Ford WOODY Madill, OK

EMPLOYEE BENEFITS GUIDE

2025

BIRCHALL & HAMPTON, LLC

EMPLOYEE BENEFITS AND LIFE INSURANCE

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of benefits offered under your employer's benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. If the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment or termination without notice to or the agreement of any employee/participant.
All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.
*This guide may or may not be applicable to union employees.

BIRCHALL & HAMPTON, LLC

A PROFESSIONAL AGENCY WITH
PERSONAL SERVICE

BIRCHALLANDHAMPTON.COM

Our Company

Birchall & Hampton was formed in 1981 by Bill Birchall and Jim Hampton. Birchall and Hampton, LLC is a firm of proven professionals and caring and conscientious people; the kind of people you can depend on.

Service

We have a commitment to maintain a high standard of excellence in all that we do and to establish a firm relationship of mutual trust and service to each of our clients.

Table of Contents

Birchall & Hampton Contact.....4
Carrier Contact.....5
Benefit Guide & Rates.....6-9
UHC Summary of Benefits (HP3300).....10-16
UHC Summary of Benefits (P2000).....17-25
Patient Rights.....26-28
Glossary of Terms.....29-32
Principal Dental.....33-36
Principal Vision.....37-39
Principal Life & LTD Policies.....40-43
COBRA Notice.....44-46
Medicare Part D Notice.....47-49
UHC Flyers.....50-58

Birchall & Hampton Contact

Jim Hampton Owner / Broker	405-528-3360	Jim@birchallandhampton.com
Dana Nursick Broker	405-962-0393	Dana@birchallandhampton.com
Jason Arnold Broker/Sales	405-528-3361	Jason@birchallandhampton.com
Kim Arnold Broker/Claims	405-962-0392	Kim@birchallandhampton.com
Cindy Smith Account Manager	405-962-0391	Cindy@birchallandhampton.com
Heather Bennett Office Manager	405-528-3360	Heather@birchallandhampton.com

Carrier Contact

Carrier	Benefit	Group #	Phone	Website/Email
UHC	Medical	1685245	866-801-4409	uhc.com
Principal	Dental, Vision, Life	1143025-10001	800-843-1371	principal.com

Woody Ford
Benefit Guide
08/01/2025 to 07/31/2026

Welcome to your Employee Benefits
Your employer has been diligent in searching for a benefits package that helps you achieve the best fit for your family's insurance needs.

While you review this packet, please remember that the choices you make affect your health and financial well-being. As a smart consumer, you should speak with your physician about generic drugs and treatment options.

You are eligible for the benefits package if you meet the definition of an eligible full-time employee and you have satisfied the required waiting period.

Any elections and/or changes made now will remain in effect until the next open enrollment period unless you or your family experience a qualifying event, such as:

·Loss of eligibility of a covered dependent
·Death of your covered spouse or child
·Birth or adoption of a child
·Marriage, divorce, or legal separation
·Switch from part-time to full-time employment status
·Loss or gain of coverage through another plan

If you have a qualifying event, contact HR within 30 days of the event. If you do not enroll for coverage for yourself or your dependents without having other coverage, you will not be able to enroll in this plan until open enrollment next year unless you experience one of these qualifying events. We ask that you please choose the coverage that is best for you and your family. Be sure to return forms to your manager.

BENEFIT BASICS

WHO IS ELIGIBLE AND WHEN?

Employee Eligibility

If you are a regular, full time employee, you and your eligible dependents are eligible to enroll in the benefits described in this guide. New hires will become eligible for benefits on their date of hire.

If you do not enroll within 30 days of your date of hire, you will not be eligible to enroll for coverage until the next annual open enrollment.

Dependent Eligibility

In most cases, you may also cover your eligible dependents, including:

- Your legal spouse
- Eligible dependents under the age of 26
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability bay be requested and disability has to have occurred prior to age 19.
- Children are defined as: 1) your natural children; 2) stepchildren; 3) legally adopted children; 4) children under your legal guardianship (documentation required).
- A child's coverage will terminate at midnight on the last day of the month in which they turn 26.
- If your child is no longer eligible, you must notify Human Resource Dept.
- A child who has been legally placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, including a foster child (documentation required).

To add a new spouse and/or dependent to your benefit coverage outside of the annual open enrollment period, you must notify Human Resource Department, by completing and returning a Benefits Election/Change Form and proof of the change within 31 days of the qualifying event.

A change in family status includes:

- Marriage or divorce
- Birth, adoption (or placement for adoption)
- Death of a spouse and/or dependent
- Your change in employment, from eligible to ineligible status or vice-versa
- Your spouse's loss/gain of coverage due to a change in their employment status or employer's open enrollment
- Your dependent's loss of eligibility because he/she has reached age 26
- Any other change that is permissible under IRS regulations and rulings as determined by your employer

Rates

Effective 08/01/2025, your medical insurance will be with UHC, and your dental, vision, and life insurance will be with Principal.

Woody Ford will pay 65% of the HP3300 medical plan and they will pay 50% of the P2000 medical plan. Woody Ford will provide $25,000 Basic Life and $25,000 AD&D for each employee. Additional Voluntary Life is available for employee, spouse, and children. Dental and Vision are voluntary benefits.

See additional sheet for cost of coverage on next page.

