to the rise in healthcare costs. SAWS works diligently to keep these increasing healthcare costs to a minimum; therefore, to mitigate the increases, there are a few plan design changes. Urgent Care and Emergency Room visit copays will increase as well as EPO Plus medical plan deductibles.

The spouse premium surcharge of $150 per month will continue for Pre-65 retirees who elect medical coverage for their spouse who has access to medical coverage through their employer. This surcharge is in addition to the regular pre-65 medical premium. If your spouse is not working or does not have access to medical coverage through his/her employer, you can file a waiver for the surcharge. A Spouse Premium Surcharge Waiver form has been included in your enrollment guide and is due to the HR Benefits office by **October 22, 2021**. If you currently have a waiver on file, you do **not** have to complete an additional waiver for 2022 if there is no change in status.

If you want to make changes to your coverage, complete the forms located at the back of this guide and drop them off using the Benefits Drop Box located at the SAWS Headquarters Tower II front entrance. You can also scan and email these forms to **benefitsinquiries@saws.org**.

Remember, if you or your dependents have coverage through another medical plan, you are eligible to opt out of the SAWS plan, and may rejoin at a later time as long as you submit proof of continuous coverage from another medical plan. If you wish to discuss this option, or have any other questions, please contact the Human Resources Benefits Office at 210-233-2025.

Best wishes for the upcoming year!

Sincerely,

Your SAWS Benefits Team
San Antonio Water System

SAWS 2022 Virtual & Teleconference

Open Enrollment Meetings for Retirees

Date	Time	Sessions	Participant Dial-In Information
Wednesday Oct. 6	10 a.m.	Pre-65 Retiree Medical Plan	Dial: 210-233-2090 Access Code: 24918450156
	6 p.m.	Medicare Advantage Plan	Dial: 844-867-6169 Access Code: 5590306
Tuesday Oct. 12	10 a.m.	Pre-65 Retiree Medical Plan	Dial: 210-233-2090 Access Code: 24907745443
	2 p.m.	Pre-65 Retiree Medical Plan	Dial: 210-233-2090 Access Code: 24911474918
Thursday Oct. 14	9 a.m.	Medicare Advantage Plan	Dial: 844-867-6169 Access Code: 5590306
	1:30 p.m.	Medicare Advantage Plan	Dial: 844-867-6169 Access Code: 5590306
Tuesday Oct. 19	10 a.m.	Medicare Advantage Plan	Dial: 844-867-6169 Access Code: 5590306
	2 p.m.	Pre-65 Retiree Medical Plan	Dial: 210-233-2090 Access Code: 24810891304

You will be able to attend the 2022 Retiree Open Enrollment Meetings from the convenience of your home or another location by phone (Pre-65 and Post-65) or computer (Pre-65). Simply dial the above number and then enter the access code. Pre-65 Retirees will have to enter the # sign when asked for the attendee ID. For Pre-65 Virtual sessions, go to saws.webex.com and enter the access code based on the time of the meeting you want to attend. Then enter the **password: 2022**.

Contact Human Resources Benefits at 210-233-2025 if you have questions on how to access the meetings. Visit saws.org/retirees for enrollment information or scan the QR code below to view open enrollment information on your mobile device.

SCAN ME

2022 Highlights

SAWS goal is to provide you with quality care that offers choices for you and your family. We will continue to have UnitedHealthcare (UHC) as our Healthcare Provider. This year we want to keep you safe and will have a Passive enrollment. Both Pre-65 and Medicare Advantage Plan (MAP) retirees do not need to submit a new enrollment form unless you want to make changes to your current benefits. If you do not submit a 2022 enrollment form, you will continue in the same plan as 2021.

Pre-65 Retirees and Dependents

- **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 increase for both SAWS and retirees.** To keep up with the cost of health care, there will be increases in both the PPO Economy and EPO Plus 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.
- **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 13 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.
- **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.

Post-65 Retirees and Dependents

- **The UnitedHealthcare Medicare Advantage Plans will not change.** Copays for office visits and emergency rooms visits, deductibles, and out-of-pocket maximums will remain the same.
- **Medicare Advantage Plan premiums are decreasing.**
- **Medicare Advantage Plan enrollment is individual.** If your covered spouse/dependent is not Medicare eligible, they must enroll in one of the Pre-65 plans.
- **Turning 65 in 2022?** If you or your dependent will turn 65 in 2022, you will be required to enroll in one of the two available Medicare Advantage Plans. Please contact the SAWS Human Resources Benefits Office at least 90 days before your 65th birthday.

Table of Contents

This guide is designed to provide information regarding the available medical plan options for eligible retirees in 2022. If you need further information regarding your plans, please contact the Human Resources Benefits Office at 210-233-2025 or attend one of the scheduled teleconference open enrollment meetings listed inside this guide. 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 about your prescription drug coverage. Please see pages 20-21 for more details.

Open Enrollment Deadline Oct. 22, 2021

Note: Benefits are subject to change without notice.

2022 Enrollment

2022 Enrollment Information

The 2022 Open Enrollment for both Pre-65 Retirees and Medicare Advantage participants is passive, meaning you will only submit a new enrollment form if you are changing plans.

A 2022 enrollment form is included in your packet. If you would like to make changes to your current plans, please complete the 2022 enrollment form and return it to the SAWS HR Benefits Office at the following address no later than **Oct. 22, 2021**. Remember, you can only change plans during an annual open enrollment period and no new dependents may be added unless there is a HIPAA Special Enrollment event.

Mailing Address:

San Antonio Water System

Human Resources Department

P.O. Box 2449

San Antonio, TX 78298

Verification of Personal Information

To receive your identification cards promptly, make sure that the SAWS Human Resources Benefit Office has your correct contact information on file. You may call the Benefits Office at 210-233-2025 to report an address change or other corrections or send your corrections to the SAWS address provided above under 2022 Enrollment Information.

