



Quote Effective: 01/01/2022 - 03/31/2022

Version Updated: 09/13/2021

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Print Package: HIOS ID (Enrollment Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 78124NY1020009-00 (SZJ9)         |
| Plan Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Univera Access Standard Platinum |
| Rating Region:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Western NY                       |
| Rate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |
| For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |
| Single                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$718.21                         |
| Subscriber & Spouse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$1,436.43                       |
| Subscriber & Child(ren)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$1,220.96                       |
| Family                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$2,046.91                       |
| Dependent Coverage To Age <b>26</b> , Pediatric Dental Coverage <b>Yes</b> , Domestic Partner Coverage <b>Yes</b> , Family Planning Coverage <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |
| Rates quoted herein are subject to change due to our implementation of the provisions of the Federal Patient Protection and Affordable Care Act.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| The Sales Representative providing this quote is a New York State licensed insurance producer employed by Univera Health Plan. The individual represents Univera Health Plan in this transaction and will be compensated by Univera Health Plan in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.                                                                                                                                                                                                    |                                  |
| <b>*The NYS Department of Financial Services has approved our rate filing for quarterly community rates. All Rates will be considered to be on a 12 month period from the effective date of coverage unless otherwise instructed by Univera Health Plan. The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal Term will be provided to Group in a rate renewal notice.</b>                                                                                                                                                                                                                                                                                |                                  |
| Please complete this section if you have selected a plan that does not include pediatric dental coverage.<br>A.) Have you obtained dental coverage, not offered by Univera Healthcare, that provides essential pediatric dental benefits through a NY State of Health certified dental plan?<br><b>Yes    No</b><br>B.) If you answered 'yes', please provide the name of the company issuing the essential pediatric dental coverage. _____<br>If you change this dental coverage at any time, you must notify Univera Healthcare to confirm continued coverage of essential pediatric benefits.<br>If you answered 'no' please be aware the ACA requires essential pediatric dental coverage. |                                  |

## Application

### Summary of Benefits & Coverage

Summary of Benefits and Coverage (SBC) for this product has been received. Group is responsible for distributing the SBC to all eligible employees in accordance with PPACA requirements.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Group Name: \_\_\_\_\_ Total Employees: \_\_\_\_\_ Total Eligible: \_\_\_\_\_  
Coverage Effective Date: \_\_\_\_\_  
Broker: \_\_\_\_\_

