Union Public Schools

Benefits Highlights for 2025
(January 1, 2025 – December 31, 2025)

Welcome to Union Public Schools!

Benefits Office Team

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Introduction

No one can predict life's ups and downs and Union Public Schools recognizes you have different needs than your coworkers. That is why we are dedicated to offering you and your family a variety of benefits that help meet those unique needs and balance your career with your personal life. Plus Union's flexible benefits program allows you to select the combination of benefits that is right for you—whether you are married or single, close to retirement, sending kids off to college or just beginning your career.

All information necessary to make an informed decision can be found within this guide or on the Union Benefits Webpage. Please contact the Benefits office staff if you need a paper copy of the packet, if you do not have computer access, or if you need assistance with enrollment.

Enrollment Instructions

All newly benefit eligible employees must access the benefits enrollment portal regardless if they want insurance or not.

If you need to know your benefits effective date please contact the Benefits office. (918) 357-6195

To make your elections please proceed to **www.afenroll.com/enroll.**

Username: Employee ID # / Password: Last 4 of your SSN and 8 digit date of birth

You must electronically sign your changes at the end in order for you changes to go into effect.

Qualifying Events

After your New Employee Enrollment period, Open Enrollment is the only time you can make changes to insurance coverage, add or delete dependents, and purchase or cancel a voluntary benefit unless an IRS-defined qualifying event occurs, including, but not limited to: Marriage, divorce, birth/adoption of a child, death of a spouse, or gaining/losing other coverage. **Should you experience a qualifying event, please notify the Benefits Office within 31 days of that event** to discuss any options or changes to coverage or the effects the event will have, if any. **If you do not notify the Benefits Office within the 31- day window, the law prohibits you from making any changes until the next available Open Enrollment or upon experiencing another qualifying event.** Please contact 918-357-6195 for a form.

WARNING: *If you fail to submit information regarding qualifying events, you could face serious consequences, including but not limited to, being held legally and financially responsible for claims paid for ineligible dependents and possible conviction for insurance fraud under certain circumstances.*

TO MAKE CERTAIN YOUR BENEFIT ELECTIONS REMAIN APPROPRIATE, YOU SHOULD NOTIFY THE DISTRICT'S BENEFITS OFFICE IMMEDIATELY IF YOU HAVE ANY CHANGES IN YOUR PERSONAL SITUATION.

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Medical Plan Options for 2025 Plan Year

Union Public Schools Self-Insured Plan through UMR
UnitedHealthcare Choice Plus Network
www.umr.com or 1-800-207-3172

Medical Base Plan and Buy Up Plan

These plans offer the flexibility of a traditional medical plan along with a national network of doctor choices and no referrals required by the plan for specialist visits.

- **Both plans utilize the UnitedHealthcare Choice Plus network and cover the same services. The differences between the two plans are the cost structure for services and the monthly premiums.** This is highlighted on the next page.
- Preventive care visits are covered at 100% without having to pay a copayment for that visit.
- Ancillary services are subject to deductible and co-insurance.
- **Always verify that a provider is in the UHC Choice Plus network to ensure in-network benefits.**
- **Teladoc—**Members on either medical plan have access to Teladoc services. Talk to a board-certified doctor or pediatrician 24/7 for non-emergency conditions with no copay required. Dermatology appointments can also be made through the app at the regular specialist copayment.
- **CareATC Near Site Clinics** – Members on either medical plan have access to CareATC clinics with no out of pocket expense. Members can make an appointment through the CareATC app or by calling (918) 948-6360.
- **Envision Imaging Discount Card** - Offers imaging at a reduced rate and not subject to your deductible. 2 locations in Tulsa. Hours of operation and available services vary by location.

918-523-7714 - 7714 E. 91st St. Tulsa, OK 74133

918-523-0002 - 6757 S. Yale Ave. Tulsa, OK 74136

Prescription drug coverage is included with your medical plan and administered by MedalistRX.

A **mail-order prescription plan** is available for additional savings for a 90-day supply.

Prescription Drug Plan
MedalistRX
www.medalistrx.com
1-855-633-2579

Medical Plan Options for 2025 Plan Year

Union Public Schools Self-Insured Plan through UMR
UnitedHealthcare Choice Plus Network
www.umr.com or 1-800-207-3172

	Base Plan	Buy Up Plan
Deductible - In Network	$750 - Individual $2,250 - Family	$250 - Individual $750 - Family
Coverage - In Network	80%	90%
Out of Pocket Maximum (In Network)	$5,000 - Individual $9,000 - Family	$3,000 - Individual $5,000 - Family
Deductible - Out of Network	$2,250 - Individual $6,750 - Family	$750 - Individual $2,250 - Family
Coverage - Out of Network	50%	50%
Primary Care Office Visit Copay	$40	$25
Specialist Office Visit Copay	$50	$25
Urgent Care Visit Copay	$60	$50
Generic Prescription (30 day supply)	$20	$10
Brand Name Prescription (30 day supply)	$50	$40
Prescriptions Costing $1,000 or more (30 day supply)	25%	20%
RX Out of Pocket Maximum	$2,000 - Individual $4,000 Family	$1,000 - Individual $2,000 Family
Monthly Premiums		
Employee Only	$0.00	$220.62
Employee + Spouse	$636.00	$979.80
Employee + Child(ren)	$330.94	$606.72
Employee + Family	$802.18	$1,203.28

Teladoc HEALTH

Your care. Your way.

Access your Teladoc Health benefits anytime.

General Medical

$0 copay for Base and Buy Up plans!

Talk to a board-certified doctor or pediatrician 24/7 for non-emergency conditions.

Prescription refills • sinus infections • allergies • stomach bug • COVID-19 advice • and more

Dermatology

Base Plan: $50/online review

Buy Up Plan: $25/online review

Upload images and details of your skin issue in the Teladoc Health app. A dermatologist will review them and provide a treatment plan within 24 hours. Follow up via in-app messaging for 7 days after your results.

Eczema • psoriasis • poison ivy • rashes • rosacea • and more

Set up your account or log in to get started today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

Group ID: 478794

10E-211B_1812851_G_08182022_PC

We've got you covered

Welcome to primary care with a proactive approach to health and well-being for you and your family. CareATC physicians and clinical staff are ready to help each patient with primary care and address important lifestyle changes like weight management, tobacco use and more.

Get started

Activate your patient account today and schedule your new patient visit. Go to www.careatc.com/activate or download the CareATC app and follow the registration prompts.

It is important each member on your health plan age 18+ create their own account.