Opting Out of Coverage

Do you have other coverage? SAWS allows you or your spouse/children an opt-out opportunity if you have coverage through another health plan. If that coverage ends and you would like to re-enroll in a SAWS plan, you will need to do the following:

1. Provide proof of continuous coverage in another health plan or plans for the entire period for which you and/or your eligible dependents were not covered under the SAWS plan.
2. Request health coverage under the plan within 31 days of the other coverage ending to re-enroll in the SAWS plans and provide proof that coverage has or will be ending. Returning children must continue to meet the age eligibility requirements (currently under age 26.)

Retiree Dependent Coverage

An eligible retiree who elects coverage under the plan may also elect to cover any dependents (including a spouse) who were covered under the plan at the time of the employee's retirement (referred to as eligible dependents). You may enroll eligible dependents at the time of your initial election for retiree coverage or upon subsequent election for retiree coverage following a period of deferral. Once enrolled in the plan, an eligible dependent's coverage will terminate upon the earliest of the following events:

- Ceasing to meet the applicable definition of dependent in the plan document;
- Termination of eligible retiree's coverage under the plan for any reason other than death; and
- Decision by you to terminate the eligible dependent's coverage.

Remember, if your dependent currently has coverage through another heath plan, he/she can opt out of SAWS and re-enroll later with proof of continuous coverage.

New dependents may not be enrolled after your retirement unless there is a special enrollment event and you apply for such coverage within 31 days of acquiring a new dependent. However, there shall be no SAWS subsidy towards the premium for any such new dependent. You will have to pay the full cost of coverage for the dependent.

Surviving Dependent Coverage

Upon the death of a retiree, a spouse who is covered by the plan may continue to participate for the remainder of his or her lifetime with no SAWS subsidy towards the premium. Likewise, dependent children may continue to participate as long as they meet the applicable definition of dependent in the plan document with no SAWS subsidy towards the premium.

Cost Sharing & Enrollment Options

Meeting the Health Care Cost Challenge

SAWS invests millions of dollars each year in retiree health care coverage. Even though the cost of providing medical and pharmacy benefits has increased significantly over the last few years, SAWS is committed to providing quality health care coverage to you at an affordable cost.

SAWS has met its goal to reach a cost share model where retirees pay one-third of the cost of health care and SAWS pays two-thirds of the cost. This has been accomplished by.

- Implementing a Medicare Advantage Plan for post-65 retirees.
- Changing plan administrators to secure better network discounts.
- Conducting validation to ensure only eligible dependents are enrolled.
- Implementing an EPO Plus in-network option.
- Realigning deductibles and out-of-pocket costs with current market practices.
- Adding a spouse premium surcharge in order to reduce plan costs and encourage spouses to use their own employer's or former employer's medical coverage when available.

Without these changes, premiums would have increased a lot more in the past few years.

Cost Share Target

Pre –65 Retiree Plan

	SAWS Pays	Retiree Pays
2021	67%	33%

Retiree Benefit Options

If you or your eligible dependents are not eligible for Medicare Parts A and B, you have the following health benefit options under SAWS' self-funded Pre-65 medical plans:

- PPO Economy (Base Plan)
- EPO Plus (Buy Up Plan)

If you or your eligible dependents are eligible for Medicare Parts A and B, you have the following health benefit option:

- Medicare Advantage Plan

IMPORTANT: When you or your eligible dependent turn 65, you must move to the Medicare Advantage Plan. You cannot continue on the SAWS Pre-65 medical plan options.

(More info on page 4.)

Medical Coverage Options

SAWS Self-Funded Medical Plans

As a pre-65 eligible retiree, you have the option of participating in the same medical plans as our employees. SAWS self-funds both the PPO Economy and EPO Plus medical plans, which means the cost of health services are paid by both you and SAWS, not an insurance company. Becoming a wise consumer of health care can lower claim costs, which in turn can keep future premium increases to a minimum.

Medicare Advantage

Once you or your dependent qualify for Medicare (usually at age 65) you will be required to move to a Medicare Advantage Plan offered through SAWS. These plans are fully-insured, meaning SAWS pays a set premium regardless of actual expenditures in the year. These plans have significantly lower premiums than the pre-65 retiree plans. Therefore, premiums for the Medicare Advantage Plans are already at the target cost share. Remember, you can begin the process of applying for Medicare three months before your 65th birthday. Be sure to contact the SAWS Benefits Office when you become eligible.

Opt-Out Deferral

Remember, SAWS allows you to leave and re-enter the SAWS plan as your coverage needs change. This allows you to take advantage of other health coverage you, your spouse or your dependents may have available at lower costs. You will need to provide proof of continuous coverage to re-enter the SAWS plan.

Medicare Advantage Retirees

SAWS provides Medicare-eligible retirees the option of selecting between two UnitedHealthcare Medicare Advantage Plans: the PPO Economy Plan and PPO Plus Plan. During the annual open enrollment you have the option of switching between the two plans. However, no action is required from you if you would like to keep your existing plan. There will be a decrease in premiums for Medicare Advantage Plans in 2022.

Eligibility Requirements

If you or your covered spouse/dependent are eligible for Medicare due to age or disability, you must enroll in Medicare Parts A and B, prior to enrolling in the Medicare Advantage Plans to continue coverage through SAWS. **Medicare eligible retirees and spouses are not eligible to continue on the SAWS Pre-65 plans, PPO Economy and EPO Plus.**

Are You Turning Age 65?

If you are turning age 65 now or during 2022, you will need to enroll in Medicare Parts A and B to continue retiree medical coverage through SAWS. Be sure to complete the following steps to ensure there is no break in coverage:

1. **Enroll in Medicare Parts A and B.** You and/or your covered spouse must enroll in Medicare Parts A and B at age 65 as a requirement of medical coverage through the SAWS benefit programs. Three months before you turn age 65, contact your local Social Security Administration office to enroll in Medicare Parts A and B or you can apply online at **ssa.gov.** You must pay the full cost of the monthly premium for Medicare Part B. Medicare may charge a penalty to retirees who delay enrollment in Medicare Part B at the time of initial eligibility.
2. **Notify the SAWS Benefits Office within 90 days of your 65th birthday.** At least 90 days prior to reaching 65, you and/or your covered spouse must report the change in age to the Benefits Office and complete a Medicare Advantage enrollment form. A copy of your Medicare card will need to accompany your enrollment form.