|                                | Univera Access Standard Platinum                                                                                                                                                                                                                                                                  |                                                       |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Plan Overview                  |                                                                                                                                                                                                                                                                                                   |                                                       |
| Plan ID                        | 78124NY1020009-00 (SZJ9)                                                                                                                                                                                                                                                                          |                                                       |
| Plan Name                      | Univera Access Standard Platinum                                                                                                                                                                                                                                                                  |                                                       |
| Aggregation Design             | Individual Aggregation                                                                                                                                                                                                                                                                            |                                                       |
| Plan Highlights                | Predictable out-of-pocket costs without a deductible, includes Wellness Rewards and Dental Rewards. Members have access to our PPO network covering 39 Upstate New York counties.                                                                                                                 |                                                       |
| Plan Type                      | Copay                                                                                                                                                                                                                                                                                             |                                                       |
| HSA Eligible                   | No                                                                                                                                                                                                                                                                                                |                                                       |
| Quote Effective                | 01/01/2022 - 03/31/2022                                                                                                                                                                                                                                                                           |                                                       |
| Plan features                  |                                                                                                                                                                                                                                                                                                   |                                                       |
| Primary Care Physician (PCP)   | Not Required                                                                                                                                                                                                                                                                                      |                                                       |
| Referrals                      | Not Required                                                                                                                                                                                                                                                                                      |                                                       |
| Out of network benefits        | Covered at 80%, subject to the deductible                                                                                                                                                                                                                                                         |                                                       |
| Out of area benefits           | Services rendered outside of the service area are subject to higher out-of-pocket costs and may be subject to balance billing (excludes emergency and dialysis services).                                                                                                                         |                                                       |
| Student/Dependent coverage     | Qualified dependents are covered to age 26                                                                                                                                                                                                                                                        |                                                       |
| Domestic partner               | Covered                                                                                                                                                                                                                                                                                           |                                                       |
| Wellness Incentives            | All plans include two health & wellness programs! With Univera Wellness Rewards, members receive up to \$300 a year for programs and services to stay healthy. Plus, a subscriber and eligible spouse can earn \$100 annually for getting a dental cleaning and exam with Univera Dental Rewards. |                                                       |
| Plan cost-sharing highlights   |                                                                                                                                                                                                                                                                                                   |                                                       |
| Plan cost-sharing highlights   | In-Network                                                                                                                                                                                                                                                                                        | Out-of-Network                                        |
| Primary Care Office Visit      | \$15 copay per visit                                                                                                                                                                                                                                                                              | Covered at 80%, subject to the deductible             |
| Specialist Office Visit        | \$35 copay per visit                                                                                                                                                                                                                                                                              | Covered at 80%, subject to the deductible             |
| Coinsurance                    | None                                                                                                                                                                                                                                                                                              | Covered at 80%                                        |
| Deductible                     | None                                                                                                                                                                                                                                                                                              | Out-of-Network: \$5,000 Individual / \$10,000 Family  |
| Out of pocket maximum          | In-Network: \$2,000 Individual / \$4,000 Family                                                                                                                                                                                                                                                   | Out-of-Network: \$10,000 Individual / \$20,000 Family |
| Lifetime maximum               | None                                                                                                                                                                                                                                                                                              | None                                                  |
| Plan Benefits                  |                                                                                                                                                                                                                                                                                                   |                                                       |
| Preventive Healthcare Services | In-Network                                                                                                                                                                                                                                                                                        | Out-of-Network                                        |
| Well child visits              | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| Adult routine physical exams   | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| +Adult immunizations           | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| +Mammography                   | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| +Pap smear                     | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| Routine GYN Exam               | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |
| +Prostate cancer               | Covered in full                                                                                                                                                                                                                                                                                   | Covered at 80%, subject to the deductible             |