Pay nothing, get everything

- → $0 Copay/deductible/coinsurance
- → $0 Labs and generic medications provided at your visit
- → Fast and easy appointment access
- → Preventive care, as well as illness, injury and chronic disease management
- → Less wait time, more face time with your medical provider

Three ways to schedule

- 918.948.6360
- www.careatc.com/patients
- CareATC app

Under HIPAA regulations, all patient information is confidential.

Area Health Centers:

Hours:
- 8 to 5
- 8 to 12pm

Tulsa
15th Street Health Center (x-rays)
1810 E 15th St, Ste C
MTWTF

Tulsa
First Place Tower Health Center
15 E 5th St, Ste 1600
MTWTF

Tulsa
Jackson Health Center
4500 S 129th E Ave
MTWTF

Broken Arrow
South Garnett Health Center
4716 W Urbana St
Ste 200
MTWTF

Owasso
Owasso Health Center
8751 N 117th E Ave
MTWTF

Sand Springs
2nd Street Health Center
302 W 2nd St
Ste 600
MTWTF

Muskogee
Muskogee Health Center
3300 Chandler Rd
Ste 107
MTWTF

Show Me The App!

CareATC
THE POWER TO BE WELL.

Waiving Health Insurance

For Waiving Insurance: Certified receives - $69.72 per month
Support receives - $189.74 per month

In order to qualify to waive the health insurance offered by the District, please remember that you must show proof of other health insurance coverage at the time of enrollment. Additionally, **you will be required to show proof each year during the open enrollment process.** We will accept a letter from your insurance company, a letter from the employer group offering the insurance coverage, or a copy of an insurance card that has your name and a recent effective date**. If proof of other health coverage is not received by the Benefits Office you will automatically be enrolled in the UPS Base Medical plan with single coverage.**

Delta Dental Plan

Delta Dental of Oklahoma
Group # - 9990005
www.deltadentalok.org or 1-800-522-0188

	Base Plan	**Buy Up Plan**
Deductible – Per Person	$100	$100
Preventative – *cleanings, x-rays, etc.*	100% (not subject to deductible)	100% (not subject to deductible)
Routine – *fillings, etc.*	90% PPO 80% Premier	90% PPO 80% Premier
Major – *bridges, crowns, root canals, extractions, etc.*	60%	75%
Calendar Year Maximum Benefit	$2,000 – In- and Out of Network	$5,000 – In- and Out of Network
Orthodontia (adults & children)	$2,000 (Lifetime Max)	$2,000 (Lifetime Max)
Monthly Premiums		
Employee Only	$0.00	$28.16
Employee + One	$71.76	$132.18
Employee + Family	$111.42	$198.32

VSP Vision Insurance Plan

VSP
Group # - 12001639
www.vsp.com or 1-800-877-7195

Exam Only		**Monthly Premium**
Exam Co-pay – every plan year	$25 co-pay	Employee Only—$0.00 Family—$0.88
Exam and Materials		
Exam Co-pay - every plan year	$10 co-pay	Employee Only—$9.78 Family—$21.80
Prescription Glasses Co-Pay – every plan year	$25 co-pay	
Contacts Allowance (instead of glasses) – every plan year	$150 allowance	
Frames Allowance – every other plan year	$130-$150 allowance	

Counseling

Counseling is available in-person, video, or telephonically with a counselor close to work, home or school. Individual, family and couples counseling are all included. Short-term, solution focused support for work-life issues such as stress, major life transitions, relationship issues, substance use, grief/loss and overwhelming emotions.

Coaching

Life Advisor Coaches offer telephonic or video support for individual life enhancement goals, such as education, career advancement, financial or self improvement goals.

Crisis Support

Mental health professionals are available by phone 24/7/365.

Work/Life Materials

Information on a wide range of work-life balance topics are easily accessed through the EAP portal in the form of webinars, videos and PDFs.

Well-being Portal

Anytime access to articles, resources, healthy-living tips, webinars as well as our orientation videos.

Referrals

Consultants provide recommendations for resources within the community.

Legal & Financial Consultations

Ulliance professionals can connect employees with resources to assist individuals regarding legal and financial issues.

No Cost | Confidential | LifeAdvisor.com | 800.448.8326

District Provided Benefits

Basic Life Employee Insurance—MetLife

The District provides a basic life insurance policy for all full time employees; up to the amount of $20,000 (*some amounts differ according to position).* This benefit is at no charge to you. **Please be sure to designate a beneficiary for this policy when enrolling online.**

Short Term Disability —MetLife

This benefit, entirely employer paid, is available to all full-time employees.

- Covers accidents and illness for up to 180 days
- Monthly taxable benefit is $300
- Benefits begin 1st day of accident – 8th day of illness
- Benefits begin after ALL paid leave is exhausted (sick, vacation, personal, sick bank, donated sick days, and sub-deduct) until the maximum benefit period is reached.

Long Term Disability —MetLife

This benefit, entirely employer paid, is available to all full-time employees.

- Benefits begin on the 181st day of disability
- Monthly taxable benefit is 60% of base pay
- Maximum taxable benefit is $6,500 per month
- Minimum taxable benefit is greater of $100 **or** 10% of gross salary
- Benefit duration: Based on age on date of disability or your normal retirement age as defined by the SSA. See certificate.

Limitations for Long Term Disability:

- Pre-existing conditions are not covered during the first 12 months of coverage. A pre-existing condition is one where treatment (consultation, medication) is received during the three-month period before coverage begins.
- Benefits are reduced by other income sources.
- Mental illness is limited to 24 months of benefits unless hospital confined.

Voluntary Life Insurance

In addition to District-paid basic life insurance provided to the employee, you may purchase additional voluntary life insurance for yourself, spouse and dependent children. The payroll deduction will vary based on your age and the amount you wish to purchase. In order to be eligible to purchase additional voluntary life insurance for your family, you must purchase additional voluntary life insurance for yourself. Will preparation services are included in the employee supplemental life insurance policies.

Guaranteed Issue Amounts for newly eligible employee/spouse:

Support & Certified personnel: $100,000 guaranteed issue amount as a newly eligible employee. Any amount above $100,000 requires evidence of good health.

Administrators: $200,000 guaranteed issue amount as a newly eligible employee. Any amount above $200,000 requires evidence of good health.

Spouse: coverage available up to 50% of the employee amount, (max $375,000) based on the age/ rate of the employee ($25,000 guaranteed issue; any amount above $25,000 requires evidence of good health).

If you are electing coverage for the first time for yourself or your spouse during Open Enrollment the full benefit amount will be subject to underwriting.

