Des Moines Pediatric and Adolescent Clinic
January 1, 2021 Benefit Open Enrollment Guide

Bernie Lowe & Associates, Inc.
"Beyond the Product"

Medical Benefits - UnitedHealthcare for 01/01/2021

Plan Name/ Network	UnitedHealthcare Choice Plus: UHC CEXC/651
Office Visit including Chiropractic	2020: $20 copay PCP type / $60 copay specialist <19 $0 copay PCP type 2021:$25 copay PCP type / $70 copay specialist <19 $0 copay PCP type Virtual Visits $0 Copay
Emergency Room Visits	2020: $250 Copay 2021: $400 Copay
Mental Health/Substance Abuse	Covered as any other illness
Rx Benefits Retail: 30 day supply Mail Order: 90 day supply	Tier 1 / Tier 2 / Tier 3 / Tier 4 / Specialty $15 / $40 / $85 / $250 / $ up to 50% $37.50 / $100 / $212.50 / $625 / NA
Deductible	2020:$2,500 Single / $5,000 Family 2021: $2,000 Single / $4,000 Family
Coinsurance	80% / 20%
Out-of-Pocket	2020: $5,000 Single / $10,000 Family 2021: $6,950 Single / $13,900 Family
Outpatient Hospital	Deductible + 20%
Inpatient Hospital	Deductible + 20%
Adult Routine Exam	Covered - 100%
Lifetime Maximum	Unlimited
Annual Vision Exam	Adult: 1 Routine exam $20 Copay Pediatric: Exam $10 Copay Glasses/Contacts - see benefit schedule

Dental Benefits: Delta Dental of Iowa - NO CHANGE

Plan Name/ Network	**Plan B Plus HC / Delta Dental Premier with Pediatric**			
Age	21 & Older		Under Age 21	
Network	Premier	Non-Par	Premier	Non-Par
Calendar Year Benefit	$2,000			
Maximum Out of Pocket	N/A		$350/child, maximum $700	
Deductible	$25/person	$50/person	$25/person	$225/person
Coinsurance	Percentage paid by member			
Preventive	0%	20%	0%	50%
Basic	20%	40%	50%	70%
Major	50%	60%	50%	70%
Implants	60%	70%	60%	70%
Orthodontia	Not Covered		50%	
Ortho Lifetime Benefit	Not Covered		$1500 * **to age 19**	
Vision Discount Program	Included		NA	

Life Insurance Benefits: The Principal

Basic Life and AD&D

Benefit	$15,000
Age Reduction	35% at age 65, additional 15% at age 70
Enrollment and Payment	Employer paid, enrolled at new hire enrollment period

Voluntary Life

Benefit	Employee: Increments of $10,000 to $300,000 Spouse: Increments of $5,000 to $100,000 (<employee) Child: Increments of $5,000 to $25,000 (<employee)
Enrollment and Payment	Employee paid, requires proof of good health

Des Moines Pediatrics

Bernie Lowe & Associates, Inc.
"Beyond the Product"

Print Employee Name:_____

Employee Sign & Date:_____

2021 Required Enrollment Worksheet

All eligible employees are required to complete this worksheet and required carrier forms. These need submitted to Nancy no later than Friday, December 11th.

Medical Benefits - UnitedHealthcare for 01/01/2021

Enrollee Name, Age, Relationship and cost from premium chart

I wish to waive medical insurance: **Waive** _____

Please complete the enrollment chart above by filling in the name, age, and relationship of each enrollee. Your premiums are age rated per person. You will find these rates onthe attached chart.

** If you are waiving medical coverage, simply initial beside the waiver option above.*
**If you are newly enrolling or changing who is covered on your medical plan, please complete a coordinating UHC form.*

Dental Benefits: Delta Dental of Iowa

Enrollee Name, Age, Relationship and cost from premium chart

I wish to waive dental insurance: **Waive** _____

Please complete the enrollment chart above by filling in the name, age, and relationship of each enrollee. Your premiums are age rated per person. You will find these rates onthe attached chart.

