**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, www.healthchoiceok.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.healthchoiceok.com or call 1-800-752-9475 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Combined medical and pharmacy deductible of $1,750 individual/ $3,500 family must be met before benefits are paid. Does not apply to preventive care. | 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 and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network providers and pharmacy combined out-of-pocket limit $6,000 individual/$12,000 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?** | Out-of-network provider charges, premiums, balance billing charges, health care this plan doesn't cover, and amounts above maximum benefit limitations. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.healthchoiceok.com or call 844-804-2642 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 | 100% until the deductible is met. $30 copay/visit after deductible. | 50% coinsurance | Charges other than for an office visit apply to deductible and coinsurance. Balance billing applies to out-of-network provider claims. |
| | Specialist visit | 100% until the deductible is met. $50/copay visit after deductible. | 50% coinsurance | |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | Balance billing applies to out-of-network provider claims. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. Balance billing applies to out-of-network provider claims. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.healthchoice.com | Generic drugs | $10 copay 30-day supply/$25 copay 31- 90 day supply/ prescription) | 50% prescription | See plan handbook for details. |
| | Preferred drugs | $45 copay 30-day supply/$90 copay 31- 90 day supply/ prescription | 50% prescription | See plan handbook for details. |
| | Non-preferred drugs | $75 copay 30-day supply/$150 copay 31- 90 day supply/ prescription | 75% prescription | See plan handbook for details. |
| | Specialty drugs | Generic - $10 copay* Preferred - $100 copay* Non-preferred - $200 copay | Not covered | *Specialty drugs are covered only when ordered through CVS/caremark specialty pharmacy. Specialty medications are covered only up to a 30-day supply per copay. |

[* For more information about limitations and exceptions, see the plan or policy document at www.healthchoiceok.com.]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. Balance billing applies to out-of-network provider claims. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $200 copay<br>20% coinsurance | $200 copay<br>20% coinsurance | Balance billing applies to out-of-network provider claims. $200 copay is waived if admitted to hospital or death occurs. |
| | Emergency medical transportation | 20% coinsurance | 50% coinsurance | |
| | Urgent care | $30 copay<br>20% coinsurance | $30 copay<br>50% coinsurance | Balance billing applies to out-of-network provider claims. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance<br>$300 copay (for each out-of-network provider non-emergent hospital stay) | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. Balance billing applies to out-of-network provider claims. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 50% coinsurance | Limit of 20 visits per calendar year without certification.<br>Balance billing applies to out-of-network provider claims. |
| | Inpatient services | 20% coinsurance | 50% coinsurance<br>$300 copay (for each out-of-network provider hospital stay) | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. Balance billing applies to out-of-network provider claims. |
| **If you are pregnant** | Office visits | 100% until the deductible is met. $30 copay/primary care visit after deductible. 100% until the deductible is met. $50 copay specialty visit after deductible. | 50% coinsurance | Balance billing applies to out-of-network provider. |

[* For more information about limitations and exceptions, see the plan or policy document at www.healthchoiceok.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 | Includes one postpartum home visit, criteria must be met. Balance billing applies to out-of-network provider claims. |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance $300 copay (for each out-of-network provider hospital stay) | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. Balance billing applies to out-of-network provider claims. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. (Up to 100 visits per calendar year.) |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. (Up to 60 visits per calendar year for each type of therapy including physical, occupational, and speech.) |
| | Habilitation services | Not Covered | Not Covered | Excluded services |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Certification may be required, if not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. (Up to 100 days per calendar year.) |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See plan handbook for details. |
| | Hospice services | 20% coinsurance | 50% coinsurance | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not Covered | Excluded services |
| | Children's glasses | Not covered | Not Covered | Excluded services |
| | Children's dental check-up | Not covered | Not Covered | Excluded services |

[* For more information about limitations and exceptions, see the plan or policy document at www.healthchoiceok.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.)**

- Acupuncture (except for anesthesia)
- Cosmetic surgery
- Dental care
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric Surgery (Limited coverage for certain treatments)
- Chiropractic care (60 visits per calendar year)
- Hearing aids (under the age of 18, 1 every 48 months per hearing impaired ear)
- Infertility treatment (Limited coverage for certain services, drugs and treatment)
- Non-emergency care when traveling outside the U.S.

**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: contact the plan at 1-800-752-9475. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EGID Health Claims Administrator 1-800-323-4314, TTY 711, HealthChoice Member Services 405-717-8780 or toll free 1-800-752-9475 TDD Oklahoma City Area: 1-405-949-2281, TDD All Areas: 1-866-447-0436. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Insurance Department at http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html.

**Does this plan provide Minimum Essential Coverage?** **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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 1-800-323-4314.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-323-4314.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-323-4314.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-323-4314.]

*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 www.healthchoiceok.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 | $1,750 |
| Specialist copayment | $50 |
| 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 | $1,750 |
| Copayments | $100 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,000** |

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

| | |
|---|---|
| The plan's overall deductible | $1,750 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $900 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,000** |

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

| | |
|---|---|
| The plan's overall deductible | $1,750 |
| Specialist copayment | $50 |
| 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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $30 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.healthchoiceok.com.

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