1) Select the amount of coverage: _____

2) Determine your cost per $1000 of coverage:

If your age is:	Your rate per $1,000 is:	If your age is:	Your rate per $1,000 is:
<25	$0.08	50 to 54	$0.30
25 to 29	$0.08	55 to 59	$0.54
30 to 34	$0.10	60 to 64	$0.76
35 to 39	$0.12	65 to 69	$1.35
40 to 44	$0.14	70 to 99	$2.18
45 to 49	$0.20		

3) Compute your monthly cost:

a) Amount of coverage you desire (subject to guaranteed issue)

b) Divide coverage amount by 1,000

c) Multiply that number by the rate for your age to get your monthly cost

_____	/ _____	=_____	X _____	= _____
Coverage amount	$1,000		Rate for your age	Monthly cost

Supplemental Life & AD&D for Child(ren)

Employees who are insured for supplemental life can also insure their child(ren) up to age 26 in increments of $2,500 up to $10,000 at the following rate per family:

$2,500 coverage:	$0.44 per month	$5,000 coverage:	$0.80 per month
$7,500 coverage:	$1.17 per month	$10,000 coverage:	$1.53 per month

Basic Dependent Life

Basic Dependent coverage is also available for your spouse and child(ren) at a monthly premium of $2.50. (Employee does not have to purchase supplemental life to insure dependents on the basic plan.)

Spousal coverage $5,000 Child(ren) coverage $2,000 up to age 26

For all dependent life coverage, the employee will be the beneficiary.

MetLife—Auto and Home Insurance

- This is **NOT PAYROLL DEDUCTED.** You will receive a bill at your home address from MetLife for direct payment.
- Product Features
    - Full Replacement Cost Coverage on new vehicles with no deduction for depreciation
    - Full Replacement Cost Coverage on damaged auto parts with no deduction taken for depreciation
    - Deductible Savings Benefit — a $50 credit toward the insured's deductible for every year of claim-free driving *(up to five years)*
    - Full Replacement on home and contents — restores your home at today's rebuilding costs with no deduction for depreciation of contents
    - ID Protection Service — an automatic feature provided at no added cost to customers with auto, homeowners, renters, condo and several other policy types
- Discounts
    - Years of Service discounts
    - Special group discounts
    - Driver improvement course discount
    - Employment tenure discount
    - Garaging discount

MetLife—Veterinary Pet Insurance

- This is **NOT PAYROLL DEDUCTED.** You will receive a bill at your home address from MetLife for direct payment.
- Coverage is available for dogs and cats from six weeks to up to 10 years of age.
- Birds must be a minimum of 3 months of age months at the time of enrollment and must have been in the owner's possession for a minimum of 60 days. Rates for dogs and cats are based on the age of the pet and the plan type selected.
- Veterinary pet insurance helps pay for office calls, prescriptions, treatments, lab fees, x-rays, surgery and hospitalization for covered medical problems and conditions (subject to policy terms).
- Pet owners can select any licensed veterinarian, veterinary specialist and animal hospital in the world.
- The premium, the amount each plan pays for approved claims, and the benefit maximums are the only differences between VPI's Superior Plan and VPI's Standard Plan.
- Coverage is also available for birds, rabbits, ferrets, reptiles and other exotic pets with the VPI Avian & Exotic Pet Plan.
- The popular "Pet Wellcare Protection Coverage" is available for dogs and cats and provides benefits for routine care treatments, such as annual physical exams, vaccinations, heartworm protection, a choice of spay/ neuter, teeth cleaning, or a comprehensive health screen, prescription flea control and much more.
- Supplement Routine Care is available for birds.

For questions or to receive a quote please call 1-800-438-6388.

MetLife—Legal Plans

The District offers legal insurance through the MetLife Legal Plans program.

Group Legal Plan – *through payroll deduction:*

- Provided through Metlife Legal Plans; access to common, everyday legal matters for those who might not otherwise have access or know where to go. For example, Estate Planning, Financial, Defense of Civil Lawsuits, Family Law, Traffic Offenses, Document Preparation and Review, Juvenile, Consumer Protection, ID Theft. 1-800-821-6400 (8am to 7pm EST)
- $18.16 per month

Teachers' Retirement System (TRS)

http://www.ok.gov/trs/
Local: (405) 521-2387 / Toll Free: (877) 738-6365

Certified employees are automatically enrolled in the Teachers' Retirement System. Support employees have the option to enroll in the Teachers' Retirement System a new employee. Please see the benefits staff for questions.

403b and 457 Retirement Plans

Please contact the vendors below for questions or to enroll in these plans. Plan comparisons can be found on the next page.

403B ASP *and* Edward Jones as Financial Advisors www.403BASP.com www.edwardjones.com	
Larry Cornwell Financial Advisor Edward Jones Investments 8556 E 101st St, Suite I Tulsa, OK 74133 (918) 369-9350 Larry.cornwell@edwardjones.com Fax (866) 302-4543	Cassie Bowers Associate Financial Advisor Edward Jones Investments 8009-A South Sheridan Rd Tulsa, OK 74133 (918) 481-1058 cassie.bowers@edwardjones.com Fax (888) 226-7349
Mark Buffington, AAMS Financial Advisor Edward Jones Investments 8009-A South Sheridan Rd Tulsa, OK 74133 (918) 481-1058 Mark.buffington@edwardjones.com Fax (888) 226-7349	Grant Simmons Financial Advisor Edward Jones Investments 9175 S. Yale Ave, Suite 120 Tulsa, OK 74137 (918) 493-3136 Grant.simmons@edwardjones.com Fax (888) 226-7349
457 TIAA and Northstar Financial Advisors www.tiaa.org	
Carter Cowan, AIF Chartered Retirement Plans Specialist 6660 S. Sheridan Rd., Suite 205 Tulsa, OK 74133 (918) 508-2834 ccowan@northstarwm.com	Judd Hatch, AAMS Financial Advisor 6660 S. Sheridan Rd., Suite 205 Tulsa, OK 74133 (918) 508-2834 jhatch@northstarwm.com

The Plan for You…

403(b) / 457 Comparison

You may contribute the Maximum to both plans!

