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- (800) 749-1422. 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.90degreebenefits.com or call 1-(800)-749-1422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	***$1,700** Employee **/ *$1,700** Spouse **/ $1,200** Child / ***$4,600** Family for In-Network and ***$3,500** Employee / ***$3,500** Spouse / **$3,000** Child / ***$10,000** Family for Out-of-Network. ***$500** credit for each adult that participates in the PHA program.	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.** In-Network: ACA preventive services, well-child care, immunizations, outpatient lab, colonoscopy, second surgical opinion, outpatient sterilization, pre-admission testing, chiropractic care, nutritional evaluation & diabetes management/self-training, hi-tech diagnostic tests through One Call Medical/Provider Partners, allergy serum, allergy injections, office visit up to $500, urgent care center, physician services for maternity care & delivery, outpatient mental health up to $500, emergency services; and Out-of-Network: emergency services 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/.

Important Questions	Answers	Why This Matters:
Are there other deductibles for specific services?	**Yes. $500** per occurrence for failure to pre-certify.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$4,000** Individual / **$8,000** Family for In-Network; **$7,500** Individual / **$15,000** Family for Out-of-Network.	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 (unless balance-billing is prohibited), amounts in excess of Maximum Allowable Charge, non-precertification reduction, benefit reduction for non-compliance of case management, ineligible charges 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 www.healthcarehighways.com or call **(866) 945-2292** for a list of participating providers. Provider Partners see www.tulsafire.providerpartners.com or call **(800) 749-1422** for assistance.	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
		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	**Up to $500:** $25/visit **Over $500:** 20% coinsurance	50% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialist visit	**Up to $500:** $50/visit **Over $500:** 20% coinsurance	50% coinsurance	----------none----------
	Preventive care/screening/ immunization	No Charge	50% coinsurance	Routine physical exams for Employee, Spouse and children over 36 months are limited to 1 per Calendar Year. Other preventive services required by ACA found at: www.uspreventiveservicestaskforce.org
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	**One Call Medical:** No Charge **Provider Partners:** $50/test **All Others:** 20% coinsurance	50% coinsurance	For a list of Provider Partners facilities, see www.tulsafire.providerpartners.com
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxbenefits.com	Generic drugs	**Retail:** $15/prescription; **Retail90 or Mail Order**: $45/prescription.	Not Covered	Limited to a 30-day supply at Retail or a 90-day supply at Retail90 or Mail Order. Compound drugs over $100 must be approved. **RX Out-of-Pocket Maximum:** $2,600 Individual / $5,200 Family
	Preferred brand drugs	**Retail:** $35 + 5% up to $300/prescription; **Retail90**: $105 + 5% up to $300/prescription. **Mail Order**: $105/prescription	Not Covered	
	Non-preferred brand drugs	**Retail:** $50 + 5% up to $300/prescription; **Retail90**: $150 + 5% up to $300/prescription. **Mail Order**: $150/prescription	Not Covered	

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)	
	Specialty drugs	**Generic:** $10/prescription; **Preferred Brand:** $40/prescription; **Non-Preferred Brand**: $50/prescription	Not Covered	Limited to a 30-day supply. Must be obtained through the Specialty Mail Order pharmacy Accredo. **RX Out-of-Pocket Maximum**: (Combined with other RX drugs) $2,600 Individual / $5,200 Family
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Provider Partners:** $300/Surgery; **All Others**: 20% coinsurance	50% coinsurance	Services must be pre-certified. If not obtained, a $500 penalty will apply. For a list of Provider Partners free-standing surgery centers see www.tulsafire.providerpartners.com
	Physician/surgeon fees	**Provider Partners:** No Charge **All Others**: 20% coinsurance	50% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$250/visit + 20% coinsurance	$250/visit + 20% coinsurance	Copayment waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	50% coinsurance	----------none----------
	Urgent care	**Up to $750:** $50/visit; **Over $750:** 20% coinsurance	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Services must be pre-certified. If not obtained, a $500 penalty will apply.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Up to $500:** PCP- $25/visit; Specialist: $50/visit **Over $500:** 20% coinsurance	50% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% coinsurance	50% coinsurance	Services must be pre-certified. If not obtained, a $500 penalty will apply.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	----------none----------
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	----------none----------
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient stays beyond 48 hours for a vaginal delivery or 96 hours for a cesarean section must be pre-certified. If not obtained, a $500 penalty will apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Services must be pre-certified. If not obtained, a $500 penalty per treatment plan will apply.
	Rehabilitation services	20% coinsurance	50% coinsurance	Inpatient limited to 20 days per Calendar Year; Outpatient pulmonary/cardiac care limited to 36 visits per condition; Outpatient occupational/speech therapy limited to 30 visits per therapy per Calendar Year; Outpatient physical therapy limited to 30 visits per condition/injury. Services must be pre-certified. If not obtained, a $500 penalty will apply.
	Habilitation services	20% coinsurance	50% coinsurance	Inpatient limited to 20 days per Calendar Year; Outpatient pulmonary/cardiac care limited to 36 visits per condition; Outpatient occupational/speech therapy limited to 30 visits per therapy per Calendar Year; Outpatient physical therapy limited to 30 visits per condition/injury. Services must be pre-certified. If not obtained, a $500 penalty will apply.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per Calendar Year. Services must be pre-certified. If not obtained, a $500 per confinement penalty will apply.

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	----------none----------
	Hospice services	20% coinsurance	50% coinsurance	Inpatient limited to 15 days per Calendar Year. Services must be pre-certified. If not obtained, a $500 penalty will apply.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	----------none----------
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's dental check-up	Not Covered	Not Covered	----------none----------

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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (must be covered on the plan for 5 consecutive years)
- Chiropractic care (26 visits per Calendar Year)
- Hearing aids (Under age 18 only. One every 48 months per year, up to 4 additional ear molds for up to age 2)
- Infertility treatment (diagnosis only)
- Weight loss programs (physician supervised)

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 Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

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

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

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (800) 749-1422.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 749-1422].

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 749-1422].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 749-1422].

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,700**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	
Deductibles	$1,700
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,970**

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

The plan's overall deductible	**$1,700**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$800
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,700**
Specialist *[cost sharing]*	**$50**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,950
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,250**

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