Woody's
Rates 8-1-25 to 7-31-26

	Monthly Premium	Monthly Employee Portion	Semi-Monthly Payroll Deduction	Bi-Weekly Payroll Deduction
Plan HP33002575i80x25B				
Employee Only	$564.44	$197.55	$98.78	$91.18
Employee & Spouse	$1,141.32	$774.43	$387.22	$357.43
Employee & Children	$1,036.44	$669.55	$334.78	$309.02
Employee & Family	$1,665.77	$1,298.88	$649.44	$599.48
Plan P2000i80LX21B				
Employee Only	$676.72	$338.36	$169.18	$156.17
Employee & Spouse	$1,377.11	$1,038.75	$519.38	$479.42
Employee & Children	$1,249.77	$911.41	$455.71	$420.65
Employee & Family	$2,013.82	$1,675.46	$837.73	$773.29
Principal DENTAL				
Employee Only	$31.69	$31.69	$15.85	$14.63
Employee & Spouse	$63.41	$63.41	$31.71	$29.27
Employee & Children	$79.25	$79.25	$39.63	$36.58
Employee & Family	$120.61	$120.61	$60.31	$55.67
Principal Vision				
Employee Only	$5.66	$5.66	$2.83	$2.61
Employee & Spouse	$12.40	$12.40	$6.20	$5.72
Employee & Children	$8.99	$8.99	$4.50	$4.15
Employee & Family	$16.39	$16.39	$8.20	$7.56

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-797-8812 or visit myuhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,300** Individual / **$6,600** Family Out-of-Network: **$6,400** Individual / **$12,800** Family per year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$7,500** Individual / **$15,000** Family Out-of-Network: **$15,000** Individual / **$30,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-877-797-8812 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	50% coinsurance	Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery.
	Specialist visit	$75 copay per visit	50% coinsurance	If you receive services in addition to office visit, additional copays or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	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	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at myuhc.com	Tier 1 - Your Lowest Cost Option	Retail: $10 copay Mail-Order: $25 copay Specialty Drugs: $10 copay	Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply. Specialty: Up to a 31 day supply. Specialty drugs are not covered through mail order. One retail copay applies per 31-day retail prescription. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out of network pharmacy, you may need to pay the cost up front, submit for reimbursement, and may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your plan being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit.
	Tier 2 - Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $87.50 copay Specialty Drugs: $150 copay	Retail: $35 copay Specialty Drugs: $150 copay	
	Tier 3 - Your Mid-Range Cost Option	Retail: $70 copay Mail-Order: $175 copay Specialty Drugs: $350 copay	Retail: $70 copay Specialty Drugs: $350 copay	
	Tier 4 - Your Highest Cost Option	Retail: $150 copay Mail-Order: $375 copay Specialty Drugs: $500 copay	Retail: $150 copay Specialty Drugs: $500 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay per visit then 20% coinsurance	*$300 copay per visit then 20% coinsurance	*Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$50 copay per visit	50% coinsurance	Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to Urgent care visit, additional copays or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copay per visit	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance
	Inpatient services	20% coinsurance	50% coinsurance	None
If you are pregnant	Office Visits	Primary Care Visit: $25 copay per visit Specialist Visit: $75 copay per visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i. e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization may apply out-of-network or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 30 visits per year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	20% coinsurance	50% coinsurance	30 combined visits per year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per year, combined with inpatient rehabilitation and residential treatment. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery • Cosmetic Surgery • Dental Care • Glasses	• Infertility Treatment • Long Term Care • Non-emergency care when traveling outside - the US • Private duty nursing	• Routine Eye Care • Routine foot care - Except as covered for Diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture Services - 10 visits per year	• Chiropractic (manipulative care) - 20 visits per year	• Hearing aids - Limited to $5,000 every 36 Months

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Insurance Department at 800-522-0071 or visit https://www.oid.ok.gov/consumers/.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-797-8812.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-797-8812.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-797-8812.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-797-8812 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-797-8812.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-797-8812.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-797-8812.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-797-8812.

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

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com.

About these Coverage Examples:

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

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

The plan's overall deductible	**$3,300**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**$3,300**
Copayments	**$10**
Coinsurance	**$1,600**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$4,970**

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

The plan's overall deductible	**$3,300**
Specialist copayment	**$75**
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	**$1,700**
Copayments	**$0**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	**$3,300**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**$2,800**
Copayments	**$0**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,800**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-797-8812 or visit myuhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,000** Individual / **$6,000** Family Out-of-Network: **$6,000** Individual / **$12,000** Family per year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,500** Individual / **$13,000** Family Out-of-Network: **$12,000** Individual / **$24,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-877-797-8812 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply	50% coinsurance	Under age 19 - Network visits are covered at No Charge. Virtual Visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$75 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	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	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at myuhc.com	Tier 1 - Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply. Specialty Drugs: $10 copay, deductible does not apply.	Retail: $10 copay, deductible does not apply. Specialty Drugs: $10 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply. Specialty: Up to a 31 day supply. Specialty drugs are not covered through mail order. One retail copay applies per 31-day retail prescription. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out of network pharmacy, you may need to pay the cost up front, submit for reimbursement, and may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your plan being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.
	Tier 2 - Your Mid-Range Cost Option	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply. Specialty Drugs: $150 copay, deductible does not apply.	Retail: $35 copay, deductible does not apply. Specialty Drugs: $150 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 copay, deductible does not apply. Mail-Order: $187.50 copay, deductible does not apply. Specialty Drugs: $350 copay, deductible does not apply.	Retail: $75 copay, deductible does not apply. Specialty Drugs: $350 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Retail: $250 copay, deductible does not apply. Mail-Order: $625 copay, deductible does not apply. Specialty Drugs: $500 copay, deductible does not apply.	Retail: $250 copay, deductible does not apply. Specialty Drugs: $500 copay, deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	$300 per occurrence copay applies prior to the overall deductible. *Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$50 copay per visit, deductible does not apply	50% coinsurance	Virtual Visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copay per visit, deductible does not apply	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance
	Inpatient services	20% coinsurance	50% coinsurance	None
If you are pregnant	Office Visits	Primary Care Visit: $25 copay per visit, deductible does not apply Specialist Visit: $75 copay per visit, deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i. e. ultrasound).