** If you are waiving dental coverage, simply initial beside the waiver option above.*
**If you are newly enrolling or changing who is covered on your dental plan, please complete a coordinating Delta Dental form.*

Age Rated Premium Chart: 2021 Health Insurance Rates - UnitedHealthcare

Age	Full Monthly Premium	Employee Cost per Month	Employee Dep Cost per Month
Under 14	**$272.19**	$95.27	$155.15
15	**$296.39**	$103.74	$168.94
16	**$305.64**	$106.97	$174.21
17	**$314.89**	$110.21	$179.49
18	**$324.85**	$113.70	$185.16
19	**$334.82**	$117.19	$190.85
20	**$345.14**	$120.80	$196.73
21	**$355.81**	$124.53	$202.81
22	**$355.81**	$124.53	$202.81
23	**$355.81**	$124.53	$202.81
24	**$355.81**	$124.53	$202.81
25	**$357.23**	$125.03	$203.62
26	**$364.35**	$127.52	$207.68
27	**$372.89**	$130.51	$212.55
28	**$386.77**	$135.37	$220.46
29	**$398.15**	$139.35	$226.95
30	**$403.84**	$141.34	$230.19
31	**$412.38**	$144.33	$235.06
32	**$420.92**	$147.32	$239.92
33	**$426.26**	$149.19	$242.97
34	**$431.95**	$151.18	$246.21
35	**$434.80**	$152.18	$247.84
36	**$437.65**	$153.18	$249.46
37	**$440.49**	$154.17	$251.08
38	**$443.34**	$155.17	$252.70
39	**$449.03**	$157.16	$255.95
40	**$454.73**	$159.16	$259.20
41	**$463.26**	$162.14	$264.06
42	**$471.45**	$165.01	$268.73
43	**$482.83**	$168.99	$275.21
44	**$497.07**	$173.97	$283.33
45	**$513.79**	$179.83	$292.86
46	**$533.72**	$186.80	$304.22
47	**$556.13**	$194.65	$316.99
48	**$581.75**	$203.61	$331.60
49	**$607.01**	$212.45	$346.00
50	**$635.48**	$222.42	$362.22
51	**$663.59**	$232.26	$378.25
52	**$694.54**	$243.09	$395.89
53	**$725.85**	$254.05	$413.73
54	**$759.65**	$265.88	$433.00
55	**$793.46**	$277.71	$452.27
56	**$830.10**	$290.54	$473.16
57	**$867.11**	$303.49	$494.25
58	**$906.60**	$317.31	$516.76
59	**$926.17**	$324.16	$527.92
60	**$965.67**	$337.98	$550.43
61	**$999.83**	$349.94	$569.90
62	**$1,022.24**	$357.78	$582.68
63	**$1,050.35**	$367.62	$598.70
64 and over	**$1,067.43**	$373.60	$608.44

Age Rated Premium Chart: 2021 Dental Insurance Rates - Delta

Age	Full Monthly Premium	Employee Cost per Month	Employee Dep Cost per Month
21 and older	**$38.60**	$13.51	$19.30
21 and under	**$32.18**	$11.26	$16.09