	403(b)	457
Eligibility	Available to employees of section 501(c)(3) organizations and public schools.	State and local governments including public school employees where a plan has been established by the employer.
Contribution Limits	Elective deferral limit is $23,500 in 2025.	Same. May contribute the elective deferral limit in both 403(b) and 457 plans without offsetting each other. (See catch-up.)
Catch-up Contributions	Can be made by individuals 50 or older. Age 50 catch-up limit: $7,500. Age 60-63 catch-up limit: $11,250.	Same catch-ups available for 457 plans.
Additional Catch-up	Not allowed.	In final 3 years before normal retirement age, may contribute up to 200% of the normal limit, subject to calculation of prior contributions.
Contribution Method	Plans are funded through salary reduction and contribution is made on a pre-tax basis. Tax deferred earnings means no taxes paid until money is distributed.	Same.
Investment Options	Funded with various Custodial Accounts	Same.
Distribution	May be withdrawn at age 59 1/2, separation from service, death, total disability, retirement, and financial hardship.	May be withdrawn at age 70 1/2, separation from service, retirement, unforeseen emergencies, total disability and death.
Hardship / Unforeseeable Emergency Withdrawals	Hardships include purchasing a home, paying for child's education, and unpaid medical bills.	Unforeseeable emergency includes financial hardship due to illness, casualty losses, and other sudden unforeseeable events beyond the participant's control.
Taxation of Distributions	All withdrawals are subject to income taxation. Withdrawals prior to age 59 1/2 will also be subject to a 10% federal tax penalty unless age 55 and separated from service, or in the event of death or disability.	Same. However, 457 withdrawals are not subject to the 10% federal penalty tax at any time.
Loans	Not allowed except for de-selected vendors	Loans are available on pre-tax dollars only. No Roth funds are available for loans. Availability and limits will apply by plan.
Buy Back Provision	Monies in the plan can be used to "buy back" past service credits of a government defined benefit plan.	Same.
Normal Retirement Age	59 1/2	55
Approved Vendor(s)	403(b) Aspire/ Edward Jones	TIAA
Rollovers Into Plan	Allowed	Allowed
Roth Option	Available	Available

American Fidelity Products

American Fidelity – Flexible Spending Accounts

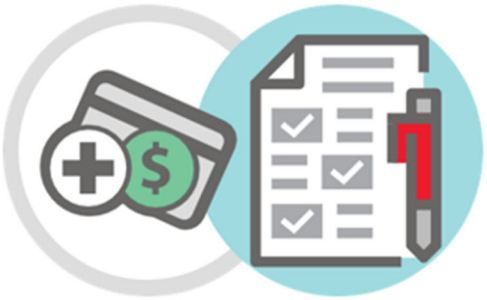
Flexible Spending Accounts

Everyone likes saving money.

Flexible spending accounts (FSA) allow you to save part of your paycheck, before taxes, to pay for eligible costs throughout the year.

Types of Accounts

- Healthcare FSAs
- Limited Purpose FSAs
- Dependent Care Accounts



To calculate medical costs that may not be covered by insurance, visit americanfidelity.com/fsa-worksheet

Explore your savings options at **americanfidelity.com/info/fsa**

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter bandages
- Physical exams
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Walkers/wheelchairs

americanfidelity.com/eligible-expenses

An Easy Way to Pay for Expenses

Would you like to gain tax savings when paying for medical or dependent care costs? With a Section 125 Plan, your money can be taken from your paycheck pre-tax and used for eligible costs. And since your money is taken out pre-tax, it reduces your taxable income, and allows you to take home more money in each paycheck.

How Does it Work?

Look at the example below. Jane makes $2,000 per paycheck and is paid twice a month. Under a Section 125 Plan, she would save $82.96 a month. That's a savings of $995.52 a year. To calculate your possible savings, visit americanfidelity.com/s125-calculator

Earnings & Hours	Without 125	With 125
Gross Pay	$2,000	$2,000
Health Insurance	-$150	-$150
Health FSA Contribution	*N/A*	-$150
Taxable Income	***$1,850***	***$1,700***
Taxes (Federal & State @ 20%)	-$370	-$340
Less Estimated FICA (7.65%)	-$141.53	-$130.05
Out-of Pocket Medical Expenses	-$150	*N/A*
Take Home Pay	***$1,188.47***	***$1229.95***

A savings of $995.52 a year

Where allowable by law. If you are subject to FICA taxes, there might be a reduction in your social security benefit due to the reduction of FICA contributions. Example is hypothetical for illustrative purposes only. Please consult your tax advisor for actual tax savings.

American Fidelity Products (Continued)

Disability Income Insurance

If you were suddenly faced without a paycheck, would you be fully prepared? Could you afford your expenses while maintaining your current lifestyle?

One of the most important assets a person possesses is the ability to earn an income. Disability Income Insurance from American Fidelity is a cost-effective solution designed to help protect you if you become disabled and cannot work due to a covered injury or sickness.

Here's How It Works

In the simplest of terms, this plan is insurance that pays a cash benefit and is designed to help protect you if you can't work due to a covered injury or sickness. It pays a monthly benefit amount based on a percentage of your gross income, so you may continue to afford everyday living expenses.

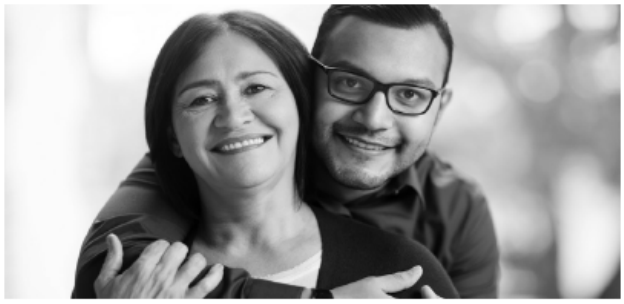
Features

- Benefits are paid directly to you, so you can use your benefit for any expense you wish.
- Payments made year-round.
- Several elimination periods to choose from.
- Premiums are not required while you are disabled, based on the length of your disability.

These products may contain limitations, exclusions, and waiting periods. Applicant's eligibility for this program may be subject to insurability.

SB-30432-0716

Permanent, Portable Life Insurance



Your employer may provide you with group life insurance, but do you have lifetime coverage that you can take with you after employment? Life insurance at retirement can be very costly. Secure a permanent, portable plan today.

Here's How It Works

Permanent Life Insurance provides protection for your entire life, up to age 121.[1]

Features

- The policy is effective to age 121.[1]
- Multiple coverage options available for you, your spouse, children, and grandchildren.[2]
- You own the policy, so you can take it with you to a different job or in retirement.

Underwritten by Texas Life Insurance Company, 900 Washington Avenue, Waco, Texas 76703. Policy Form: PRFNG-NI-10 / 16M117-C AF 109 (expires 0718). See brochure for details.

[1]As long as you pay the necessary premium. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued.