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization may apply out-of-network or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 30 visits per year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	20% coinsurance	50% coinsurance	30 combined visits per year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per year, combined with inpatient rehabilitation and residential treatment. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery • Cosmetic Surgery • Dental Care • Glasses	• Infertility Treatment • Long Term Care • Non-emergency care when traveling outside - the US • Private duty nursing	• Routine Eye Care • Routine foot care - Except as covered for Diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture Services - 10 visits per year	• Chiropractic (manipulative care) - 20 visits per year	• Hearing aids - Limited to $5,000 every 36 Months

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Insurance Department at 800-522-0071 or visit https://www.oid.ok.gov/consumers/.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-797-8812.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-797-8812.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-797-8812.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-797-8812 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-797-8812.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-797-8812.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-797-8812.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-797-8812.

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

* For more information about limitations and exceptions, see the plan or policy document at myuhc.com.

PATIENT PROTECTION NOTICE

BCBS generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

► All states of reconstruction of the breast on which the mastectomy was performed;
► Surgery and reconstruction of the other breast to produce a symmetrical appearance;
► Prostheses, and
► Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its' "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a State Children's Health Insurance Program.

New Dependent by Marriage, Birth Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a State Children's Health Insurance Program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the Human Resources Department.

MICHELLE'S LAW

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under the Group Health Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the Group Health Medical Plan but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the Group Health Medical Plan and was enrolled as a student at a post secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's Law. Please contact Human Resources.

NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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 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 (1-877-543-7669) 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.

You may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility at https://oklahoma.gov/ohca.html

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an **emergency medical condition**.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

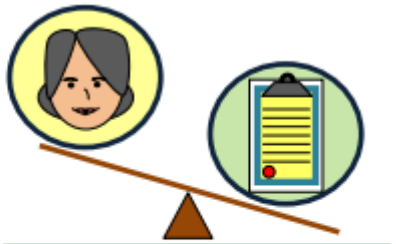
Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

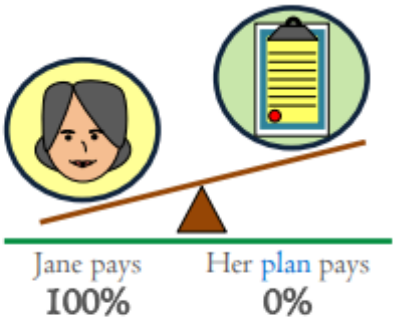
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

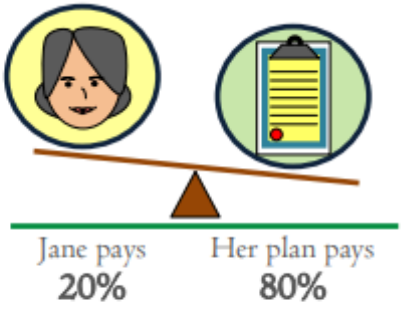
Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

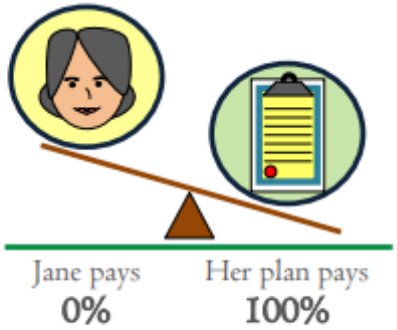
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Policyholder: TYLOFRANK INVESTMENTS

Group voluntary dental insurance
Benefit summary for
all members
Your coverage renews every August 1
This summary was created on 07/02/2024 and shows benefits available at that time.

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policypays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%
Orthodontia	$0	$0	50%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your in-network deductiblesfor basic and major services are combined. Your out-of-network deductibles for basic and major are combined. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Combined maximum	Yourcalendar yearyear maximum for basic and major in-network services are combined. Yourcalendar yearyear maximum for basic and major out-of-network services are combined. In-networkcalendar yearyear maximums are $1,500 per person or out-of-networkcalendar yearyear maximums are $1,500 per person. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Orthodontia lifetime maximum	$1,500 PPO in-network maximum / $1,500 PPO out-of-network maximum			
Preventive passport	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees can't purchase.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year(covered only for dependent children under age 14)
Sealants	Covered only for dependent children under age 14; once per tooth each36 months

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Harmful habit appliance	Covered only for dependent children under age14

Major	
Crowns	Each 84 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 84 months per tooth
Implants	Each 84 months per tooth
Bridges	84 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Orthodontia	
Coverage	For you and your dependents.