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, visit www.welcometouhc.com or by calling 1-800-782-3158. 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?	Designated Network and Network: $2,000 Individual / $4,000 Family out-of-Network: $6,000 Individual / $12,000 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.
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?	Designated Network and Network: $6,950 Individual / $13,900 Family out-of-Network: $13,500 Individual / $27,000 Family	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 www.welcometouhc.com or call 1-800-782-3158 for a list of network providers.	You pay the least if you use a provider in the Designated Network. You pay more if you use a 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
		Designated Network Provider (You will pay the least)	Network Provider	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	$25 copay per visit, deductible does not apply	$25 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. Children under age 19: No Charge.
	Specialist visit	$40 copay per visit, deductible does not apply	$70 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening /immunizatio-n	No Charge	No Charge	Not Covered	No coverage out-of-Network. Includes preventive health services specified in the health care reform law. 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)	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	$400 copay per service, deductible does not apply	$400 copay per service, deductible does not apply	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	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.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $15 copay Mail-Order: $37.50 copay	Deductible does not apply. Retail: $15 copay Mail-Order: $37.50 copay	Deductible does not apply. Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network Pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Certain preventive medications and Tier 1 contraceptives are covered at No Charge. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $40 copay Mail-Order: $100 copay	Deductible does not apply. Retail: $40 copay Mail-Order: $100 copay	Deductible does not apply. Retail: $40 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $85 copay Mail-Order: $212.50 copay	Deductible does not apply. Retail: $85 copay Mail-Order: $212.50 copay	Deductible does not apply. Retail: $85 copay	
	Tier 4 - Additional High-Cost Options	Deductible does not apply. Retail: $250 copay Mail-Order: $625 copay	Deductible does not apply. Retail: $250 copay Mail-Order: $625 copay	Deductible does not apply. Retail: Retail: $250 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$400 copay per visit, deductible does not apply.	$400 copay per visit, deductible does not apply.	$400 copay per visit, deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50 copay per visit, deductible does not apply	$50 copay per visit, deductible does not apply	50% coinsurance	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	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply	$25 copay per visit, deductible does not apply	50% coinsurance	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	50% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit, deductible does not apply	$25 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational, Cardiac: Unlimited. Pulmonary: 20 visits.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$25 copay per outpatient visit, deductible does not apply	$25 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: Unlimited. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit reduces to 50% of allowed.
	Skilled nursing care	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit, deductible does not apply	$10 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
	Children's glasses	$25 copay per frame, deductible does not apply	$25 copay per frame, deductible does not apply	50% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit does not cover both.
	Children's dental check-up	0% coinsurance	0% coinsurance	50% coinsurance	Cleanings covered 2 times per 12 months.

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)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- 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	• Chiropractic care	• Hearing Aids-$2,500/ calendar year	• Private Duty Nursing	• Routine eye care (Adult)-1 exam/12 months

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-800-782-3158 . 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: 1-800-782-3158 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Iowa Insurance Division at 1-877-955-1212 or www.iid.state.ia.us.

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 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 1-800-782-3158 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3158 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3158 .

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** $ 2,000
- **Specialist copayment** $70
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal 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	
Deductible	$2,000
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,870

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

- **The plan's overall deductible** $ 2,000
- **Specialist copayment** $70
- **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	
Deductible	$200
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,300

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

- **The plan's overall deductible** $ 2,000
- **Specialist copayment** $70
- **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	
Deductible	$1,200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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

Notice of Non-Discrimination

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 به طور 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।