Need Proof of Your Social Security or Medicare Benefits?

If you need proof you have Medicare or receive Social Security benefits, or proof you aren't receiving benefits at all, you can request a Benefit Verification Letter from the Social Security Administration (SSA). A Benefit Verification Letter is an official letter from SSA that proves the following information:

- Income when you apply for a loan or mortgage.
- Income for assisted housing or other state or local benefits.
- Current Medicare health insurance coverage.
- Retirement status.
- Disability.
- Age.

If you applied for benefits but have not received an answer yet, you can request a Benefit Verification Letter that shows your claim is still pending.

You can request your Benefits Verification Letter online at ssa.gov/myaccount or you can request your letter by phone at 800-772-1213 (TTY 800-325-0778) Monday through Friday from 7 a.m. to 7 p.m.

For more information, explore MedicareMadeClear.com or contact the Medicare helpline 24 hours a day, seven days a week at 800-MEDICARE (800-633-4227), TTY 877-486-2048.

Resources:

- **SocialSecurity.gov** — Services and information on how to create an account.
- **Medicare.gov** — The official U.S. government site for Medicare.
- **Helpful Links** — Get a list of helpful links related to Medicare, Social Security, aging and more: MedicareMadeClear.com.

Medicare Advantage PPO Plans

SAWS will continue to offer the choice of two carefully developed plans with UHC for our retirees who have Medicare Parts A & B. Your pharmacy benefit manager will continue to be Optum RX, a UHC company.

Benefit Coverage	PPO Plus	PPO Economy
Annual deductible	$300	$500
Annual out-of-pocket maximum	$2,550	$3,600
Primary Care Provider (PCP) office visit	$20	$25
Specialist office visit	$40	$40
Urgent care	$40	$40
Emergency room	$65	$65
Inpatient hospitalization	Deductible plus 20% coinsurance up to OOP Maximum of $2,550	Deductible plus 20% coinsurance up to OOP Maximum of $3,600
Outpatient surgery	Deductible plus 20% coinsurance up to OOP Maximum of $2,550	Deductible plus 20% coinsurance up to OOP Maximum of $3,600
Medicare-covered podiatry	$40	$40
Medicare-covered chiropractic care	$20	$20
Medicare-covered vision services	$40	$40
Medicare-covered hearing services	$40	$40

Preventive Services

Benefit Coverage	PPO Plus	PPO Economy
Annual physical	$0	$0
Annual wellness visit	$0	$0
Immunizations	$0	$0
Breast cancer screenings	$0	$0
Colon cancer screenings	$0	$0

Virtual Education Center

Serves as a guide to better understand benefits, find providers, manage costs and get the most out of the health plans. It also provides information about programs, resources and tools available to UnitedHealthcare members. Go to https://uhcvirtualretiree.com/ra/.

Medicare Advantage Plan Premiums

SAWS will continue to coordinate with Principal Financial Group to have your monthly premiums automatically deducted from your monthly SAWS Retirement Plan annuity payment. If you do not receive a monthly benefit from Principal or if your premium is more than your annuity, you will need to set up a monthly bank draft for payment of your premium. Contact the Benefits Office at 210-233-2025 for the appropriate bank draft form.

Medicare Advantage Benefits Information

The Centers for Medicare and Medicaid (CMS) require UnitedHealthcare Medicare Advantage Plans to provide participants specific information regarding their medical plans each year. You will be receiving the following information from UHC in the mail during the month of October:

- 2022 annual notice of change.
- Getting started guide.

The documents listed above will require no action on your part because you are already enrolled.

Important to Remember:

- You must keep Medicare Parts A and B and continue to pay your Medicare Part B premium.
- You do **not** need to show your Medicare card when receiving service. Your UnitedHealthcare card should be provided as identification for medical and prescription services.
- If you receive a **new** Medicare card, please provide a copy to the HR Benefits team. You will not receive a new Medicare card each year. You will continue to use just your UnitedHealthcare card for medical and prescription services.
- You can only be in one Medicare Advantage plan at a time, including Medicare supplemental plans. Enrolling in another plan will **automatically disenroll** you from the SAWS Medicare Advantage Plan.
- If SAWS is notified by UHC that you have been enrolled in another plan, we will make an effort to contact you via phone, email, or mail to confirm this change. If we are not able to contact you within 30 days of your new plan's effective date, your coverage with SAWS will end.

MEDICARE ADVANTAGE PLAN

2022 MONTHLY PREMIUMS

	Retiree Pays	SAWS Pays	Total Cost/No Subsidy
PPO Economy Retiree 65+			
Retiree Only	$48.09	$96.17	$144.26
Spouse	$72.13	$72.13	$144.26*
Dependent	$72.13	$72.13	$144.26*
Retiree <2002**	$0	$144.26	$144.26
Spouse <2002**	$0	$144.26	$144.26
Dependent <2002**	$0	$144.26	$144.26
PPO Plus Retiree 65+			
Retiree Only	$54.39	$108.77	$163.16
Spouse	$81.58	$81.58	$163.16*
Dependent	$81.58	$81.58	$163.16*
Retiree <2002**	$0	$163.16	$163.16
Spouse <2002**	$0	$163.16	$163.16
Dependent <2002**	$0	$163.16	$163.16

*No subsidy for surviving spouse or surviving dependent(s)

**Grandfathered Retirees that retired prior to 9/2/2002 and were on Medicare prior to 12/31/2011

UnitedHealthcare Medicare Programs

Take Charge with Renew Active

Introducing Renew Active. The gold standard in Medicare programs for body and mind.

- Stay active with a free gym membership.
- Access to UHC's network of gyms and fitness locations.
- Personalized fitness plan to help get you started.
- Online brain health program from AARP Staying Sharp.
- Work out from home with Fitbit Premium workout videos.