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 99th percentile of the usual and customary charges.
Preventive passport	Benefits paid for preventive services will not be applied to your annual benefit maximum
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth provision –This means the initial placement of bridges, partials, dentures, and implant services to replace teeth missing before this coverage starts may not be covered. If the policy your employer purchased replaces coverage with another carrier, continuous coverage under the prior plan may be applied and you may be eligible for coverage to replace teeth missing before this coverage started. Your effective date with your current employer, along with the employer's effective date with Principal are used to determine coverage. MIssing tooth provision doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information. We strongly recommend submitting a predetermination to determine benefits.

What are the restrictions of my coverage?

Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 2) Ortho treatment has been continued while insured under this policy. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

There are additional limitations to your coverage. A complete list is included in your booklet.

Principal®

principal.com

This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issuedby Principal Life Insurance Company,711 HighStreet,Des Moines,IA 50392

Policyholder: TYLOFRANK INVESTMENTS

Group voluntary vision Benefit summary for all members
Your coverage renews every August 1 This summary was created on 07/02/2024 and shows benefits available at that time.

What's available to me?

Vision insurance is offered through Principal® and VSP® Vision Care. It provides choice, flexibility and savings through a VSP doctor.
If you buy this coverage, an established network of VSP doctors will provide quality care for you and your dependents.

VSP choice network	
Exams	Every 12 months, one exam is covered in full after $10 copay
Prescription glasses Lenses - 1 pair covered every 12 months Frames - covered up to $150 every 24 months; 20% off amount over allowance1	$25 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses • Polycarbonate lenses for dependent children under age 18
Lens enhancements	Standard progressive lenses covered once every 12 months with a $0 copay[1] Most other popular lens enhancements are covered after a copay, saving our members an average of 30%[1]
Elective contacts	Covered up to $150 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evaluation	Up to $60 copay
Necessary contacts	Covered in full after $25 copay every 12 months Contact lenses can be chosen instead of glasses.

[1]This can vary based on state laws and provider location Savings may not apply at participating retail chains.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees can't purchase.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period.
- If you're covered, you may buy coverage for your dependents.

Additional eligibility requirements may apply.

What's thedifference betweenelectiveand necessary contacts?

- Elective - when vision can be corrected by glasses, but contacts are worn.
- Necessary - when vision can't be corrected with glasses due to extreme vision problems.

Why am I charged anadditionalcopay for contactfitting andevaluation?

- Contact lens wearers require an additional evaluation of the eyes' measurements, and possible follow-up appointments, for fitting and training on proper use of contact lenses.
- For these additional services, you won't pay more than $60 at in-network providers.

Are benefits the same for all VSP doctors?

- Yes, with the exception of Costco®, Walmart®, and Sam's Club®. The frame allowance at these locations is $80 which is equivalent to a $150 allowance at other VSP doctor locations. Not all providers at participating retail chains are in-network for exam services.
- Benefits may also vary by location due to state law.

How doI find aVSP doctor?

- Visit vsp.com to locate VSP doctors close to you -- or to see if your current eye care professional is in the VSP network.
  - o You'll need to choose the "Choice" doctor network to view the VSP doctors for your coverage.
- Call 800-877-7195.

WillI getanID card?

- Yes, your card will have a unique member ID that your doctor will use to verify benefits.

Willmy doctor submitmy claim?

- If you're seeing a VSP doctor, they'll submit the claim for you.
- If you're seeing someone outside the VSP network, you're responsible for submitting your own claim. You can get that form from vsp.com after logging in as a member using your member ID. Or call 800-877-7195.

Are there any additional savings with VSP?

- Glasses and sunglasses - you can save an average of 20-25% off glasses or sunglasses from any VSP doctor within 12 months of your last covered vision exam.
- Laser vision correction - you pay an average of 15% off the regular price and 5% off the promotional price. You'll only receive these discounts from contracted clinics. Go to VSP.com and register using your member ID to see the laser vision promotions and find a contracted clinic.

These savings can vary based on state laws and provider location.

What benefits do I receive if my doctor is outside VSP's network?

Covered charges	Benefit	Frequency
Exams	Up to $45	Once every 12 months
Single lenses	Up to $30	One pair every 12 months
Lined bifocal lenses	Up to $50	One pair every 12 months
Lined trifocal lenses	Up to $65	One pair every 12 months
Lenticular lenses	Up to $100	One pair every 12 months
Frames	Up to $70	One set every 24 months
Elective contacts	Up to $105	Contacts are instead of frames and lenses
Necessary contacts	Up to $210	Contacts are instead of frames and lenses

What are the limitations of my benefits?

- Visual analysis or vision aids that aren't medically necessary aren't covered.
- No benefits will be paid for:
  - Non-prescription glasses
  - Medical or surgical treatment of the eyes
  - Claims submitted by a doctor who is part of your family

Once enrolled, you'll receive a booklet with more details regarding your plan limitations and exclusions.

Policyholder: TYLOFRANK INVESTMENTS

Group term life insurance

Benefit summary for all members

Your coverage renews every August 1.

This summary was created on 07/02/2024 and shows benefits available at that time.

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Guaranteed issue[1]	Benefit reduction[2]
You	$25,000	If you're under 70: $25,000 If you're 70 or older: The lesser of $25,000 or the amount with the prior carrier	35%reduction atage65,with an additional 15%reduction atage70

[1]Amount of coverage you may buy within 31 days of initial eligibility for coverage without providing health information.

[2]As you get older, your life insurance benefit amount decreases. Age reductions apply to the benefit amount after providing health information.

Whoreceives coverage?

•You'll receivecoverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.

oIf you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.

