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?	$1,000 person/$1,500 family. Applies after **Plan** pays first $500 of Allowable Fees. Does not apply to **preventive care** and pharmacy.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive Services are covered at 100% of allowed charges.	$0 **copayment** for two preventive services office visits per calendar year for members and dependents ages 18 and older one mammogram per year at no charge for women ages 40 and older. No **deductible** for well child care visit. https://www.ok.gov/sib/Preventive_Services.html
Are there other deductibles for specific services?	Yes. $100 person/$300 family for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services. See the chart starting on page 2 for other costs for services this **plan** covers.
What is the out-of-pocket limit for this plan?	Yes. $4,000 person/$9,000 family. For **Network** pharmacy $2,500 person/$4,000 family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you **plan** for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this **plan** doesn't cover, 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.	If you use a **Network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network provider** for some services. **Plans** use the term **in-network**, preferred, or participating for **providers** in their **Network**. See the chart starting on page 2 for how this **plan** pays different kinds of **providers**
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this **plan**.

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	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Balance billing applies to **non-Network** claims.
	Specialist visit	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
	Preventive care/screening/ immunization	No charge	Amount above Allowable Fees.	Balance billing applies to **non-Network** claims.
If you have a test	Diagnostic test (x-ray, blood work)	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	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 **non-Network** claims.
	Imaging (CT/PET scans, MRIs)	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthchoiceok.com	Generic drugs	$10 **copayment** 30 day supply/$25 **copayment** 31- 90 day supply/ prescription	50%/prescription	See **plan** handbook for details.
	Preferred brand drugs	$45 **copayment** 30 day supply/$90 **copayment** 31- 90 day supply/ prescription	50%/prescription	See **plan** handbook for details.
	Non-preferred brand drugs	$75 **copayment** 30 day supply/$150 **copayment** 31- 90 day supply/ prescription	75%/prescription	See **plan** handbook for details.

[* 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)	
	Specialty drugs	Generic - $10 **copayment** * Preferred - $100 **copayment** * Non-preferred - $200 **copayment**	Not Covered	*Specialty medications are covered only when ordered through CVS/caremark specialty pharmacy. Specialty medications are covered only up to a 30 day supply per **copayment**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	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 **non-Network** claims.
	Physician/surgeon fees	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
If you need immediate medical attention	Emergency room care	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Balance billing applies to **non-Network** claims. $200 **copayment** is waived if admitted to hospital or death occurs.
	Emergency medical transportation	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
	Urgent care	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 /	Amount above Allowable Fees.	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may

[* 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)	
		Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.		occur. See **plan** handbook for details. Balance billing applies to **non-Network** claims.
	Physician/surgeon fees	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Limit of 20 visits per calendar year without certification. Balance billing applies to **non-Network** claims.
	Inpatient services	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	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 **non-Network** claims.
If you are pregnant	Office visits	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Balance billing applies to **non-Network** claims.
	Childbirth/delivery professional services	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Includes one postpartum home visit, criteria must be met. Balance billing applies to **non-Network** claims.
	Childbirth/delivery facility services	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See **plan** handbook for details.

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)	
				Balance billing applies to **non-Network** claims.
If you need help recovering or have other special health needs	Home health care	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Certification may be required, if 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	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Certification may be required, if 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 service**.
	Skilled nursing care	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	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	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	Certification may be required, if not obtained, a 10% penalty or denial of benefits may occur. See **plan** handbook for details.
	Hospice services	Based on Allowable Fee: for the first $500: $0 / Member or $0 / Family. Next $1,000 / Member or $1,500 / Family: 100%. Next $6,000 / Member or $15,000 / Family: 50%.	Amount above Allowable Fees.	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	**Excluded service.**
	Children's glasses	Not Covered	Not Covered	**Excluded service.**
	Children's dental check-up	Not Covered	Not Covered	**Excluded service.**

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. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/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 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 405-416-1800 or toll free 1-800-782-5218, 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 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 1-800-323-4314.]

[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.]

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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** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

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	**$**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$**

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

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

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	**$**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$**

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

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

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	**$**

In this example, Mia would pay:

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

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