To learn more, sign into your plan website, go to Health & Wellness and look for Renew Active.

RenewActive™ by UnitedHealthcare

UHCRetiree.com Website

The UHCRetiree.com website offers tools and information that will help you get the most out of your plan benefits. Register at UHCRetiree.com and take advantage of the following:

- Find network doctors, hospitals and other health care providers. **Select**: Provider Search > Search providers.
- Make sure your drugs are covered — Use the drug lookup tool to find out what drugs are covered and how much you will pay. **Select**: Drug Lookup > Look up drugs or Estimate costs.
- Find a pharmacy near you, whether you're at home or away. There are more than 65,000 local and national pharmacies to choose from in the network.
  Select: Pharmacy Locator.
- View and update your health information.
  Select: My Personal Health Record.
- Learn more about health and wellness.
  Select: My Health and Wellness.
- Get savings and convenience delivered to your door through mail service pharmacy, Optum Rx.
  Select: Order drugs from your Preferred Mail Service Pharmacy (under quick links).
- Learn more about your coverage.
  Select: myPlans > Benefits and Coverage.
- Manage your medical and drug claims.
  Select: myPlans > Claims.
- Request replacement materials.
  Select: myPlans > Order Plan Materials.
- Save with pharmacy saver.
  Select: myPlans > Pharmacy Saver > Get Savings Now.

Other services on UHCRetiree.com include checking your claims status and history, printing a temporary ID card or requesting a replacement ID card and downloading plan forms.

Create your online account today! Signing up is easy, fast and secure. All you need to set up your account is an email address and your health plan member ID. Visit UHCRetiree.com and click "Register Now."

Advocate4Me

Managing your health plan benefits and your health isn't always easy. UnitedHealthcare provides a team of people dedicated to helping you, from understanding your claims to estimating costs ahead of time. Email Advocate4Me@uhc.com or call the number listed on your member ID card.

Pre-65 Retiree Health Plan Options

SAWS will continue to offer the choice of two self-funded medical plans in 2022. Self-funded plans use retiree premiums and SAWS contributions to pay for the increasing cost of health care (claims). UnitedHealthcare will continue as our third party administrator and Express Scripts, Inc. will continue as our pharmacy benefit manager.

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. All of these savings contribute to keeping premium increases to a minimum. 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.

Out-of-Network providers do not have a contract with UnitedHealthcare and can bill you above the reasonable and customary rates. The PPO Economy plan may cover only a fraction of the cost while the EPO Plus plan does not cover any out-of-network costs.

Plan Benefit	PPO Economy (Base Plan)		EPO Plus (Buy Up Plan)	
	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	100% (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.

Pre-65 Medical Plan Premiums

SAWS will continue to coordinate with Principal Financial Group to have your monthly premiums automatically deducted from your monthly SAWS Retirement Plan annuity payment. If you do not receive a monthly benefit from Principal or if your premium is more than your annuity, you will need to set up a monthly bank draft for payment of your premium. Contact the Benefits Office at 210-233-2025 for the appropriate bank draft form.

2022 Pre-65 Monthly Premiums

Years of Service	30+ and Pre 9-1-2002		25-29		20-24		15-19		5-14		No Subsidy
	Retiree	SAWS	Retiree	SAWS	Retiree	SAWS	Retiree	SAWS	Retiree	SAWS	Retiree
2022 PPO Economy Pre-65 Retirees											
Retiree Only	$194	$777	$243	$728	$291	$680	$388	$583	$437	$534	$971
Retiree + Spouse*	$622	$1,418	$724	$1,316	$826	$1,214	$1,029	$1,011	$1,132	$908	$2,040
Retiree + Child(ren)*	$544	$1,204	$632	$1,116	$718	$1,030	$893	$855	$981	$767	$1,748
Retiree + Family	$972	$2,038	$1,113	$1,897	$1,253	$1,757	$1,534	$1,476	$1,676	$1,334	$3,010
2022 EPO Plus Pre-65 Retirees											
Retiree Only	$357	$834	$417	$774	$476	$715	$596	$595	$655	$536	$1,191
Retiree + Spouse*	$1,014	$1,491	$1,140	$1,365	$1,264	$1,241	$1,516	$989	$1,641	$864	$2,505
Retiree + Child(ren)*	$883	$1,264	$991	$1,156	$1,097	$1,050	$1,313	$834	$1,420	$727	$2,147
Retiree + Family	$1,540	$2,155	$1,714	$1,981	$1,885	$1,810	$2,233	$1,462	$2,406	$1,289	$3,695

*No subsidy for surviving spouse or surviving dependent(s)

Spouse Premium Surcharge

There is a $150 monthly Spouse Premium Surcharge above and beyond the regular medical premium when you choose to cover your spouse who is working and has access to medical coverage through their own employer and is on a Pre-65 non-Medicare plan. If your spouse is not working or does not have access to medical coverage through his/her employer, you may file for a waiver to the surcharge. Contact the HR Benefits Office at 210-233-2025 for waiver forms. If you currently have a waiver on file, you do not have to complete an additional waiver for 2022, if there is no change in status. Waivers are due by October 22, 2021.

Points to Remember About the Spouse Premium Surcharge:

- All retirees who cover spouses on a Pre-65 non-Medicare plan will have a Spouse Premium Surcharge unless we have a waiver on file.
- The Spouse Premium Surcharge applies to all active employees and pre-65 retirees whose spouse is a dependent on a SAWS medical plan ***unless*** one of the following conditions applies:
- Your spouse is not presently employed and does not have access to any other employer-sponsored medical coverage, whether as an active employee, retiree, or dependent.
- Your spouse is self-employed without access to other medical coverage.
- Your spouse is covered by Medicare Part A, Tricare, or the Marketplace (these are not considered other employer group health benefits).
- Your spouse is employed, but his or her employer does not offer medical coverage or he/she is not eligible for medical coverage by his or her employer.

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.

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 www.whyuhc.com/saws.