[2]Coverage and spouse/domestic partner eligibility may vary by state. Coverage not available for children and grandchildren in Washington. Texas Life complies with all state laws regarding marriages and legally recognized familial relationships. Not generally qualified benefits under Section 125 Plans. PureLife-plus not available in NJ, NY, or PA.

SB-30509-0716

American Fidelity Products (Continued)

Accident Only Insurance

Accidents are inevitable. Even though you can't always prepare for unforeseen events, you can plan ahead. A **Limited Benefit Accident Only Insurance** plan may help ease the impact on your finances.

American Fidelity's Accident Only Insurance is designed to help cover some of the expenses that can result from a covered accident, and benefit payments are made directly to you.

Here's How It Works

This plan provides 24-hour coverage for accidents that occur both on and off the job and can help offset your medical expenses. There are over 30 plan benefits available, and coverage may also extend to your family.

Features

- Choose the coverage option that best fits your lifestyle and financial needs.
- Apply with no medical questions asked.
- The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physical exam, including immunizations and preventive testing.
- The plan pays a benefit when an Accidental Death or Dismemberment occurs within 90 days of a covered accident.
- Policy is guaranteed renewable for as long as premiums are paid as required.
- You own the policy, so you can take it with you if you change jobs.

Limitations, exclusions, and waiting periods may apply. Not all products and benefits may be available in all states. ***This product is inappropriate for people who are eligible for Medicaid coverage.***

SB-30426-0716

Cancer Insurance

If you were unexpectedly faced with a cancer diagnosis, will your major medical insurance be enough? Even with a good plan, the out-of-pocket costs of treatment, such as travel, child care, and loss of income, can be expensive. American Fidelity's **Limited Benefit Cancer Insurance** may help.

Here's How It Works

If cancer touches someone in your family, this plan may help ease the impact on your finances. Benefit payments are made directly to you, allowing you to pay for expenses like copayments, hospital stays, and house and car payments.

Features

- Benefit payments made directly to you, so you can use your benefit for any expense you wish.
- Choose the coverage option that best fits your lifestyle and financial needs.
- More than 25 plan benefits available for cancer treatment, including wellness and early detection.
- Radiation, chemo, and hormone therapy.
- Covers transportation and lodging.
- You own the policy, so you can take it with you if you change jobs.

Not all riders may be available in every state. Limitations, exclusions, and waiting periods may apply. ***This product is inappropriate for people who are eligible for Medicaid coverage.***

SB-30430-0716

American Fidelity Products (Continued)

File Your Claims Faster

AFmobile®

Our mobile app is the easiest way to submit your claims and documentation. Upload documentation* directly from your device's picture gallery.

americanfidelity.com®

Filing online is convenient, secure, and provides faster claim processing than filing by paper. From your laptop or desktop, log in to file a claim and upload documentation*.

Need assistance?

Visit americanfidelity.com/fileaclaim

**The Internal Revenue Code regulations require proof of eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.*

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

View account balances

Manage claims and reimbursements

Submit documentation

Receive alerts

Maintain personal information

Get Started

Register at americanfidelity.com/register or **download AFmobile** and select the New User link.

Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.

Legal Notices

Women's Health and Cancer Rights of 1998

ANNUAL NOTICE TO PARTICIPANTS

Your group health plan provides coverage for mastectomies. It also provides coverage for procedures necessary to effect reconstruction of the breast on which a mastectomy has been performed, the cost of prostheses (implants, special bras, etc.), and physical complications of all stages of mastectomy (including lymph edemas), as recommended by the attending physician of any patient receiving Plan benefits in connection with a mastectomy in consultation with the patient.

In addition, the Plan provides coverage for any necessary surgery and reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance.

This coverage is subject to the same deductibles, benefit percentages and applicable co payments that apply to mastectomies under the Plan's current terms (see your group health plan's summary plan description for details of the Plan's deductible, benefit percentage, and co payment requirements for mastectomies).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Union Public School's Self-Insured Medical Plan
Creditable Coverage Notice

Important Notice from Union Public School District
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Union Public School's Self-Insured Medical Plan with Medical and Rx coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered and at what cost, with the information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Union Public Schools has determined that the Union Public School's Self-Insured Medical Plan with Medical and Rx Plan's prescription drug coverage (through MedalistRx) on average expected to pay out as much as the standard Medicare prescription drug coverage pays and therefore considered Creditable Coverage.

Because the Union Public School's Self-Insured Medical Plan with Medical and Rx prescription drug coverage (through MedalistRx), is "creditable", which means that the benefits are, on average, at least as good as standard Medicare prescription drug coverage, and you can keep this coverage and not pay a percentage penalty if you later decide to enroll in Medicare, Part D coverage.

You will have the opportunity to enroll in a Medicare Part D prescription drug plan each year from October 15th to December 7th for a January 1st effective date. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

You should also know that if you drop or lose your Union Public School's Self-Insured Medical Plan with medical and prescription drug coverage (through MedalistRx), and you don't enroll in Medicare Part D prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare Part D prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium could go up at least 1% per month for every month that you did not have prescription drug coverage. For example, if you go nineteen months without prescription drug coverage, your premium may be at least 19% higher on average than what most other people pay for Medicare, Part D. You may have to pay this higher premium as long as you have Medicare Part D coverage. In addition, you may have to wait until Open Enrollment in the fall to enroll for a January 1 effective date.

For members of Union Public School's Self-Insured Medical Plan, you have three options if you are Medicare eligible:

1. **KEEP** your current coverage with Union Public School's Self-Insured Medical Plan with Medical and Rx coverage under either the current rate tier if you are on the Early Retiree Incentive (ERI), or can choose to move to the Medicare Medical and Rx rate tier. If you are not ERI you can keep the Medicare Medical and Rx rate tier coverage which provides prescription drug coverage (administered by MedalistRx) that you will automatically be moved to upon becoming Medicare eligible. You may also elect to move to the "Medical Only" Medicare Rate Tier Option with Union Public Schools Self Insured Medical Plan. If you move to this plan you MUST purchase an outside Part D Drug Program as no Rx benefits will be available with this plan option.

OR

2. **DROP** the Union Public School's Self-Insured Medical Medical and Rx plan **and ENROLL** in the CommunityCare Senior Health Plans (HMO) offered by Community Care of Oklahoma or Plan F, Plan G or Plan G Plus through Blue Cross Blue Shield of Oklahoma. If you enroll in the CommunityCare Senior Health Plans (HMO) or a Blue Cross Blue Shield plan, your TRS contribution will still be applied to your premium payment because this health plan is one of the health plans offered by Union Public Schools. CommunityCare Senior Health Plans (HMO), have a creditable prescription component.

