This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthchoiceok.com or by calling 1-800-752-9475.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person/**$1,750** family. Applies **after** Plan pays first **$250** 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 other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **Network Providers**, see www.healthchoiceok.com, or call **1-800-752-9475.**	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 I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
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 $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Balance billing applies to non-Network claims.
	Specialist visit	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	
	Other practitioner office visit	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	
	Preventive care/screening/immunization	No charge.	Amount above Allowable Fees.	
If you have a test	Diagnostic test (x-ray, blood work)	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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.
	Imaging (CT/PET scans, MRIs)	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
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 copay for 30 day supply/$25 copay for 31-90 day supply	50%/prescription	See plan handbook for details.
	Preferred brand drugs	$45 copay for 30 day supply/$90 copay for 31-90 day supply	50%/prescription	See plan handbook for details.
	Non-preferred brand drugs	$75 copay for 30 day supply/$150 copay for 31-90 day supply	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 drugs are covered only up to a 30 day supply per copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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.
	Physician/ surgeon fees	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	
If you need immediate medical attention	Emergency room services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Balance billing applies to non-Network claims.
	Emergency medical transportation	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	
	Urgent care	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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 $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Certification may be required, if not obtained, a 10% penalty or denial of benefits may occur. See plan

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	handbook for details.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Limit of 20 visits per calendar year without certification. Balance billing applies to non-Network claims.
	Mental/Behavioral health inpatient services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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.
	Substance use disorder outpatient services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Limit of 20 visits per calendar year without certification. Balance billing applies to non-Network claims.
	Substance use disorder inpatient services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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.
If you are pregnant	Prenatal and postnatal care	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	Includes one postpartum home visit, criteria must be met. Balance billing applies to non-Network claims.
	Delivery and all inpatient services	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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 $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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 $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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 $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / 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 service	Based on Allowable Fee: for the first $250: $0 / Member or $0 / Family. Next $1,250 / Member or $1,750 / Family: 100%. Next $5,500 / Member or $14,500 / Family: 50%.	Amount above Allowable Fees.	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Excluded service.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-752-9457.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,390
- **Patient pays** $4,150

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,250
Copays	$0
Coinsurance	$2,750
Limits or exclusions	$150
Total	**$4150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,020
- **Patient pays** $2380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,250
Copays	$510
Coinsurance	$540
Limits or exclusions	$80
Total	**$2,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.