UnitedHealthcare App

UnitedHealthcare app (formerly Health4Me) 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:

- 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 on myuhc.com with myClaims Manager (Manage Your Claims). 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 for any claim that has a "You May Owe" amount using the "Make Payment" feature.

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, coinsurance 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, see quality and cost efficiency ratings, and even map out where you'll be going. Most importantly, you'll be able to make a more informed decision about what option is best for you.

The more you use myHealthcare Cost Estimator, the more you'll see that not all doctors are the same. Depending on what you're looking for, you could see a wide range of estimates for the same procedure or treatment. With this information, you'll be more prepared to decide which choice is best for you, plan your care and budget for medical expenses. You may save money, find doctors who better meet your needs or even find out about a new option you've never heard of before. It's all about having the information you need to make the best decisions for your health and your pocket book.

Quickly and easily estimate your health care costs on myuhc.com or the UnitedHealthcare app.

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 UnitedHealth Premium Program. Or you may call **888-651-7277** and verify with an Advocate4me representative.

Choose Smart. Before the 2022 plan year begins, please look for the Tier 1 icon or two blue hearts to confirm that your doctor will have the Tier 1 or Premiums Care Physician status when your benefits start for the new year.

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 Clinics	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 for 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.

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.

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.

For more information or to speak to a nurse advocate, call toll-free at 866-561-7518. TTY users can dial 711.

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 or call toll-free at the number on your health plan ID card. Travel and lodging assistance is not available as part of the Cancer Resource Services program.

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 Resources Services at 866-534-7209 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

The 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.
- Expectations of treatment.
- Information on high quality providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee and hip replacement.
- Prostate disease and cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.

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®

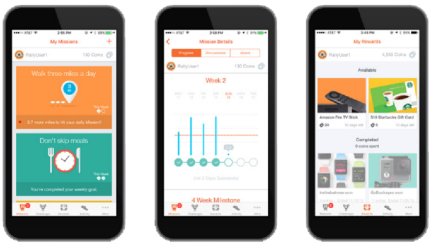
What is Rally?

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.

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.

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

220 SAWS participants lost 1,955 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)

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, 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. 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 **saws.org/retirees** 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 contact SAWS Human Resources at 210-233-2025.

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.

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.

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 Coverage Disclosure Notice please see pages 20 and 21 of this benefit guide or contact the HR Benefits Office at 210-233-2025 for a copy.

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 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 **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 states other than Texas or the states listed on the current CHIPRA model notice have added a premium 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 Retirees 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 enroll in the UHC Medicare Advantage Prescription Drug Plan (UHC MAPD Plan) offered through SAWS and **not** enroll in a standalone Medicare Part D plan. Since the SAWS plan is a MAPD Plan and prescription drug coverage is included, you may not enroll in another Medicare prescription drug plan at the same time. If you decide to drop coverage through SAWS, you will be able to enroll in Medicare Part D prescription drug coverage at that time without penalty.
2. You may reject coverage under the UHC MAPD Plan offered through SAWS and choose coverage under a Medicare Part D Plan for prescription drug coverage. If you reject coverage under SAWS' UHC MAPD Plan, you may re-enroll in this plan at a later date. SAWS allows you or your dependents an opportunity to opt out of SAWS coverage and re-enroll at a later date as long as you have coverage through another plan, including Medicare. If that coverage ends, you will need to provide proof you had continuous coverage within 31 days of it ending to re-enroll in the SAWS 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 (either a Medicare Part D Plan or another MAPD plan) 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.

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.

* 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.

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	$1,000
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

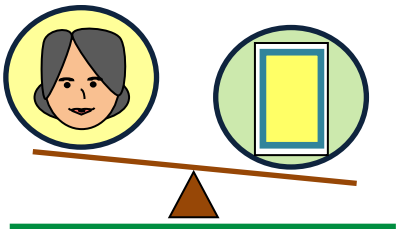
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $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.

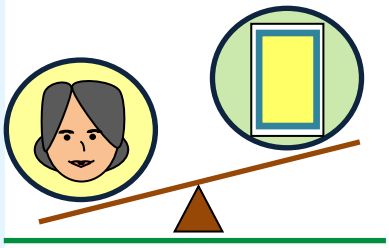
Cost-sharing Reductions

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."

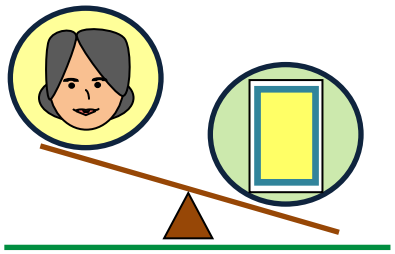
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

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.

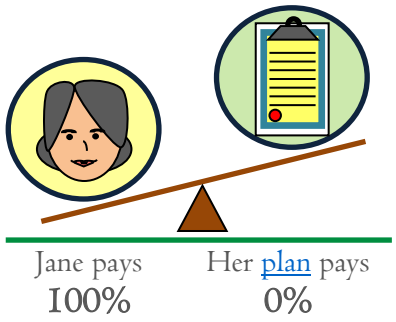
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

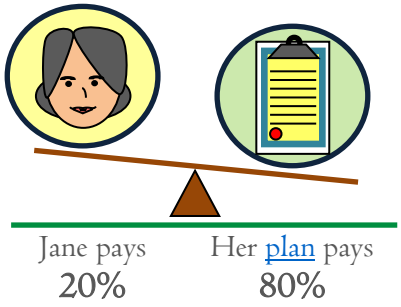
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

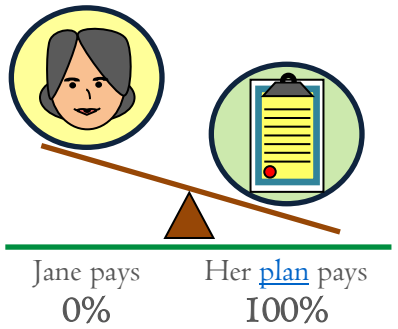
December 31st
End of Coverage Period



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

San Antonio Water System

RETIREE - 2022 BENEFITS ENROLLMENT FORM

Human Resources – Benefits Office
2800 U.S. Hwy. 281 North
San Antonio, Texas 78212