However, Plan F, Plan G and Plan G Plus through Blue Cross Blue Shield does not offer prescription coverage and MUST be purchased additionally, outside of the Union Schools offerings. **CAUTIONARY STATEMENT: If you are a retiree and you drop the Union Public School's Self-Insured Medical plan, you will not be allowed to re-enroll in the plan.**

OR

3. **DROP** your current plan with Union Public School's Self-Insured Medical and Rx plan **and ENROLL** in an independent health plan, along with prescription coverage through a Medicare, Part D program, or retain only Medicare health coverage and purchase a Medicare D prescription drug plan. **CAUTIONARY STATEMENT: If you are a retiree and drop health coverage offered through Union Public Schools and enroll in an independent medical plan, you are no longer eligible for the TRS supplement that pays a portion of your health insurance premium. Also, if you are a retiree and drop off of the Union Public School's Self-Insured Medical plan, you will not be allowed to re-enroll in the plan.**

If you wish to enroll or receive more information in regards to the Union Medical Medicare tiers, the CommunityCare Senior Health Plans (HMO) or the Blue Cross Blue Shield supplements, below please find information about who to contact:

ROONEY INSURANCE AGENCY

Sydney Jones

918-878-3373

5100 E. Skelly Dr, Suite 1010

Tulsa, OK 74135

sydney.jones@rooneyinsurance.com

Contact our Benefits Office for further information:

Brandi White	Carlie Kenny
918-357-6194	918-357-6195

• Visit www.medicare.gov for personalized help,

• Call your State Health Insurance Assistance Program (see *Medicare & You* handbook for their telephone number)

• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Union Public Schools
Contact--Position/Office:	Benefits Office: Brandi White
Address:	8506 E. 61st Street, Tulsa, OK 74133-1926
Phone Number:	(918) 357-6194 or (918) 357-6195

Union Public Schools, OK

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by U.S. OMNI & TSACG Compliance Services (OMNI/TSACG). Visit the OMNI/TSACG website at *https://www.tsacg.com* for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b) and 457(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b) & 457(b) Contributions

Contributions made to a Roth account are after-tax deductions from your paycheck and are subject to limited coordination with traditional accounts. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Roth 403(b) and Roth 457(b) distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. OMNI/TSACG monitors 403(b) and 457(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2025 IS $23,500.

Additional provisions allowed:

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 to 59 or 64 or older by 12/31/2025 qualify to make an additional contribution of up to $7,500 to the 403(b) and/or 457(b) accounts. Participants aged 60, 61, 62, or 63 on 12/31/2025, can contribute an additional amount of up to $11,250.

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to U.S. OMNI & TSACG Compliance Services. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. An SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

2025

INVESTMENT PROVIDER INFORMATION
A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com.*

PLAN DISTRIBUTION TRANSACTIONS
Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS
A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous employer's plan and retaining the same account with the authorized investment provider under the new employer's plan.

ROLLOVERS
Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS
Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service. Generally, a distribution cannot be made from a 457(b) account until you have reach age 59½ or have a severance from employment. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

EXCHANGES
Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS
Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer's plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer's plan. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

HARDSHIP WITHDRAWALS
Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must certify and may be asked to provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com.*

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL
You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at *https://www.tsacg.com.*

EMPLOYEE INFORMATION STATEMENT
Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037 | Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786 | https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202 | Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786 | https://www.tsacg.com

UNION PUBLIC SCHOOLS, INDEPENDENT DISTRICT #9, TULSA COUNTY
Notice of Privacy Practices for Protected Health Information

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To: Participants in the Union Public Schools Employee Benefit Plan and Flexible Benefit Plan (individually and collectively, "Plan").

Effective Date of Notice: July 1, 2017

In this Notice, we sometimes refer to the Plan as "we" and sometimes as the "Plan." When we say "you" or "your" in this Notice, we mean any person entitled to benefits under the Plan.

Union Public Schools, Independent District #9 sponsors the Plan ("Plan Sponsor") that is a "covered entity" under the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulation ("Privacy Rule"). The Privacy Rule regulates the Plan's use and disclosure of protected health information ("PHI") about you. This Notice describes how we may use and disclose your PHI, as permitted by the Privacy Rule. This Notice also describes your individual rights concerning your PHI.

The term "*protected health information*" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

Section 1. Plan Duties

Federal law says that we must maintain the privacy of your PHI and give you notice of our legal duties and privacy practices concerning your PHI. We must follow the terms of this Notice, as currently in effect. However, we have the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all PHI that we have then or will later have. We will provide you with a revised Notice if we make material changes to our privacy practices.

Section 2. Required PHI Uses and Disclosures

The following categories describe the types of uses and disclosures of your PHI that we are required to make.

Required Access. Upon your request, we are required to give you access to certain PHI in order to copy, inspect, or amend it, or if you ask for an accounting of certain types of disclosures.

For Compliance Purposes. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services without your authorization to investigate or determine our compliance with the Privacy Rule.

Section 3. Primary Uses and Disclosures of Your PHI

The following categories describe the types of uses and disclosures of your PHI that we are permitted to make without your written authorization.

For Treatment Purposes. We may disclose PHI about you for the treatment activities of a health care provider, as permitted by the Privacy Rule. These activities include a health care provider's providing, coordinating or managing your health care and related services, health care providers' consulting with one another about you, and referrals by one provider to another. For example, we may disclose your Plan enrollment status to a hospital in connection with a planned admission without your authorization.

For Payment Purposes. We may use or disclose your PHI for our payment activities and those of other covered entities and health care providers, as permitted by the Privacy Rule. For example, without your authorization, we may disclose your PHI in order to make coverage determinations and payment (including billing, claims management and plan reimbursement). In the same way, we may also disclose your PHI to another covered entity or a health care provider for its payment activities. For example, without your authorization, we may disclose your PHI to a health care provider who has filed a claim for payment for health care services provided to you.

