Coverage for: Individual/Family| Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 405-682-4581. 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.dol.gov/ebsa/healthreform.com or call 405-682-4581 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300.00/individual or $900.00/family**	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. Preventative care is covered before you meet your deductible.**	This plan covers some items and services even if you haven't yet met the deductible amount. But 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: https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, in addition to the overall deductible, **Out-of-Network Hospital Inpatient Stay**: $250; **Prescription Drugs**: $100	You must pay all of the costs for these services up to the specific deductible amount, in addition to the overall deductible, before this plan begins to pay for these services..
What is the out-of-pocket limit for this plan?	In-network Medical benefits: Individual: $3,300/Family: $6,600; Individual Prescription: $3,300;Family: $6,600	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, preauthorization fees and health care this plan doesn't cover.	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 whyuhc.com/uhss or call 1-866-236-3148 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's 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 permission from this plan

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% after deductible	50% after deductible	----------none----------
	Specialist visit	20% after deductible	50% after deductible	Spinal Manipulation Treatment/ Chiropractic Care limited to 24 visits per Calendar Year
	Preventive care/screening/ immunization	No charge, deductible does not apply	50% after deductible	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	50% after deductible	----------none----------
	Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	----------none----------
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available by calling 1-800-334-8134.	Generic drugs	Retail: $10/prescription Mail Order: $20/prescription		Amounts as indicated are after the additional $100 prescription drug deductible has been applied. Preauthorization required for Compound Prescription benefits that exceed $300 for the year. CVS Caremark Specialty Pharmacy cvsspecialty.com or 1-800-237-2767
	Preferred brand drugs	Retail/Mail Order: 20% after deductible		
	Non-preferred brand drugs	Retail/Mail Order: 25% after deductible		
	Specialty drugs	Preferred Brand: 20% after deductible Non-preferred Brand: 25% after deductible Must be filled at CVS Caremark Specialty Pharmacy		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	50% after deductible	Surgical procedures for the treatment of obesity and any complications arising from surgical procedures are excluded by the plan.
	Physician/surgeon fees	20% after deductible	50% after deductible	Surgical procedures for the treatment of obesity and any complications arising from surgical procedures are excluded by the plan.
If you need immediate medical attention	Emergency room care	20% after deductible	20% after deductible	----------none----------
	Emergency medical transportation	20% after deductible	20% after deductible	----------none----------
	Urgent care	20% after deductible	50% after deductible	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at http://pp344.com/.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	$250/per confinement copay then 50% after deductible	You must obtain authorization from the Plan for all inpatient stays prior to each stay. Failure to obtain preauthorization from the Plan will result in a $250 fee. This is in addition to the $250 per confinement out-of-network copay.
	Physician/surgeon fees	20% after deductible	50% after deductible	Surgical procedures for the treatment of obesity and any complications arising from surgical procedures are excluded by the plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	50% after deductible	Outpatient care for drug, alcohol or substance abuse services are excluded from the Plan.
	Inpatient services	20% after deductible	50% after deductible	Inpatient care for drug, alcohol or substance abuse services are excluded from the Plan.
If you are pregnant	Office visits	20% after deductible	50% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Dependent Maternity is excluded by the plan.
	Childbirth/delivery professional services	20% after deductible	50% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Dependent Maternity is excluded by the plan.
	Childbirth/delivery facility services	20% after deductible	50% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Dependent Maternity is excluded by the plan. You must obtain authorization from the Plan for all inpatient stays which ***exceed*** the 48/96 hour rule. Failure to obtain preauthorization from the Plan for inpatient stays which exceed the 48/96 hour rule will result in a $250 fee. This is in addition to the $250 out-of-network copay for each inpatient hospital stay.
If you need help recovering or have other special health needs	Home health care	20% after deductible	50% after deductible	Limited to 30 visits per calendar year
	Rehabilitation services	20% after deductible	50% after deductible	Limited to 26 visits per calendar year

[* For more information about limitations and exceptions, see the plan or policy document at http://pp344.com/.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	20% after deductible	50% after deductible	Limited to 25 visits per calendar year
	Skilled nursing care	20% after deductible	50% after deductible	Limited to 30 days per calendar year.
	Durable medical equipment	20% after deductible	50% after deductible	The Plan will pay 80% per 12 months not to exceed the purchase price. The Plan will pay 100% for replacement parts, with a maximum allowance of 1 replacement part every 5 years
	Hospice services	20% after deductible	50% after deductible	6 months per 3 years
If your child needs dental or eye care	Eye exam	No charge under age 18. Age 18 & older, up to $150 per individual	No charge under age 18. Age 18 & older, up to $150 per individual	All Participants (Employee, Spouse, Child) Limited to one exam every 12 months.
	Glasses and Contacts	No charge up to: Frames: $250; Single vision: $235; Bifocals: $250;Contacts: $280 then No Coverage	No charge up to: Frames: $250; Single vision: $235; Bifocals: $250;Contacts: $280 then No Coverage	All Participants (Employee, Spouse, Child) limited to one pair of eyeglass frames and one pair of conventional lenses or contact lenses (but not both) up to the stated allowable charge every 12 months. However, Participants up to age 18, the Plan will allow single vision lenses at 100%.
	Children's dental check-up	No charge Class I Preventive Services	No charge Class I Preventive Services	Class I, Out-of-Network Preventive Services No Charge up to a yearly maximum of $200

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
- Bariatric surgery
- Hearing aids (with limits for active members)
- Infertility
- 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.)

- Chiropractic care
- Cosmetic surgery only if such surgery is to restore bodily function or correct deformity resulting from illness or injury covered under the Plan
- Dental care (Adult)
- Long-term Care
- Private-duty nursing
- Routine eye care (Adult)

[* For more information about limitations and exceptions, see the plan or policy document at http://pp344.com/.]

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or call 1-405-682-4581. 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 405-682-4581.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 405-682-4581.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 405-682-4581.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 405-682-4581.

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

If you are a participant in the HRA (i.e., you have met all of the HRA eligibility requirements and have completed a personal health assessment), you may use your HRA account to obtain reimbursement for deductibles, copayments and coinsurance amounts.

[* For more information about limitations and exceptions, see the plan or policy document at http://pp344.com/.]

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** **$300**
- **Specialist *coinsurance*** **20%**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *coinsurance*** **20%**
- *Plan's Health Reimbursement Account (HRA), if applicable, will reduce the participants cost by $1,000 or $500.*

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,800**

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

- **The plan's overall deductible** **$300**
- **Specialist *coinsurance*** **20%**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Prescription Deductible*** **$100**
- *Plan's Health Reimbursement Account (HRA), if applicable, will reduce the participants cost by $1,000 or $500.*

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$20
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,720**

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

- **The plan's overall deductible** **$300**
- **Specialist *coinsurance*** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other *coinsurance*** **20%**
- *Plan's Health Reimbursement Account (HRA), if applicable, will reduce the participants cost by $1,000 or $500.*

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$610
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

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