❑ **Open Enrollment** ❑ **Initial Enrollment** ❑ **Benefit Change**

HR Use Only
Monthly Cost: _____
Lawson ID: _____
Contribution Rate: _____
Hire Date: _____
Retirement Date: _____

SECTION 1 – RETIREE INFORMATION *(Please complete all sections.)*

Effective Date:

Last Name (Print)	First Name (Print)	Middle Initial	Birth Date (MM/DD/YR)	Last 4 digits of SSN XXX-XX-_____

Address	Apt #	City	State	Zip

Email Address	Home Phone Number	Cell Phone Number

SECTION 2 – MEDICARE INFORMATION *(If you and/or your dependent(s) are eligible for Medicare, you are required to be enrolled in Medicare Part A and B in order to participate in the SAWS Medicare Advantage Plan.)*

Both Parts A & B of Medicare			**Reason for Eligibility**			
Retiree	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease
Spouse	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease
Child	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease

If Yes, attach a copy of your Medicare Card, your letter from Social Security, or the Railroad Retirement Board.

SECTION 3 – DEPENDENT INFORMATION *(Complete for each dependent. If dropping coverage complete Section 6.)*

Enrolling member(s), elect all that apply: ❑ **Spouse** ❑ **Child(ren)**

❑ Add ❑ Drop	Spouse Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F

SECTION 4 – COVERAGE SELECTION *(If declining coverage skip Section 4 and complete Section 5 and 6.)*

A. Coverage Level *(Select one option only)*

❑ **Retiree Only** ❑ **Retiree + Spouse** ❑ **Retiree + Child(ren)** ❑ **Retiree + Family**

B. Health Options (*If declining coverage go to Section 5*)

Under Age 65 (Non-Medicare)			**Over Age 65 or Disabled (With Medicare A & B)**		
Retiree	❑ PPO Economy	❑ EPO Plus	**Retiree**	❑ Medicare PPO Economy	❑ Medicare PPO Plus
Spouse	❑ PPO Economy	❑ EPO Plus	**Spouse**	❑ Medicare PPO Economy	❑ Medicare PPO Plus
Child(ren)	❑ PPO Economy	❑ EPO Plus	**Child(ren)**	❑ Medicare PPO Economy	❑ Medicare PPO Plus

SECTION 5 – EMERGENCY CONTACT INFORMATION

Contact Name	Contact Relationship to You	Contact Phone Number

SECTION 6 – DECLINATION OF HEALTH COVERAGE *(Complete if you and/or your dependent(s) are declining coverage.)*

_____ ***(Initial)*** This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below and am exercising my opt-out option at this time.

Reason for Declining Coverage

Name of Retiree:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Spouse:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other

If reason for declining is "Other", please explain:

COVERAGE CONDITIONS

1. I am a retiree of the San Antonio Water System. I am eligible to participate in the health coverage(s) afforded by SAWS Health and Welfare Benefit Plan ("Plan"), which is either underwritten or administered by United Healthcare (UHC), and Express Scripts/Optum RX. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. Furthermore, if this is an initial enrollment election, I waive the COBRA rights I have with respect to health coverage under the Plan, for myself and for any children I am electing to enroll. My spouse (if applicable) is also waiving on his/her own behalf. I state that the information on the application is true and correct. I understand and agree that any incorrect statements knowingly made by me will invalidate my coverage(s).
2. Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this application is accepted, the Plan provisions regarding the coverage(s) will determine when the effective date.
3. I authorize SAWS to deduct from my SAWS Retirement Plan benefit check or, if I do not receive a SAWS Retirement Plan benefit check, to draft my bank account for my portion of the contributions, if any, as they become due or ensure timely payment on a monthly basis. I also agree that my participation in the Plan is subject to any future amendments.
4. I understand that if I do not pay required premiums when due, my coverage/s under the Plan will be terminated.
5. I understand that if I elect health coverage for my spouse, a spouse premium surcharge will be applied to my premium unless I submit a Spouse Premium Surcharge Waiver form to HR Benefits. SAWS will not retroactively reimburse amounts already paid due to failure to submit a timely waiver.
6. I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity, upon request, to provide SAWS/United Healthcare/Express Scripts/Optum RX any information covering the health condition of any person included under my coverage(s) whenever the information is considered necessary by SAWS/United Healthcare/Express Scripts/Optum RX for proper disposition of this application or of a claim submitted for payment.
7. I understand that Retirees may opt out of the health coverage offered under the Plan. If I, and/or my dependent(s) terminate or reject such coverage, I may re-enroll in the Plan at a later date, if I provide proof of continuous group insurance coverage during the period I and/or my dependent(s) were not enrolled and request enrollment within 31 days of the loss of that coverage.
8. I understand that if I and/or my dependent(s) become eligible for Medicare, that we are ***required to enroll in both Parts A & B***. I will contact SAWS HR Benefits Office and provide a copy of the Medicare cards within 30 days of receipt.

REQUIRED SIGNATURES

- I understand that my signature on this Benefits Enrollment Form means that I have read and understood the contents of this form, including the Coverage Conditions, and that the information provided by me is accurate and complete.
- **This Benefits Enrollment Form must be signed, dated and received prior to your effective date of coverage. Upon receipt, the plan will process the form according to Centers for Medicare & Medicaid Services (CMS) guidelines.**

SAWS Retiree *Handwritten* Signature	**Date**
Spouse (if applicable) Handwritten Signature	**Date**

If someone assisted you in completing this form, please have that person sign below.

