The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-215-5094. 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 https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or call 1-844-215-5094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers – **$500** individual / **$1,500** family Out-of-Network Providers – **$1,000** per individual / No maximum per family for Out-of-Network	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 in-network deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. For the out-of-network deductible, each family member must meet their own individual deductible before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network Preventive care, Network office visits, and Network urgent care 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 https://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?	**Medical:** In-Network Providers – **$3,000** individual / **$9,000** family Out-of-Network Providers - No maximum limitation for Out-of-Network **Prescription drugs:** **$3,600** individual / **$4,200** 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?	Amounts in excess of reasonable and customary, and healthcare not covered by this plan.	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. Healthcare Highways Call 1-866-945-2292 or visit www.healthcarehighways.com 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 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
		In-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	$25 copay per visit	50% coinsurance	Premise clinics – no charge. Aim clinics - no charge.
	Specialist visit	$25 copay per visit	50% coinsurance	100% coverage through Evolution – Please call to pre-arrange services at 1-855-633-2684.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	With LabCard: No charge Without LabCard: 20% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	If utilizing Healthcheck Radiology – No Charge.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from CVS Caremark at www.caremark.com	Generic drugs	Retail 34 - $5 Retail 90 - $15 Mail 90 - $10	No out-of-network benefit	There is a separate out–of–pocket limit for prescription drugs: **$3,600** individual / **$4,200** family Once the prescription out-of-pocket amount has been met, copays for covered prescription drugs will no longer apply for the remaining calendar year. Retail – 34 to 90 day supply. Mail order – 90 day supply.
	Preferred brand drugs	Retail 34– Formulary 20% with $20 minimum and $60 maximum Retail 90 – 20% with $60 minimum and $180 maximum Mail 90 - $55	No out-of-network benefit	
	Non-preferred brand drugs	Retail 34 – Brand Name 30% with $40 minimum and $80 maximum Retail 90 – 30% with a $120 minimum and $240 maximum Mail 90 - $75	No out-of-network benefit	
	Specialty drugs	Mail order only: Generic - $10 copay Preferred brand – $55 copay Non-Preferred brand - $75 copay	No out-of-network benefit	CVS/Caremark Specialty Pharmacy exclusively.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	100% coverage through Evolution – Please call to pre-arrange services at 1-855-633-2684.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Network deductible applies to out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$25 copay per visit	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit	50% coinsurance	Services covered at 100% through Rivus, please call 1-405-607-2233.
	Inpatient services	20% coinsurance	50% coinsurance	Requires Case Management. Call HealthSmart 1-877-202-6379. Failure to call and receive prior approval for these services may result in denial of benefits.
If you are pregnant	Office visits	No charge with the Prenatal Care Management Program; otherwise 20% coinsurance	50% coinsurance	100% coverage through Evolution – Please call to pre-arrange services at 1-855-633-2684.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	----------none----------
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.
	Rehabilitation services	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.
	Skilled nursing care	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.
	Durable medical equipment	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.
	Hospice services	20% coinsurance	50% coinsurance	Requires Case Management. Failure to call and receive prior approval for these services may result in denial of benefits.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Assessment only.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	No charge	Not covered	Assessment only.

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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (Limit 24 visits per calendar year.)
- Hearing aids (Dependent children only – restrictions apply.)

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at Director of HR, Benefits and Retirement at 1-405-713-1535. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Claims Administrator at 1-844-215-5094. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-215-5094.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-215-5094.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-215-5094.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-215-5094.

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	$500
Specialist copayment	$25
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 *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,260**

These numbers assume participation in the Prenatal Care Management Program.

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

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$425
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,085**

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

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$75
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$975**

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