Additional eligibility requirements may apply.

DoI need to provide healthinformation?

Benefit amounts up to the guaranteed issue shown in the table above won't require health information.

Whatbenefits does AccidentalDeathand Dismemberment(AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%

Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000
Repatriation - If you die at least 100 miles from your home	Up to $2,000
Education - If your children are enrolled in an accredited post-secondary school at the time of your death	$3,000/year for up to 4 years
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

The benefit summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Principal®

principal.com

This is a summary of group term life coverage insured by or with administrative services provided by Principal Life Insurance Company®. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Save money. Improve your life.

Use discounts and services available through your group benefits. **These discounts are not insurance**.

Laser vision correction	**Imagineyourlifefreefromglassesandcontacts.**You,yourspouse,anddependentchildren save$800withfeaturedprovidersLasikPlus,TLCLaserEyeCenters,orTheLASIKVision Institute.Orreceive15%offstandardpricingor5%offpromotionalpricingonLASIKthrough the National Lasik Network's 600 locations. Administered by LCA Vision. principallasik.com | 888-647-3937
Hearingaid program	**Protectyourhearinghealthtoimproveyourqualityoflife.**You,yourspouse,children,parents, andgrandparentscangetdiscountsupto48%offhearingaids,includingrechargeableand Bluetooth options, with a 60-day trial to ensure full satisfaction. You can also receive a free hearing consultation at any of the 3,000+ locations nationwide. Administered by Start Hearing. www.starthearing.com/partners/principallife | 877-890-4694
Emotional health support line	**Gethelpwhenyou'refeelingoverwhelmedorneedsupport.**You,yourspouse,and dependentchildrencancallthisfree,confidentialsupportline24/7toreachlicensedbehavioral healthclinicianswhocanprovideemotionalsupport,tipsforcoping,andreferralstolocal resources. If your employer offers an employee assistance program (EAP), use it instead. 800-424-4612

Available with your dental insurance

Principal oralhealth center	**Getinformationtomakebetteroralhealthcaredecisions.**Submitadentalcarequestionandget aresponsefromadentistin48hours.Usethecostestimatortofindapproximatedentalcarecosts, andaccessarticlesaboutdentalhealthtopics. http:// c3.go2dent al.com/ scontent/
Teeth whitening	**Share a smile you can be proud of.** You, your spouse, and dependents can save 20% on a dentist-invented teeth whitening technology from GLO Science. Available for home use, it's fast and sensitivity-free so you can smile with confidence. gloscience.com/principal and use discount code PRINCIPAL
Oral care products	**Help your smile be as healthy as possible.** Buy one and get one free--choose from the Z Dental sonic pulse toothbrush or the Z Dental water flosser. myzsonic.com/principal and use coupon code PRINCIPAL

Available with your life insurance

Travel assistance	**Ease some of the worriesof traveling—whether inthe U.S.or internationally.**You, your spouse, and dependent children haveaccess to avarietyofbenefits provided through AXA Assistance1. These services include travel and medical assistance plus emergency medical evacuation benefits. Assistanceis availablefor travel100+ miles awayfrom homefor up to 120consecutivedays. Availablewith group term lifeinsuranceonly. principal.com/travelassistance
Will &Legal Document Center	**Consider preparingyour simple legal documentsonline.** Theseonlineresources and tools, provided by ARAG®2, are easy-to-use. You and your spouse can prepare, print, and store essential legal documents — such as a will, living will, healthcare power of attorney, durable power of attorney, and medical treatment authorization for minors. Plus, you can access estate planning tools and resources, and a personal information organizer. principal.araggroup.com Enter your group policy number: 1143025
Identity theft kit	**Be proactive in protecting one of your most important assets—your identity.** If your identity is stolen, despite your best efforts, you'll get valuable tips on how to restore it. principalaraggroup.com Enter your group policy number: 1143025
Beneficiary support	**Get help coping with the death of a loved one.** Beneficiaries receive help coping with the emotions and financial decisions that surface when a loved one dies. Services include grief support from Magellan Healthcare and financial review from Principal®. Spouses and dependents receive three months of free online will preparation services provided by ARAG®2 Information is provided after the loss of a loved one.

principal.com

Insurance products issued by Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, IA 50392. Thediscounts and services listed hereareavailableto members, and/or their dependents or beneficiaries, with group coverage underwritten byor with administrativeservices provided byPrincipal LifeInsuranceCompany. Thediscounts and services arenot apart ofthepolicyor contract and maybechanged or discontinued at anytime.

For group lifeand dentalpolicies issued in New York: travel assistance, Will& LegalDocument Center, identitytheft kit, emotionalhealth support line, beneficiarysupport, teeth whitening , and oralcareproducts arenot available; laser vision correction and hearing aid program areonlyavailablewith dentalor vision insurance. ARAG Services, LLC, AXA AssistanceUSA, Inc., LCA Vision, Magellan Healthcare, Magellan Health Services ofCalifornia, Inc.—Employer Services, Start Hearing, and VSP arenot affiliated with any company of the Principal Financial Group®. Third party providers aresolelyresponsiblefor their products and services.

[1] Participants areresponsiblefor anyincurred fees or expenses. Indemnified transportation services areadministered byAXA AssistanceUSA, Inc. and underwritten byathird party licensed insurancecompany.

2 Theuseoftheservices provided byARAG Services, LLC should not beconsidered as asubstitutefor consultation with an attorney. Neither your employer nor Principal® is responsible for any loss, injury, claim, liability, or damages related to theuseof theARAG legaldocument s er vice.