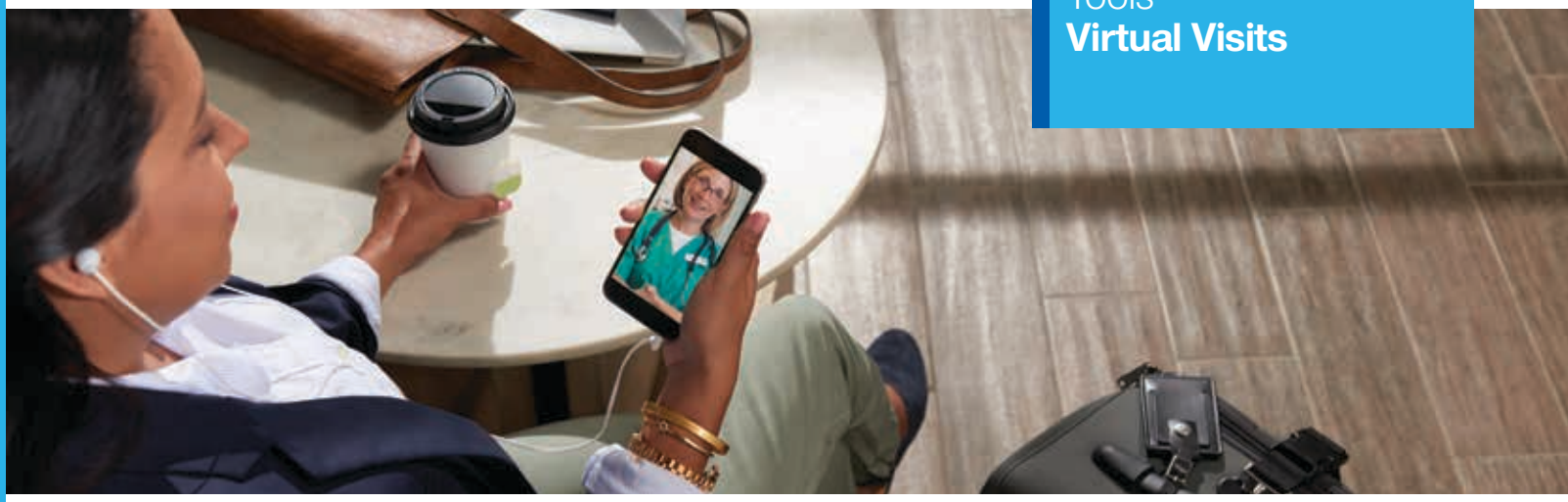
CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (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).



See a doctor whenever, wherever. Virtual Visits

Get access to care 24/7 with Virtual Visits. A Virtual Visit lets you see a doctor from your mobile device or computer without an appointment.

Choose from an AmWell or Doctor on Demand network provider and pay $50 or less for the visit.

AmWell app


Doctor On Demand app*

To learn more and start a visit, go to **uhc.com/virtualvisits.** You can also go directly to **amwell.com** or **doctorondemand.com**—or the AmWell or Doctor On Demand mobile apps.

Virtual Visits are covered under your health plan benefits either way you decide to access care.

Tips for registering:

1. Locate your member ID number on your health plan ID card.
2. Have your credit card ready to cover any costs not covered by your health plan.
3. Choose a pharmacy that's open in case you're given a prescription.**

To learn more about Virtual Visits,
go to **uhc.com/virtualvisits** or **myuhc.com**.

UnitedHealthcare®

*Doctor On Demand does not support any version of Internet Explorer®.

** Prescription services may not be available in all states.

Take advantage of Care24® services – information and support is just a phone call away.

Care24 services, a complimentary benefit from your health plan, offers you access to a wide range of health and well-being information and support—seven days a week, 24 hours a day at the following toll-free phone number, **1-888-887-4114**. Care24 services connects you with registered nurses or master's-level counselors who are here to to help you with almost any problem ranging from medical and family matters to personal legal*, financial and emotional needs.

Connecting people with information and resources

Care24 services provides you with access to experienced professionals including:

- Registered nurses
- Master's-level counselors
- Legal and financial professionals
- Community resources

Audio resources available on a wide range of health topics

With Care24 services, you can also choose to listen to audio messages on more than 1,100 health and well-being topics. To listen to your message of choice, press * to speak with a nurse who will provide you with information on the health topics along with the three digit access pin number. More than 600 audio messages are recorded and available in Spanish, along with multi-lingual translation services, and service for callers with hearing impairments.

Care24 helps you with:

- Childhood illnesses
- Minor illnesses and injuries
- Medication information and safety
- Relationship worries
- Choosing appropriate medical care
- Stress and anxiety
- Coping with grief and loss
- Personal legal and financial issues
- Self-care information
- Finding a doctor

Call the following toll free number **1-888-887-4114** to get started.

UnitedHealthcare®

Local support

A Care24 professional may offer to find local, in-person help in some situations. Counselors may also be able to connect you with other helpful resources in your community.

Care24 nurses are here to help you find a doctor or specialist, and check if the doctor is in your network and available. We may even be able to make the appointment for you.