|                                            | Univera Access Standard Platinum                                                |                                                                                              |
|--------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| screening                                  |                                                                                 |                                                                                              |
| +Colonoscopy                               | Preventive screenings covered in full                                           | Covered at 80%, subject to the deductible                                                    |
| +Family Planning Services                  | Covered in full                                                                 | Covered at 80%, subject to the deductible                                                    |
| <b>Physician Office Services</b>           | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |
| Diagnostic office visits                   | \$15 PCP copay; \$35 Specialist copay per visit                                 | Covered at 80%, subject to the deductible                                                    |
| Telemedicine and Telehealth Services       | Covered in full                                                                 | Covered at 80%, subject to the deductible                                                    |
| Diagnostic x-rays                          | \$15 PCP copay; \$35 Specialist copay per visit                                 | Covered at 80%, subject to the deductible                                                    |
| Advanced Imaging Services                  | \$35 copay per visit                                                            | Covered at 80%, subject to the deductible                                                    |
| Diagnostic laboratory and pathology        | \$15 PCP copay; \$35 Specialist copay per visit                                 | Covered at 80%, subject to the deductible                                                    |
| Allergy tests                              | \$15 PCP copay; \$35 Specialist copay per visit                                 | Covered at 80%, subject to the deductible                                                    |
| Allergy injections                         | \$15 PCP copay; \$35 Specialist copay per visit                                 | Covered at 80%, subject to the deductible                                                    |
| Chemotherapy                               | \$15 copay                                                                      | Covered at 80%, subject to the deductible                                                    |
| Radiation therapy                          | \$15 copay                                                                      | Covered at 80%, subject to the deductible                                                    |
| <b>Maternity Services</b>                  | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |
| Prenatal care                              | Covered in full (cost share may apply to ultrasounds, lab work and sick visits) | Covered at 80%, subject to the deductible                                                    |
| Hospital care for mom (including delivery) | Subject to \$500 copay per admission                                            | Covered at 80%, per admission, subject to the deductible                                     |
| Newborn nursery care                       | Covered in full                                                                 | Covered at 80%, per admission, subject to the deductible                                     |
| <b>Prescription Drug</b>                   | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |
| Prescription Drug Coverage                 | \$10/\$30/\$60                                                                  | Not Covered                                                                                  |
| Diabetic drugs, insulin, and supplies      | \$15 copay per 30 day supply                                                    | Covered at 80%, subject to the deductible                                                    |
| <b>Inpatient Hospital Benefits</b>         | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |
| Hospital benefits                          | Subject to \$500 copay per admission for unlimited days                         | Covered at 80%, per admission for unlimited days, subject to the deductible                  |
| Physician visits in the hospital           | Covered in full                                                                 | Covered at 80%, subject to the deductible                                                    |
| Inpatient physical rehabilitation          | Subject to \$500 copay per admission for up to 60 days per contract year        | Covered at 80%, per admission for up to 60 days per contract year, subject to the deductible |
| Surgery                                    | \$100 copay per visit                                                           | Covered at 80%, subject to the deductible                                                    |
| Anesthesia                                 | Covered in full                                                                 | Covered at 80%, subject to the deductible                                                    |
| <b>Emergency Care</b>                      | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |
| Emergency room care                        | \$100 copay per visit                                                           | \$100 copay per visit                                                                        |
| Freestanding urgent care center            | \$55 copay per visit                                                            | Covered at 80%, subject to the deductible                                                    |
| Ambulance                                  | \$100 copay per visit                                                           | \$100 copay per visit                                                                        |
| <b>Outpatient Hospital</b>                 | <b>In-Network</b>                                                               | <b>Out-of-Network</b>                                                                        |

|                                          | Univera Access Standard Platinum                                                                   |                                                                                                                               |
|------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                 |                                                                                                    |                                                                                                                               |
| Diagnostic x-rays                        | \$35 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Advanced Imaging Services                | \$35 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Diagnostic laboratory and pathology      | \$35 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Surgical Care Facility Fee               | \$100 copay per visit                                                                              | Covered at 80%, subject to the deductible                                                                                     |
| Chemotherapy                             | \$15 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Radiation Therapy                        | \$15 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Mental Health and Substance Use          | In-Network                                                                                         | Out-of-Network                                                                                                                |
| Inpatient mental health care             | Subject to \$500 copay per admission for unlimited days                                            | Covered at 80%, per admission for unlimited days, subject to the deductible                                                   |
| Outpatient mental health care            | \$15 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Inpatient substance use                  | Subject to \$500 copay per admission for unlimited days                                            | Covered at 80%, per admission for unlimited days, subject to the deductible                                                   |
| Outpatient substance use                 | \$15 copay per visit                                                                               | Covered at 80%, subject to the deductible                                                                                     |
| Other Services                           | In-Network                                                                                         | Out-of-Network                                                                                                                |
| Skilled nursing facility                 | Subject to \$500 copay per admission for up to 200 days per year                                   | Covered at 80%, per admission for up to 200 days per year, subject to the deductible                                          |
| Home care                                | \$15 copay per visit for 40 visits per year                                                        | Covered at 80%, for up to 40 visits per year, subject to the deductible                                                       |
| Hospice                                  | Subject to \$500 copay per admission for up to 210 days per year                                   | Covered at 80%, for up to 210 days per year, subject to the deductible                                                        |
| Outpatient therapy                       | \$25 per visit for physical, speech and occupational therapy for up to 60 visits per contract year | Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year |
| Durable medical equipment                | Covered at 90%                                                                                     | Covered at 80%, subject to the deductible                                                                                     |
| External prosthetics                     | Covered at 90%                                                                                     | Covered at 80%, subject to the deductible                                                                                     |
| Chiropractic                             | \$15 PCP copay                                                                                     | Covered at 80%, subject to the deductible                                                                                     |
| Acupuncture                              | Not Covered                                                                                        | Not Covered                                                                                                                   |
| Hearing Aids                             | Covered at 90% for a single purchase once every 3 years                                            | Covered at 80%, subject to the deductible for a single purchase once every 3 years                                            |
| Vision Benefits                          | In-Network                                                                                         | Out-of-Network                                                                                                                |
| Adult Routine Vision Exam                | Not Covered                                                                                        | Not Covered                                                                                                                   |
| Adult Diagnostic Vision                  | \$15 PCP copay; \$35 Specialist copay per visit                                                    | Covered at 80%, subject to the deductible                                                                                     |
| Adult Eyewear                            | Not Covered                                                                                        | Not Covered                                                                                                                   |
| Pediatric Routine Vision Exam            | \$15 copay per visit for one routine exam every year                                               | Covered at 80% for one routine exam every year, subject to the deductible                                                     |
| Pediatric Eyewear                        | Covered at 90%, for one purchase per plan year                                                     | Covered at 80%, subject to the deductible for one purchase per plan year                                                      |
| Dental Benefits                          | In-Network                                                                                         | Out-of-Network                                                                                                                |
| Adult Dental Care                        | Not Covered                                                                                        | Not Covered                                                                                                                   |
| Pediatric Dental: Preventative & Routine | \$15 per visit                                                                                     | \$15 per visit, subject to the deductible and balance billing                                                                 |
| Pediatric Major Dental                   | \$15 per visit                                                                                     | \$15 per visit, subject to the deductible and balance billing                                                                 |