GP58554C-20(SP1285C)|05/2024|3608045-062024|©2024PrincipalFinancialServices,Inc.

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance

Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Jennifer Williams
Tylofrank Investments, LLC
201 S. 2nd Street
Madill, OK 73446
580-795-3323

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Important Notice from Tylofrank Investments, LLC 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 Tylofrank Investments, LLC, 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 at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a 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. Tylofrank Investments, LLC has determined that the prescription drug coverage offered by your group plan through United HealthCare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your existing group coverage with United HealthCare will not be affected. You may keep this coverage, and benefits will be coordinated with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current group coverage with United HealthCare, be aware that you and your dependents will be able to get this coverage back, during an open enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with United HealthCare and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current Prescription Drug Coverage…

Contact Birchall and Hampton at 405-962-0392.

NOTE: You'll get this notice each year. You will also get it before the next period you

can join a Medicare drug plan, and if this coverage through United HealthCare of Oklahoma changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

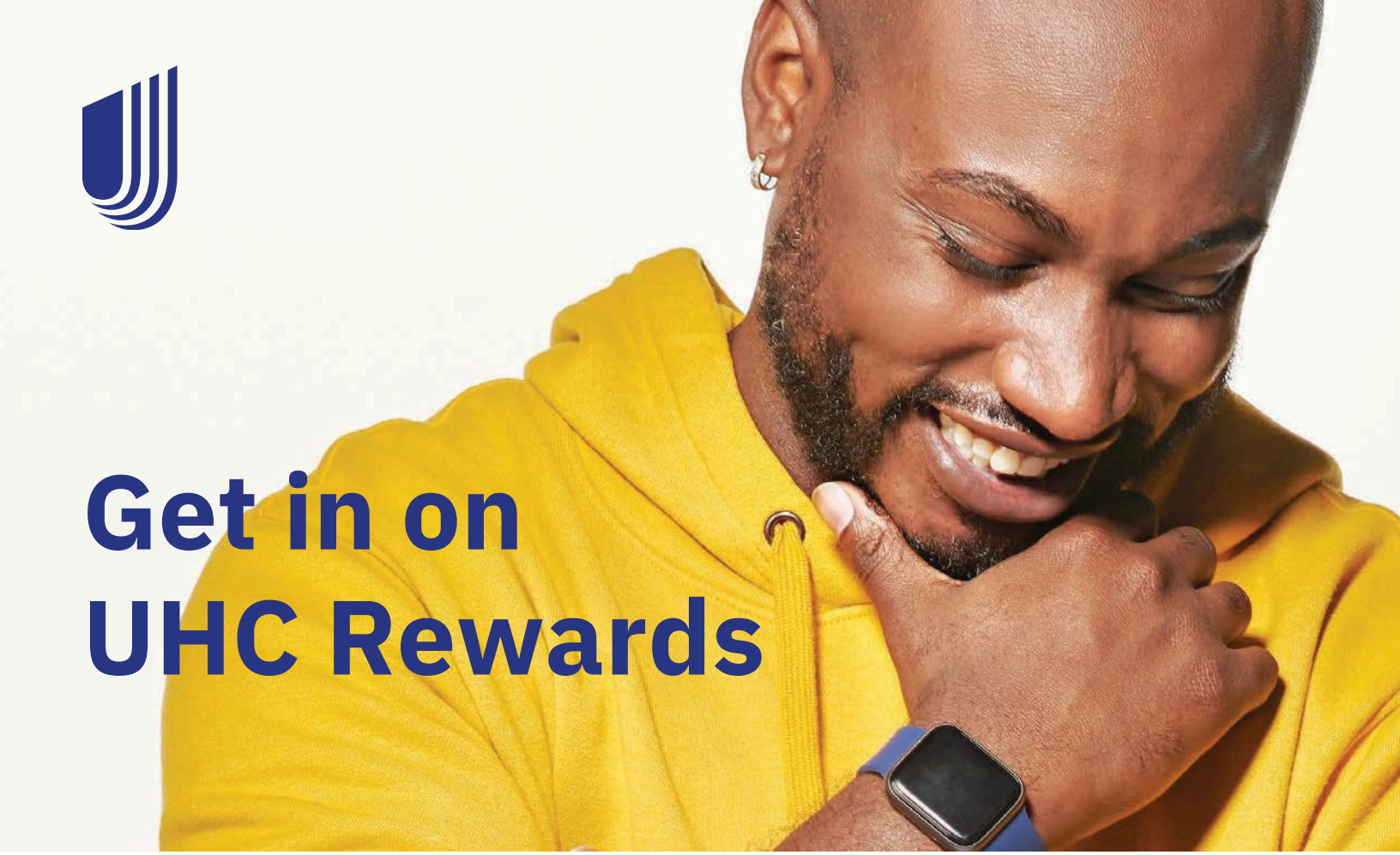
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325- 0778).

Remember: Keep this Creditable Coverage 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Tylofrank Investments, LLC
201 S. 2nd Street
Madill, OK 73446



Get in on UHC Rewards

Good news — your health plan comes with a new way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions — including many things you may already be doing — lead to rewards. The activities you go for are up to you — same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day,

  or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you — and look for new ways of earning rewards to be added throughout the year.