24-hour convenience

Care24 nurses and counselors are available 24 hours a day, 7 days a week and will work with you to help identify and address concerns in your work and home life.

How to call

To take advantage of Care24 services, nurses and counselors available 24 hours a day, 7 days a week by calling **1-888-887-4114**. TTY/TDD callers, please call the National Relay Center at **1-800-828-1120** and ask for the toll free number on the back of your health plan ID card.

UnitedHealthcare®

* Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving Optum services directly or indirectly (e.g. employer or health plan).

Delta Dental Premier®
Plan B Plus - HC (with orthodontia)
Small Group Employer Choice

	Delta Dental Premier® Dentist		Out-of-Network Dentist	
	Adult 21 +	Child 0-20	Adult 21 +	Child 0-20
Deductible (per person per calendar year)	$25*	$25*	$50	$225*
Adult Annual Benefit Maximum with To Go℠**	$2,000			
Benefit Categories	Coinsurance paid by member			
Diagnostic & Preventive Services check-ups, teeth cleaning, x-rays, maintenance therapy	0%	0%	20%	50%
Routine & Restorative Services cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery	20%	50%	40%	70%
Posterior Composites tooth-colored filling on back teeth	50%	60%	60%	70%
Endodontic Services root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings	50%	50%	60%	70%
Periodontal Services gum and bone diseases, complex procedures	50%	50%	60%	70%
High Cost Restorations cast restorations – crowns, inlays, onlays, posts, cores	50%	50%	60%	70%
Prosthetics bridges, dentures	50%	50%	60%	70%
Implants	60%	60%	70%	70%
Medically Necessary Orthodontia	–	50%	–	50%
Child Annual Out-of-Pocket Limit (only applies to in-network)	$350 per child or $700 for all children under 21		–	–
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum			
Enhanced Benefits Program extra dental benefits based on medical conditions	Pregnancy, high-risk cardiac conditions, suppressed immune systems, diabetes, periodontal disease, cancer, chemotherapy, radiation, and kidney failure or dialysis			

H = High Child Plan; C = Corrective Orthodontia
* Deductible is waived for all diagnostic and preventive care.
** To Go℠ annual maximum carryover – see Benefits Certificate for details.

The information on this page summarizes your benefits and payment obligations. This is a general description of your benefits. Please see your benefits document for a full description of coverage.

Delta Dental of Iowa is a Qualified Health Plan issuer on the Iowa Health Insurance Marketplace.

Policyholder: Des Moines Pediatric and Adolescent Clinic PLC

Group Term Life Benefit Summary

Effective Date: 09/01/2018

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS
Benefits Payable	
Employee Life Benefits	
Benefit Amount	$15,000
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are Under 70: $15,000 If you are 70 and older: The lesser of $15,000 or the amount with the prior carrier
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at age 70. Age reductions apply to the benefit amount after proof of good health .
Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived.
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to an individual policy.
Limitations & Exclusions	
Coverage Outside of the US	Benefits will not be paid if you are outside the United States for certain reasons for more than six months.

Accidental Death & Dismemberment (AD&D) Coverage	
Benefit Amount	Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered. You may be paid: • **Full benefit** when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.
Additional Benefits	
Seatbelt/Airbag	$10,000 if you are wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of your death
Repatriation	Up to $2,000 for preparation and transportation of your body if you die at least 100 miles from your permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months, the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Other Limitations	The Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Understanding Your Life Coverage Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Spouse and child coverage is not available.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed $250,000, as long as: • Your life expectancy is 12 months or less (as diagnosed by a physician), and • Your death benefit is at least $10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in the premium.
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to individual life coverage. Upon coverage termination your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation. Contact Principal Life for details.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Policyholder: Des Moines Pediatric and Adolescent Clinic PLC