For Health Care Operations. We may use or disclose your PHI for our own health care operations activities, as permitted by the Privacy Rule. We may also disclose your PHI to another covered entity for its own health care operations activities. If we participate in an organized health care arrangement, we may also disclose PHI about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement. Health care operations activities for this purpose include: (i) quality assessment and improvement activities; (ii) population-based activities relating to reducing health care costs; (iii) case management and care coordination; (iv) evaluating health plan

performance; (v) underwriting, premium rating and similar activities; and (vi) the general business management and general administrative activities of the entity for whom the health care operations activities are performed. For example, without your authorization, we may use or disclose information about your claims to project future benefit costs or audit the claims processing functions. However, we may not use or disclose PHI that is *"genetic information",* as required by the Genetic Information Non-Discrimination Act (GINA) for *"underwriting purposes."*

To Business Associates. We may disclose your PHI without your authorization to our third party "*business associates"* that perform various activities on our behalf. These business associates may include, but are not limited to, third party claims administrators and consultants. We require these business associates to appropriately safeguard the privacy of your PHI in compliance with the Privacy Rule.

For Health Related Services. We may use your PHI to contact you with information about health related benefits and services, such as refill reminders, or about treatment alternatives that may be of interest to you. We may disclose your PHI to a Business Associate to assist us in these activities. We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with nominal promotional gifts.

To the Plan Sponsor*.* We may disclose your PHI to the sponsor of the Plan for purposes related to treatment, payment, and health care operations. The Plan Sponsor has amended the Plan document to protect your PHI, as required by the Privacy Rule. For example, without your authorization, we may disclose your PHI to the Plan Sponsor so that it may evaluate plan design changes.

Section 4: Uses and Disclosures of Your PHI that Require Your Written Authorization

The following categories describe types of uses and disclosures of your PHI that generally require your written authorization. You may give us written authorization to use your PHI or to disclose it to another person for the purpose you designate. If you give us an authorization, you may revoke it at any time, but only if you make the request to revoke in writing and give or send it to the Plan's Privacy Contact or Office at the address below. Your revocation of an authorization will not apply to any action the Plan has already taken in reliance on such authorization. Unless you give us written authorization, we cannot use or disclosure your PHI for any reason not described in this Notice or as permitted by law.

Psychotherapy Notes. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

For Marketing Purposes. Your written authorization generally will be obtained for any use or disclosure of PHI for marketing, which means a communication to encourage you to purchase or use a product or service. Marketing does not include communications for health related purposes, as described above.

For Sale. Your written authorization would be required for any disclosure that constitutes a "*sale*" of PHI disclosure.

Section 5. Other Uses and Disclosures of Your PHI Without Your Authorization

The following categories describe the other types of uses and disclosures of your PHI that we are authorized by law to make for purposes deemed to be in the public interest or benefit without your consent, authorization, or request.

Disclosures Required By Law. We may use or disclose your PHI when required by law, as permitted by the Privacy Rule, without your authorization.

For Public Health Activities. We may disclose your PHI without your authorization for certain public health activities, as permitted by the Privacy Rule. Examples of public health activities include: (i) activities to prevent or control disease, injury or disability (including reporting a disease); and (ii) the conduct of public health surveillance, public health investigations and public health interventions.

About Victims of Abuse, Neglect or Domestic Violence. We may disclose your PHI if we reasonably believe that you are a victim of abuse, neglect, or domestic violence. We may only make this disclosure to a government authority (including a social service or protective services agency) authorized by law to receive reports of such abuse, neglect or domestic violence, as permitted by the Privacy Rule. We will make this type of disclosure only if you agree to the disclosure or if the disclosure is otherwise required or authorized by law.

For Health Oversight Activities. We may disclose your PHI without your authorization to a public health oversight agency for certain oversight activities authorized by law, as permitted by the Privacy Rule. Examples of oversight activities include: (i) audits; (ii) investigations; (iii) inspections; (iv) licensure; and (v) other activities generally necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

For Judicial and Administrative Proceedings. We may disclose your PHI without your authorization in response to a court or administrative order issued in any judicial or administrative proceeding, as permitted by the Privacy Rule. We may also disclose your PHI in response to a subpoena, discovery request or other lawful purpose, without a court or administrative order, but only: (i) if we obtain an order protecting the information requested; or (ii) if efforts have been made to tell you about the request for your PHI.

For Law Enforcement Purposes. We may disclose your PHI without your authorization to a law enforcement official for certain law enforcement purposes, as permitted by the Privacy Rule. Examples of this type of disclosure include: (i) disclosure in response to a court order, subpoena, warrant, summons or similar process; and (ii) disclosure made in emergency circumstances to prevent a crime.

To Coroners, Medical Examiners, and Funeral Directors. We may disclose your PHI without your authorization to a coroner or medical examiner for the purpose of: (i) identifying a deceased person; (ii) determining a cause of death; or (iii) other duties as authorized by law, as permitted by the Privacy Rule. Also, we may disclose your PHI to funeral directors, consistent with applicable law, as necessary to carry out their duties regarding the decedent.

For Organ and Tissue Donation Purposes. We may use or disclose your PHI without your authorization to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation, as permitted by the Privacy Rule.

For Research. We may use or disclose your PHI for research without your authorization, as permitted by the Privacy Rule. A number of conditions must be met before we use or disclose your PHI for research.

To Avert a Serious Threat to Health or Safety. We may use or disclose your PHI without your authorization when necessary to prevent a serious threat to someone's health and safety, as permitted by the Privacy Rule. We may only make that kind of disclosure, however, to someone able to lessen or prevent the threat.

For Specialized Governmental Functions. We may use or disclose your PHI without your authorization for specialized governmental functions, as permitted by the Privacy Rule. Examples of this kind of disclosure are: (i) disclosure of PHI of military personnel for activities deemed necessary by military command authorities; and (ii) disclosure to authorized federal officials for lawful national security activities.

For Workers' Compensation. We may use or disclose your PHI without your authorization when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault, as permitted by the Privacy Rule.

For Care and Notification. We may use or disclose your PHI without your authorization to your family member, other relative or a close personal friend or other person you identify. Our disclosure will be limited to PHI that is directly relevant to your care or payment related to your care. This includes information about your location, general condition or death, as permitted by the Privacy Rule.

Incident to a Use or Disclosure Permitted by the Privacy Rule. We may make a use or disclosure of your PHI without your authorization if the use or disclosure is incidental to a use or disclosure otherwise permitted by the Privacy Rule. We will make reasonable efforts to limit PHI used and/or disclosed to the minimum necessary to accomplish the intended purpose of the use and/or disclosure. We have in place appropriate administrative, technical and physical safeguards to protect the privacy of your PHI.

Section 6. Your Rights Regarding Your PHI

Right to Request Restrictions on PHI Uses and Disclosures. You have the right to request that we restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or in payment for your care, as permitted by the Privacy Rule. However, we are not required to agree to your request.

Your request for restrictions must be in writing to the Plan's Privacy Contact or Office at the address below.