Earn up to
$300

continued

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Menu** tab and choose **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you — and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 and use it however you want

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

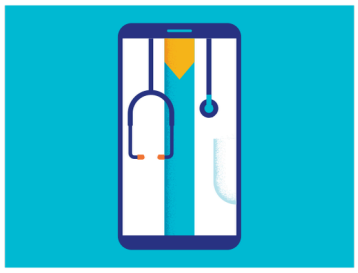
Level Funded Wellness

Get started with Level Funded Wellness, programs included in your health plan and designed to help you with a healthier lifestyle — all at no extra cost to you.

Motion

Rewards for meeting program walking goals

Use a wearable activity tracker to track steps, reach goals and earn rewards



HealthiestYou™ Virtual Care

Virtual care from your mobile device or computer

Talk with medical doctors who can diagnose, treat and prescribe medication

24/7 Virtual Visits

Connect with a doctor 24/7

Speak to a doctor by phone* or video when you want care — anytime, anywhere

Rally

Your personalized health journey

Complete a health survey, choose and complete missions, join and complete challenges and earn rewards

* Data rates may apply.

Earn rewards with Motion

With UnitedHealthcare Motion®, every step moves you closer to hitting program goals and earning rewards. All you have to do is sign up, slip on a tracker and get moving — no gym required. With Motion, you get a wearable activity tracker and a set of 3 daily goals. Meet the goals, and you may earn rewards every day — up to $1,095* a year.

Get started

Visit **unitedhealthcaremotion.com** to set up your account.

Download the UnitedHealthcare Motion app.

Get moving

Step 1:

Simply put on your activity tracker in the morning.

Step 2:

Sync your tracker to your personal account. It will regularly send your information to a secure place online.

Step 3:

Check your progress regularly and track your earnings at **unitedhealthcaremotion.com** or on the Motion app.

*Or $1,150 if not applying registration credit toward an activity tracker.

Get rewards

Motion rewards you for meeting 3 daily goals. This may maximize your health benefits and helps you get FIT.

	Daily goal	Potential benefits	Reward
F	**Frequency** 6 brief walks over the course of a day, at least 1 hour apart. (For each walk, need 300 steps within 5 minutes.)	May reduce risk factors for metabolic and cardiac health	$1
I	**Intensity** 1 brisk walk of 3,000 steps within 30 minutes or 30 minutes performing other eligible activities.	May reduce risk factors for cardiovascular, metabolic, bone and mental health conditions, as well as cancer	$1
T	**Tenacity** At least 10,000 steps in a day. (The activity devices will reset at midnight local time.)	May increase energy expenditures and can help manage weight	$1
	Participation 2,500+ steps per day with no FIT rewards.	May encourage those who do not regularly hit their FIT goals to continue being active	$.25
	Total possible per day		**$3.00**

When you get FIT every day, you and your covered spouse may each earn up to $1,095* per calendar year. We'll help you get started by giving you $55 just for registering at **unitedhealthcaremotion.com**. You can use the credit toward an activity tracker — or if you already have a compatible tracker, you can save the credit for reimbursement of your out-of-pocket medical expenses.

Key features:

- Plan participants and eligible spouses may be reimbursed up to $1,095* or 30% of the cost of plan participant-only coverage (or family coverage if dependents are covered) for available incentives under all programs combined as applicable, whichever is less, each calendar year
- Quarterly reimbursements for expenses are applied to the out-of-pocket limit calendar year spend
- 50% calendar year rollover of unreimbursed rewards for those on a non-HSA plan
- $55 registration credit can be used toward purchase of an activity tracker or saved for quarterly reimbursements. The unused credit will be deposited into the plan participant's HSA (if plan participant has this set up).

Considerations:

- Point tracking does not start until after your effective date
- Every quarter, all earned credits will be deposited into your health savings account (HSA) to be used at your discretion, or you may elect to receive a gift card**
- Plan participants and spouses on a high deductible health plan are required to provide UnitedHealthcare Motion with their HSA bank information at the time of registration to receive reimbursement

HSA contribution limits for 2021: Plan participants are responsible for ensuring that they do not exceed the 2021 HSA contribution limits imposed by the IRS. For 2021, the maximum contribution is $3,600 for individual coverage and $7,200 for family coverage. If you are age 55 or older, you may be eligible for an additional $1,000 catch-up contribution. Please seek your own tax advice.

Questions about Motion

Call **1-855-256-8669** | Email **unitedhealthcaremotion@uhc.com**

*Or $1,150 if not applying registration credit toward an activity tracker.
**Gift cards are generally taxable. Please seek your own tax advice.

Get well. HealthiestYou virtual care.

Virtual care from your mobile devices!

HealthiestYou – Your one-stop shop for all things virtual healthcare. All 4 services are available to all family members in your household, even those not taking medical coverage with UnitedHealthcare Level Funded. HealthiestYou may help you save time, money and avoid unnecessary in person doctor visits for non-life threatening illnesses. Doctors may prescribe medication when necessary as well.

Your virtual care services include:

General medical

Consult with a doctor 24/7 in all 50 states for minor illnesses (cold, flu, sinus infection, pink eye, UTI, allergies, etc.)

Dermatology

Communicate with a Dermatologist through the HealthiestYou app via message center for skin conditions (acne, eczema, shingles, psoriasis, etc.)