---

| Univera Access Standard Platinum        |                                                                                                                       |                                                                                                                                           |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| Care & Medical Ortho                    |                                                                                                                       |                                                                                                                                           |
| Accidental Dental - Outpatient Surgical | \$100 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible |

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.



**Benefit Summary (Effective: 1/1/2022 - 3/31/2022) (Version Updated: 09/10/2021)**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--|
| UAD-1500-PPO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Univera Access Dental |  |
| Rating Region: Western NY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Small Group           |  |
| Rate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       |  |
| 4-Tier- Ind/Subscriber Spouse/Subscriber Child(ren)/Family                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |  |
| Single                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$28.46               |  |
| Sub w/Spouse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$56.92               |  |
| Sub w/Child                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$69.31               |  |
| Sub w/Children                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$69.31               |  |
| Sub w/Spouse and one or more Children                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$108.23              |  |
| We are quoting these rates on the express condition that, if the rates actually approved by the New York State Insurance Department are different than the rates quoted above, your rates for the effective date will change                                                                                                                                                                                                                                                                                                                                                                                    |                       |  |
| The Sales Representative providing this quote is a New York State licensed insurance producer employed by Excellus Health Plan. The individual represents Excellus Health Plan in this transaction and will be compensated by Excellus Health Plan in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.                                                                                                                 |                       |  |
| <b>For Groups moving to Plan Year benefit renewal:</b> I understand that my benefit plan year will change to the coverage effective date indicated below and that my group dental plan premium rate will also change on the coverage effective date indicated below. As a result of this change, all current deductibles, benefit limits, and annual maximum accumulators for all plan offerings will reset to zero on the coverage effective date indicated below. I agree to hold a new open enrollment for my employees and communicate to my employees the fact that their accumulators will reset to zero. |                       |  |

Signature: \_\_\_\_\_

Title:

Date:

Group Name:

Total Employees:

Total Eligible:

Coverage Effective Date:

Broker:

| UAD-1500-PPO                                                        |                                                                      | Univera Access Dental                                   |  |
|---------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------|--|
| Plan Overview                                                       |                                                                      |                                                         |  |
| Package ID                                                          | UAD-1500-PPO                                                         |                                                         |  |
| Plan Name                                                           | Univera Access Dental                                                |                                                         |  |
| Plan Type                                                           | Passive PPO ACA Qualified                                            |                                                         |  |
| Package Status                                                      | New                                                                  |                                                         |  |
| Effective Date                                                      | 1/1/2022 - 3/31/2022                                                 |                                                         |  |
| Activity Status                                                     | Active                                                               |                                                         |  |
| Dental Plan Features                                                |                                                                      |                                                         |  |
| Dependents and students                                             | Qualified dependents and students are covered to age 26.             |                                                         |  |
| Domestic partner                                                    | Covered                                                              |                                                         |  |
| Waiting Periods                                                     | Does not apply                                                       |                                                         |  |
| Orthodontia Lifetime Maximum includes dependents to age 19          | Does not apply                                                       |                                                         |  |
| Network Benefits                                                    |                                                                      |                                                         |  |
|                                                                     | In Network                                                           | Out of Network                                          |  |
| In Area                                                             | Coverage provided through Univera Healthcare dental provider network | Same coverage as in network, subject to balance billing |  |
| Out of area                                                         | Covered at fee schedule, subject to balance billing                  | Covered at fee schedule, subject to balance billing     |  |
| Dental Plan Benefits                                                |                                                                      |                                                         |  |
| Dental Plan Benefits                                                | Pediatric (members to 19)                                            | Adult                                                   |  |
| Annual Deductible                                                   | \$0 enrollee/\$0 two+ enrollees                                      | \$0 Single/\$0 Family                                   |  |
| Annual Maximum                                                      | None                                                                 | \$1,500 applies to all covered services                 |  |
| Out of Pocket Maximum                                               | \$350 / \$700<br>(In network only)                                   | None                                                    |  |
| Covered Services                                                    |                                                                      |                                                         |  |
| Covered Services                                                    | Pediatric (members to 19)                                            | Adult                                                   |  |
| Preventive Cleanings                                                | Covered at \$0                                                       | Covered at 100%                                         |  |
| Exams                                                               | Covered at \$25                                                      | Covered at 100%                                         |  |
| Fluoride treatments                                                 | Covered at \$0                                                       | Not Covered                                             |  |
| Sealants                                                            | Covered at \$0                                                       | Not Covered                                             |  |
| Bitewing x-rays                                                     | Covered at \$25                                                      | Covered at 100%                                         |  |
| Full mouth and panorex x-rays                                       | Covered at \$25                                                      | Covered at 100%                                         |  |
| Space maintainers                                                   | Covered at \$0                                                       | Not Covered                                             |  |
| Emergency palliative treatment                                      | Covered at \$0                                                       | Covered at 100%                                         |  |
| Fillings                                                            | Covered at \$25                                                      | Covered at 50%                                          |  |
| Simple Extraction Oral Surgery                                      | Covered at \$25                                                      | Covered at 50%                                          |  |
| Oral surgery                                                        | Covered at \$100                                                     | Covered at 50%                                          |  |
| Endodontics                                                         | Covered at \$100                                                     | Covered at 50%                                          |  |
| Limited non-surgical Periodontic services due to medical conditions | Covered at \$100                                                     | Covered at 50%                                          |  |
| Periodontal surgery                                                 | Not Covered                                                          | Covered at 50%                                          |  |
| Periodontal scaling and root planing                                | Not Covered                                                          | Covered at 50%                                          |  |
| Periodontal maintenance following surgery                           | Not Covered                                                          | Covered at 50%                                          |  |
| Fixed prosthetics (limited Pediatric services covered)              | Covered at \$100                                                     | Covered at 50%                                          |  |
| Removable prosthetics                                               | Covered at \$100                                                     | Covered at 50%                                          |  |
| Inlays / Onlays                                                     | Not Covered                                                          | Covered at 50%                                          |  |
| Crowns (Pediatric stainless steel only)                             | Covered at \$25                                                      | Covered at 50%                                          |  |
| Relines / rebases                                                   | Covered at \$100                                                     | Covered at 50%                                          |  |
|                                                                     |                                                                      |                                                         |  |

| UAD-1500-PPO                     | Univera Access Dental |                |
|----------------------------------|-----------------------|----------------|
| Implants                         | Not Covered           | Covered at 50% |
| Medically Necessary Orthodontics | Covered at \$300      | Not Covered    |
| Orthodontics                     | Not Covered           | Not Covered    |