Right to Receive Confidential Communications. You have the right to request that we make certain communications of your PHI to you by alternative means or to alternative locations, if the Plan's traditional means of communication could endanger you. Your request for confidential communications of PHI must be in writing to the Plan's Privacy Contact or Office at the address below. Your request must include a statement that the disclosure of all or part of the information could endanger you.

Right to Inspect and Copy PHI. You have the right to request access to inspect or obtain a paper or electronic copy of certain types of PHI that the Plan has about you. We will use the format you request unless we cannot practicably do so.

Your request for access must be in writing to the Plan's Privacy Contact or Office at the address below. If you ask for a copy of the information, we may charge a fee for the costs of copying, mailing or other charges related to fulfilling your request.

We may deny your request for access to inspect or obtain a copy of your PHI in certain circumstances, as permitted by the Privacy Rule.

Right to Amend PHI. If you feel that your PHI that we have is incorrect or incomplete, you may ask us to amend your information.

Your request for an amendment must be in writing to the Plan's Privacy Contact or Office at the address below. Your written request must also specify the basis for the amendment.

We may deny your request for an amendment in certain circumstances, as permitted by the Privacy Rule.

Right to Receive an Accounting of PHI Disclosures. You have the right to receive an accounting of certain disclosures of your PHI that we have made.

Your request for an accounting of disclosures must be in writing to the Plan's Privacy Contact or Office at the address below. Your written request must specify the time period for which you are requesting an accounting. That time period may not be longer than six years from the date of your request. Your written request should state the format (paper, electronic, etc.) in which you want to receive your accounting. We may charge a fee for the costs of responding to more than one accounting request in a 12-month period.

We may deny your request for an accounting in certain circumstances, as permitted by the Privacy Rule.

Right to Receive Notification of Breaches. You have the right to be notified if any *"breach"* occurs involving your *"unsecured"* PHI. You will only receive notification if your unsecured PHI is used or disclosed in violation of the Privacy Rule.

Right to Obtain a Paper Copy of Notice. You have the right to receive a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please make your request in writing to the Plan's Privacy Contact or Office at the address below.

Section 7. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, write to the Plan's Privacy Contact or Office at the address below. Your complaint must be submitted in writing. You will not be retaliated against for filing a complaint.

Section 8. Plan's Contact Information

If you have any questions about the Plan's privacy practices or the information contained in this Notice, please **contact the Plan's Privacy Contact or Office** at:

Union Public Schools
8506 E. 61st Street
Tulsa, OK 74133-1926
ATTN: Jay Loegering,
Executive Director of Human Resources
(918) 357-6048

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.umr.com or by calling 1-800-207-3172. 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.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 person / $2,250 family In-network $2,250 person / $6,750 family Out-of-network	Generally, you must pay all 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 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/
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?	$5,000 person / $9,000 family In-network Unlimited person / Unlimited family 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?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover. ***Outpatient RX expenses do not apply to the Medical Out of Pocket Maximum***	Even though you pay these expenses, they don't count toward the medical out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-207-3172 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 (You will pay the least)	Out-of-network (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	$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	Specialist visit	$50 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	50% Coinsurance	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	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	None
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.medalistrx.com	Generic drugs (Tier 1)	$20 retail/ $40 mail order per prescription Maximum out-of-pocket $2,000 individual/ $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90-day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 25% coinsurance. Prescription benefits do not apply to medical only coverage. ***Coinsurance does not apply to the Generic or Biosimilar Drug Categories*** *Biosimilar medications available at the Generic Copay amount
	Preferred brand drugs (Tier 2)	$50 retail/ $100 mail order per prescription Maximum out-of-pocket $2,000 individual/ $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
	Non-preferred brand drugs (Tier 3)	$50 retail/ $100 mail order per prescription Maximum out-of-pocket $2,000 individual/ $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
	*Specialty drugs (Tier 4)	$50 Copay for <$1,000 Maximum out-of-pocket $2,000 individual/ $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you need immediate	Emergency room care	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
medical attention	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$60 Copay per visit; Deductible Waived office visits; 20% Coinsurance all other services	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$40 Copay per visit; Deductible Waived office visits; 20% Coinsurance other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	20% Coinsurance	50% Coinsurance	None
	Habilitation services	20% Coinsurance	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Hospice service	20% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	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 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
- Hearing aids

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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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. Additionally, a consumer assistance program may help you file

your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov 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 Standard? **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.

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	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$750
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,920**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
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*	$400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,000**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$750
Copayments	$50
Coinsurance	$400
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,210**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-207-3172.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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

UMR: UNION PUBLIC SCHOOLS ISD-009: 7670-00-415598 002

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.umr.com or by calling 1-800-207-3172. 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.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 person / $750 family In-network $750 person / $2,250 family Out-of-network	Generally, you must pay all 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 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/
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?	$3,000 person / $5,000 family In-network Unlimited person / Unlimited family 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?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover. ***Outpatient RX expenses do not apply to the Medical Out of Pocket Maximum***	Even though you pay these expenses, they don't count toward the medical out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-207-3172 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 (You will pay the least)	Out-of-network (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 Waived	50% Coinsurance	None
	Specialist visit	$25 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	50% Coinsurance	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)	10% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	50% Coinsurance	None
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.medalistrx.com	Generic drugs (Tier 1)	$10 retail/ $20 mail order per prescription Maximum out-of-pocket $1,000 Individual/ $2,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage. ***Coinsurance does not apply to the Generic or Biosimilar Drug Categories*** *Biosimilar medications available at the Generic Copay amount
	Preferred brand drugs (Tier 2)	$40 retail/ $80 mail order per prescription Maximum out-of-pocket $1,000 Individual/ $2,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
	Non-preferred brand drugs (Tier 3)	$40 retail/ $80 mail order per prescription Maximum out-of-pocket $1,000 Individual/ $2,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
	*Specialty drugs (Tier 4)	$40 Copay for <$1,000 Maximum out-of-pocket $1,000 Individual/ $2,000 Family	Covered upon request for reimbursement at appropriate pricing levels	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	10% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$50 Copay per visit; Deductible Waived office visits; 10% Coinsurance all other services	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	10% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; Deductible Waived office visits; 10% Coinsurance other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	10% Coinsurance	50% Coinsurance	None
	Habilitation services	10% Coinsurance	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	10% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Durable medical equipment	10% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Hospice service	10% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	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 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
- Hearing aids

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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov 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 Standard? 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.

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	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$250
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,420**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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*	$250
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,760**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$30
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$490**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-207-3172.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.