Mental Health

Connect with a psychiatrist/therapist for support for anxiety, stress, depression, family difficulties, etc. (For 18+ only)

Back/neck care

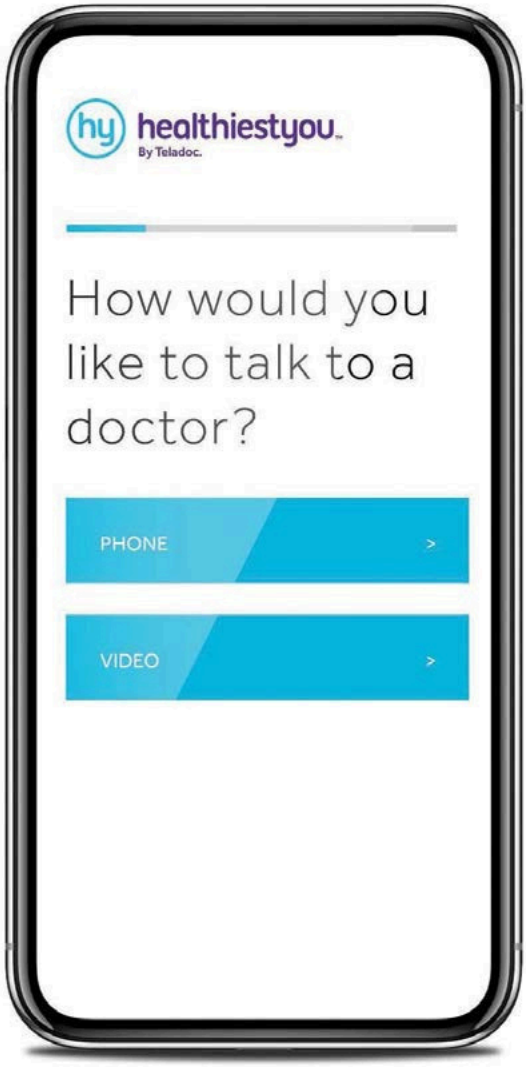
Get help to relieve your back and neck pain through guided videos with a certified health coach

HealthiestYou Expert Medical Services

If you're dealing with a difficult diagnosis or questioning a treatment plan, you need to be sure. Have your medical case reviewed at no additional cost to you by a leading expert and get a second opinion on conditions like cancer, orthopedic problems, digestive system issues, chronic illnesses and more.

1. **Contact HealthiestYou** via app or phone
2. **Provide details** about your medical history
3. **Get results and recommendations** in a personalized report at no additional cost

1- 866 -703 -1259



Download the app to connect to doctors by phone or video 24/7, shop the lowest cost prescriptions, and much more

1. **Download the app**
   Search "HealthiestYou" in the app store or on Google Play
2. **Set up your account**
   Once you've downloaded the app, select "Register," then choose "Employee" as your membership type
3. **Enter basic contact information**
   Type in your last name, date of birth, and ZIP code
4. **Type in your security information**
   Enter a valid email address, password, the best number for our doctors to reach you, your preferred language, and accept terms and conditions

Questions about HealthiestYou virtual care?

Do you have a question on how to set up the member website? Need help downloading or using the app? We're happy to help. Contact us using the information below.

Call: 1-866-703-1259 | **Send us an email at: help@healthiestyou.com**

HealthiestYou.com
Download the app.

Search "HealthiestYou" in the App Store® or Google Play® to download.

Download on the App Store | GET IT ON Google Play

See a doctor 24/7 with Virtual Visits

24/7 Virtual Visits let you and your covered family members connect with a doctor whenever you want care — from anywhere. Care is at your fingertips on **myuhc.com®** or the UnitedHealthcare® app — and you can choose a phone or video visit.

With 24/7 Virtual Visits, doctors can diagnose a wide range of common medical conditions — and even may prescribe medications, if needed.**

Through your UnitedHealthcare Level Funded plan, your cost for a 24/7 Virtual Visit is $0.***

Get started

Visit **myuhc.com/virtualvisits** or download the UnitedHealthcare app.

To register by phone, call **1-855-615-8335**.

When you request your visit, you can choose to speak to a doctor on the phone or have a video visit.

Use 24/7 Virtual Visits for common, nonemergency conditions like:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- And more

Questions about Virtual Visits

See the 24/7 Virtual Visits FAQ on **myuhc.com** or call the member number on your health plan ID card

** Certain prescriptions may not be available, and other restrictions may apply.
*** The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Download on the App Store GET IT ON Google Play

Reach healthier goals with Rally

Rally® encourages a healthier lifestyle and is designed to help you make changes to your daily routine, set goals and track your progress all to help encourage a healthier lifestyle. You'll get fun, personalized recommendations to help you move more and eat better, which may improve your health.

See your Rally Age

Start by taking an interactive health survey to see your Rally Age, that may help you assess your health. Based on your Rally Age, you'll get personal recommendations called "missions" to help you reach your health goals.

Take on a challenge

Use the Rally app to track your activity and compete with other Rally participants to earn extra rewards.

Accept your missions

Missions are custom-picked activities designed to help you eat better, and get active. Choose the missions you want to work on and level up to more challenging missions when you're ready.

Earn rewards

You'll earn Rally coins for completing your health survey, missions and challenges — even just for logging in once a day. You can use the coins to enter drawings for chances to earn rewards, get discounts or trigger a donation to a charity.

Get started

Register at **werally.com/client/allsavers/register** | Access Rally anytime at **werally.com** or **r**

For questions about registration, call us at **1-844-334-4944**

Questions about Rally

Visit our support page **rally-support.force.com/customer**
Email the Rally support team **support@werally.com**