This is not a contract or binding agreement, but a summary of benefits and services. You should rely on the subscriber contract as the complete description of member rights, responsibilities, benefits available under the benefit plan, and the definition of contract year as it applies to any benefit limitations. In the event of a dispute between this summary and your member contract, the member contract will prevail.

Certain services require pre-certification. Please refer to your contract for additional information regarding applicable services and penalties charged if pre-certification is not obtained.

For technical web issues please contact our Web Help Desk at 1-800-278-1247

### COBRA Administration Services

|                                                                                                    |                                                               |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> COBRA Buy-Up (for groups with 2-100 full-time employees)                  | \$25 Per Month                                                |
| <input type="checkbox"/> COBRA Administration* (for groups with more than 100 full-time employees) | \$1.00 Per Enrolled Per Month<br>(Monthly minimum of \$55.00) |

### Flexible Spending Account Administration Services

|                                                          |                                                                                                                                     |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| FSA Administration                                       | \$4.50 Per Enrolled Account<br>(\$99 Monthly Minimum)                                                                               |
| Account Type Options                                     |                                                                                                                                     |
| <input type="checkbox"/> Health Care Account             |                                                                                                                                     |
| <input type="checkbox"/> Dependent Care Account          |                                                                                                                                     |
| <input type="checkbox"/> Transportation Spending Account |                                                                                                                                     |
| <input type="checkbox"/> Limited Purpose FSA             | (Combination pricing available for multiple types of FSA accounts and/or limited purpose accounts combined with an HRA/HSA account) |

### Health Reimbursement Account Administration Services

|                                                       |                                                                                                                                     |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| HRA Administration                                    | \$4.50 Per Enrolled HRA Participant Per Month<br>(\$99 Monthly Minimum)                                                             |
| Account Type Options                                  |                                                                                                                                     |
| <input type="checkbox"/> Health Reimbursement Account |                                                                                                                                     |
| <input type="checkbox"/> Limited Purpose HRA          | (Combination pricing available for multiple types of FSA accounts and/or limited purpose accounts combined with an HRA/HSA account) |

### Health Savings Account Administration Services

|                                                 |                                               |
|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Health Savings Account | \$2.00 Per Enrolled HSA Participant Per Month |
|-------------------------------------------------|-----------------------------------------------|

### Retiree and/or Active Premium Billing Administration Services

|                                                                |                                                                                                                                                           |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Retiree and/or Active Premium Billing | \$4.00 Per Billed Retiree/Active Per Month<br>(Monthly minimum of \$50 for retiree premium billing<br>Monthly minimum of \$75 for active premium billing) |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|

### Compliance Documentation Services

|                                                         |                                                                                  |
|---------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Summary Plan Description (SPD) | Please contact your Univera Healthcare Sales Consultant for pricing information. |
|---------------------------------------------------------|----------------------------------------------------------------------------------|

### Retirement Plan Services

|                                                                                |                                                                   |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> 401(k) Administration                                 |                                                                   |
| <input type="checkbox"/> Defined Benefit Administration<br>(Cash Balance Plan) | Please contact your LBS Sales Consultant for pricing information. |

Please check the corresponding box to indicate which services you would like quoted.

The fees listed above are Lifetime Benefit Solutions' standard market pricing. Quotes requested will include comprehensive plan detail and a listing of any additional fees.

Discounts may be available for larger accounts (lower per member or account fees, depending on group size).

There may be discounts available when purchasing multiple ancillary options.

\* Included with all medical plans for groups with 2-100 full-time employees at no additional charge.

Powered by