Signature and Printed Name	**Relationship to Applicant**	**Date**

RETURN TO HUMAN RESOURCES **Revised 9/22/2021**

RETIREE's SURVIVING SPOUSE/DEPENDENT CHILD(REN)
2022 BENEFITS ENROLLMENT FORM

Human Resources – Benefits Office
2800 U.S. Hwy. 281 North
San Antonio, Texas 78212

HR Use Only
Monthly Cost: _____
Lawson ID: _____
Yrs of Service: _____
Hire Date: _____
Retirement Date: _____

SECTION 1 – DECEASED RETIREE INFORMATION *(Please complete all sections)*

Effective Date:

Deceased Retiree's Last Name	First Name	Middle Initial	Birth Date (MM/DD/YR)	Last 4 digits of SSN
				XXX-XX-_____

SECTION 2 – DEPENDENT INFORMATION *(Complete for each dependent. If dropping coverage complete Section 5)*

❑ Add ❑ Drop	Spouse Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No
Cell Phone	Home Phone	Email Address		

❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No
Cell Phone	Home Phone	Email Address		

❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No

SECTION 3 – MEDICARE INFORMATION *(If you and/or your dependent(s) are eligible for Medicare, you are required to be enrolled in Medicare Part A and B in order to participate in the SAWS Medicare Advantage Plan.)*

	Both Parts A & B of Medicare	Reason for Eligibility
Spouse	❑ Yes ❑ No	❑ Entitled Age ❑ Disability ❑ End-Stage Renal Disease ❑ Disability & Current Renal Disease
Child	❑ Yes ❑ No	❑ Entitled Age ❑ Disability ❑ End-Stage Renal Disease ❑ Disability & Current Renal Disease
Child	❑ Yes ❑ No	❑ Entitled Age ❑ Disability ❑ End-Stage Renal Disease ❑ Disability & Current Renal Disease

If Yes, attach a copy of your Medicare Card, your letter from Social Security, or the Railroad Retirement Board.

SECTION 4 – COVERAGE SELECTION

A. Coverage Level (Select one option only)

❑ Spouse Only ❑ Child(ren) Only ❑ Spouse & Child(ren) ❑ I decline medical coverage

B. Health Options

	Under Age 65 (Non-Medicare)		Over Age 65 or Disabled (With Medicare A & B)	
Spouse Options	❑ PPO Economy	❑ EPO Plus	❑ Medicare PPO Economy	❑ Medicare PPO Plus
Child(ren) Options	❑ PPO Economy	❑ EPO Plus	❑ Medicare PPO Economy	❑ Medicare PPO Plus

SECTION 5 – EMERGENCY CONTACT INFORMATION

If we are unable to reach you at the address and/or phone number provided, who may we contact:

Contact Name	Contact Relationship to You	Contact Phone Number

SECTION 6 – DECLINATION OF HEALTH COVERAGE

_____***Initial*** This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below and am exercising my opt-out option at this time.

	Reason for Declining			
Name of Surviving Spouse:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Surviving Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Surviving Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other

If reason for declining is "Other", please explain:

COVERAGE CONDITIONS

1. I am a retiree of the San Antonio Water System. I am eligible to participate in the health coverage(s) afforded by SAWS Health and Welfare Benefit Plan ("Plan"), which is either underwritten or administered by United Healthcare (UHC), and Express Scripts/Optum RX. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. Furthermore, if this is an initial enrollment election, I waive the COBRA rights I have with respect to health coverage under the Plan, for myself and for any children I am electing to enroll. I state that the information on the application is true and correct. I understand and agree that any incorrect statements knowingly made by me will invalidate my coverage(s).
2. Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this application is accepted, the Plan provisions regarding the coverage(s) will determine when the effective date.
3. I authorize SAWS to deduct from my SAWS Retirement Plan benefit check or, if I do not receive a SAWS Retirement Plan benefit check, to draft my bank account for my portion of the contributions, if any, as they become due or ensure timely payment on a monthly basis. I also agree that my participation in the Plan is subject to any future amendments.
4. I understand that if I do not pay required premiums when due, my coverage/s under the Plan will be terminated.
5. I understand that if I elect health coverage for my spouse, a spouse premium surcharge will be applied to my premium unless I submit a Spouse Premium Surcharge Waiver form to HR Benefits. SAWS will not retroactively reimburse amounts already paid due to failure to submit a timely waiver.
6. I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity, upon request, to provide SAWS/United Healthcare/Express Scripts/Optum RX any information covering the health condition of any person included under my coverage(s) whenever the information is considered necessary by SAWS/United Healthcare/Express Scripts/Optum RX for proper disposition of this application or of a claim submitted for payment.
7. I understand that Retirees may opt out of the health coverage offered under the Plan. If I, and/or my dependent(s) terminate or reject such coverage, I may re-enroll in the Plan at a later date, if I provide proof of continuous group insurance coverage during the period I and/or my dependent(s) were not enrolled and request enrollment within 31 days of the loss of that coverage.
8. I understand that if I and/or my dependent(s) become eligible for Medicare, that we are ***required to enroll in both Parts A & B***. I will contact SAWS HR Benefits Office and provide a copy of the Medicare cards within 30 days of receipt.

REQUIRED SIGNATURES

- I understand that my signature on this Benefits Enrollment Form means that I have read and understood the contents of this form, including the Coverage Conditions, and that the information provided by me is accurate and complete.
- **This Benefits Enrollment Form must be signed, dated and received prior to your effective date of coverage. Upon receipt, the plan will process the form according to Centers for Medicare & Medicaid Services (CMS) guidelines.**

SAWS Retiree's Surviving Spouse/Child(ren) *Handwritten* Signature	**Date**

If someone assisted you in completing this form, please have that person sign below.

Signature and Printed Name	Relationship to Applicant	**Date**

SAN ANTONIO WATER SYSTEM
2022 Spouse Premium Surcharge Waiver Form

The 2022 Spouse Premium Surcharge is a $150 monthly surcharge ($75.00 per pay period) that is required above and beyond the regular employee medical contribution (premium) rate for SAWS active and pre-65 retiree medical plans. It is intended to encourage those spouses who have access to alternative medical coverage to move from the SAWS sponsored medical plan to his or her own employer's plan. If your spouse does not have access to other available coverage through his/her own employer or former employer, you may be eligible to waive this surcharge (see criteria below).

