
 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](http://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](http://www.healthchoiceok.com) or call 1-800-752-9475 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 individual/\$2,750 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 individual/\$300 family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$3,550 individual/\$8,400 family; for <a href="#">out-of-network providers</a> \$4,050 individual/\$9,900 family. For <a href="#">network pharmacy</a> \$2,500 individual/\$4,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and amounts above maximum benefit limitations.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or call 844-804-2642 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit	50% <a href="#">coinsurance</a>	Charges other than for an office visit apply to <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthchoice.com">www.healthchoice.com</a>	Generic drugs	\$10 <a href="#">copay</a> 30-day supply/\$25 <a href="#">copay</a> 31- 90 day supply/ prescription	50% prescription	See <a href="#">plan</a> handbook for details.
	Preferred drugs	\$45 <a href="#">copay</a> 30-day supply/\$90 <a href="#">copay</a> 31- 90 day supply/ prescription	50% prescription	See <a href="#">plan</a> handbook for details.
	Non-preferred drugs	\$75 <a href="#">copay</a> 30-day supply/\$150 <a href="#">copay</a> 31- 90 day supply/ prescription	75% prescription	See <a href="#">plan</a> handbook for details.
	<a href="#">Specialty drugs</a>	Generic - \$10 <a href="#">copay</a> * Preferred - \$100 <a href="#">copay</a> * Non-preferred -\$200 <a href="#">copay</a>	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 <a href="#">copay</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.healthchoiceok.com](http://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 need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims. \$200 <a href="#">copay</a> is waived if admitted to hospital or death occurs.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> 50% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> non-emergent hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limit of 20 visits per calendar year without certification. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> non-emergent hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> /Primary care visit \$50 <a href="#">copay</a> /Specialist visit	50% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes one postpartum home visit, criteria must be met. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> non-emergent hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.healthchoiceok.com](http://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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims. (Up to 100 visits per calendar year.)
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. (Up to 60 visits per calendar year for each type of therapy including physical, occupational, and speech.)
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	<a href="#">Excluded services</a>
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required, if not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. (Up to 100 days per calendar year.)
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	<a href="#">Excluded services</a>
	Children's glasses	Not covered	Not covered	<a href="#">Excluded services</a>
	Children's dental check-up	Not covered	Not covered	<a href="#">Excluded services</a>

[\* For more information about limitations and exceptions, see the plan or policy document at [www.healthchoiceok.com](http://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](#).)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture (except for anesthesia)</li><li>• Cosmetic surgery</li><li>• Dental care</li></ul> | <ul style="list-style-type: none"><li>• Habilitation services</li><li>• Long-term care</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--|---|---|

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

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"><li>• Bariatric Surgery (Limited coverage for certain treatments)</li><li>• Chiropractic care (60 visits per calendar year)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids (under the age of 18, 1 every 48 months per hearing impaired ear)</li><li>• Infertility treatment (Limited coverage for certain services, drugs and treatment)</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul> |
|---|---|--|

**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](http://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](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, kwijigo holne' 1-800-323-4314.]

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

About these Coverage Examples:



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

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$70
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,600</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$1,100
Copayments	\$1,200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,800</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

<b>Total Example Cost</b>	<b>\$2,000</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

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](http://www.healthchoiceok.com).

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.