Voluntary Term Life Benefit Summary

Effective Date: 09/01/2018

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility			
Job Class	ALL MEMBERS		
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. If you are covered as an employee, your dependents may also be eligible. Additional eligibility requirements may apply.		
Benefits Payable			
	Employee Life Benefits	**Spouse Life Benefits**	**Child Life Benefits**
Benefit Amount	You may choose to purchase benefits in increments of $10,000	You may choose to purchase benefits in $5,000 increments	For eligible children 14 days or older, you may choose to purchase benefits of • $5,000, or • $10,000, or • $15,000, or • $20,000, or • $25,000 Eligible children under 14 days of age receive $1,000.
Minimum	$10,000	$5,000	Not Applicable
Maximum	$300,000	$100,000	Not Applicable
		Cannot exceed 100% of your benefit amount	
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are under age 70: $70,000 If you are age 70 and over: $10,000	Proof of good health is required for life insurance amounts greater than: If your spouse is under age 70: $20,000 If your spouse is age 70 and over: $10,000	Not Applicable
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at 70 Age reductions apply to the benefit amount after proof of good health.		Not Applicable
Additional Employee Benefits			
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived for you and your covered dependents.		
Accelerated Death Benefit	If you become terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.		

Open Enrollment	If you and your enrolled dependents have existing coverage you may be able to increase coverage one increment per year during your open enrollment period without proof of good health.
Individual Purchase Rights	If you terminate employment, you may be able to convert benefits to an individual policy.
Portability	If you cease to qualify as a member, you may be able to continue coverage for you and your covered dependents.
Limitations & Exclusions	
Suicide Exclusion	Benefits are not paid if you or your dependents commit suicide within the first 24 months of coverage (prior group voluntary life coverage applies towards the 24 month time period).
Coverage Outside of the US	Benefits will not be paid if you or your dependents are outside the United States for certain reasons for more than six months.

Accidental Death & Dismemberment (AD&D) Coverage	
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. AD & D coverage does not apply to children.
Benefit Amount	Your employee benefit is equal to your voluntary term life benefit amount, if loss is due to accident or injury. Your spouse's benefit is equal to their voluntary term life benefit amount, if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, the loss may be covered. Benefits may be paid: • **Full benefit** when you or your spouse lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you or your spouse lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you or your spouse lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.
Additional Benefits	
Seatbelt /Airbag	$10,000 if wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of death
Repatriation	Up to $2,000 for preparation and transportation of the body if the insured dies at least 100 miles from their permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Occupational Coverage	For your covered spouse, benefits will not be paid for an injury arising from or during employment for wage or profit
Other Limitations	This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Understanding Your Voluntary Term Life Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Are My Dependents Eligible For Coverage?

If you are covered as a member, your dependents may also be eligible. Additional eligibility requirements may apply.

Eligible dependents include your spouse (if not also enrolled as an employee), if not hospital or home confined and provided they do not elect benefits as an employee, and children.

Special eligibility requirements may exist for step, foster, adopted, legal age or other child relationships. Additional information may be necessary to determine child eligibility.

Additional eligibility requirements may apply.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived for you and your covered dependents. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed $250,000, as long as: • Your life expectancy is 12 months or less (as diagnosed by a physician), and • Your death benefit is at least $10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in your premium.
Open Enrollment	An open enrollment period will be available to you and your enrolled dependents each year during the calendar month prior to the policy anniversary. You and your dependents can request an increase of one benefit increment per year up to the guaranteed coverage amount without proof of good health. Once approved for coverage over the guaranteed coverage amount you can request an increase of one benefit increment per year up to the policy maximum benefit without proof of good health.

Individual Purchase Rights	If you terminate employment, you, your spouse and your children may be able to convert coverage to individual life coverage. Upon coverage termination, your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.
Portability	You may continue benefits for yourself and your covered dependents until age 70 if you cease to qualify as a member. You or your spouse must enroll within 60 days from the date you cease to qualify as a member. Refer to your benefit booklet for maximum age requirements.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company.This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

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