To request a waiver of the surcharge for the 2022 Benefit Plan Year, please complete and submit this waiver form along with required documentation (as listed below) *within 31 days of your hire date or qualifying event date.*

SECTION 1: AFFIDAVIT TO WAIVE THE 2022 SPOUSE PREMIUM SURCHARGE

I am hereby requesting to have the Spouse Premium Surcharge **WAIVED** because I meet one of the following criteria. I understand that I must provide documentation as indicated on my selection below. If my spouse's employment statuschanges, I understand that this form must be updated and re-submitted.

Please select ONE of the following criteria below that applies to your spouse (check one box only):

☐ My spouse is not presently employed and does not have access to health coverage through his/her own employer or former employer. **Submit this Waiver Form only, unless this event occurs after the Open Enrollment period, in which case provide a letter from the former employer.**

☐ My spouse is self-employed without access to other medical coverage. **Submit this Waiver Form only.**

☐ My spouse is covered by Medicare Part A, Tricare or CHAMPVA insurance and enrolled in a SAWS medical plan. **Submit this Waiver Form AND a copy of spouse's Medicare, Tricare or CHAMPVA ID.**

☐ My spouse is employed, but his or her employer does not offer medical coverage or is not eligible for medicalcoverage by his or her employer. **Submit this Waiver Form AND complete Spouse Employer Certification on reverse side of this form.**

NOTE: THERE IS NO RETROACTIVE REIMBURSEMENT OF THE SURCHARGE.

EMPLOYEE CERTIFICATION

I certify that the information I am providing is true and accurate to the best of my knowledge. I understand that intentional misrepresentation of the facts above is considered insurance fraud and may result in recoupment of any and all benefits improperly paid on my behalf by SAWS self-funded medical plans AND may lead to disciplinary action,up to and including employment termination.

Printed Name of SAWS Employee/Retiree	Employee ID#
Signature of SAWS Employee/Retiree	Date
Printed Name of Spouse	
Signature of Spouse	Date

Deadline: 31 Days from Hire Date or Qualifying Event Date

Submit your form and documentation to the attention of SAWS HR Benefits Office:
SCAN AND EMAIL:
BenefitsInquiries@saws.org
For Questions: 210-233-2025

NOTE: This form must be updated and re-submittedif your spouse's status changes.

See reverse side for Section 2, Spouse Employer Certification

SAN ANTONIO WATER SYSTEM
2022 Spouse Benefits Eligibility Verification Form

SECTION 2: SPOUSE EMPLOYER

If your spouse is employed, but his or her employer does not offer medical coverage or he/she is not eligible for coverage, you may be eligible to waive this surcharge. This page must be completed by your spouse's employer if he/she is not eligible for the employer's coverage.

Instructions to employer: Please certify that the spouse named herein is employed by your company and indicatehis or her medical benefits eligibility with your company. If this member will be eligible for medical benefits at a future date, please provide the date his or her coverage may begin. Please contact the Benefits Office at San Antonio Water System, with any questions, at 210-233-2025.

I hereby certify that _____ is employed by
Spouse of SAWS Employee

_____.
Company name

I further certify that:

☐ This employer does not provide medical coverage to employees.

☐ Employee will be eligible for medical coverage in the future. Date Eligible: _____

☐ The employee named above is not eligible for employer medical coverage.
Reason for no coverage: _____

_____
Name and Title of Benefits Analyst/HR Administrator (please print)

_____
Phone number and email address of Benefits Analyst/HR Administrator

_____
Benefits Analyst/HR Administrator Signature Date Signed

Deadline: 31 Days from Hire Date or Qualifying Event Date

Submit your form and documentation to the attention of SAWS HR Benefits Office:

MAIL: P.O. BOX 2449, San Antonio, TX 78298
SCAN AND EMAIL: BenefitsInquiries@saws.org
FAX: 210-233-5460
PHONE: 210-233-2025

NOTE: This form must be updated and re-submitted if your spouse's status changes.

Information Update Form

SAWS Human Resources needs your help in updating your contact information! To keep you updated on new benefits material and other important retiree information, we want to make sure we have your most updated contact information on file. Please fill out and return this form to us. You can also scan this page and email it to benefitsinquiries@saws.org. If you have any questions, feel free to contact SAWS Human Resources at 210-233-2025.

Retiree's Name: _____ Last 4 digits of SSN: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Physical Address

Street: _____

City: _____ State: _____ County: _____ Zip: _____

Mailing Address (If different from Physical Address)

Street: _____

City: _____ State: _____ County: _____ Zip: _____

Alternative Contact Information

Name: _____ Relationship to Retiree: _____

Home Phone: _____ Cell Phone: _____

Retiree's Signature: _____ Date: _____

Important Contact Information

Organization	Phone	Website/Email Address
SAWS Human Resources - Benefits Office	210-233-2025	
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
UnitedHealthcare (PRE-65)		
Customer Service	888-651-7277	myuhc.com
Mental Health Providers	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@saws.org
Express Scripts - Pharmacy Benefit Manager (PRE 65)	844-553-9111	express-scripts.com
Accredo - Specialty Pharmacy	800-803-2523	
Group # SAWATER		
UnitedHealthcare– Medicare Advantage Plans	800-457-8506	UHCretiree.com
Telephonic Nurse Support	877-365-7949	
OptumRx	800-457-8506	
Virtual Education Center		https://uhcvirtualretiree.com/ra/
Other Helpful Numbers		
Texas Municipal Retirement System (TMRS)	800-924-8677	tmrs.com
SAWS Retirement Plan - Principal	800-247-7011	principal.com
Empower Retirement, 457(b) Plan #100026-01	800-701-8255	Empowermyretirement.com
Standard Life Insurance — Group # 753337	800-628-8600	standard.com

Administration on Aging

For help in finding local, state and community-based organizations that serve older adults and their caregivers in your area, call Eldercare at 800-677-1116, TTY 711, 8 a.m. -8 p.m., Eastern Standard Time, Monday through Friday, or visit **ElderCare.gov**.

210-233-2025

saws.org/benefits

benefitsinquiries@saws.org

San Antonio Water System