




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 ?	\$1,250 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 services covered before you meet your deductible ?	Yes. Preventive Services are covered at 100% of allowed charges.	\$0 copay 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 \$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.	
	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 \$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 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 \$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 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.
	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 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)	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 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 \$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 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.	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 \$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 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 \$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.	

[* 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 need mental health, behavioral health, or substance abuse services	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.
	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 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 \$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.
	Childbirth/delivery professional 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.	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 \$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 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 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	Amount above Allowable	Certification may be required, if not obtained, a 10% penalty or denial of benefits may occur. See

[* 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)	
		\$5,500 / Member or \$14,500 / Family: 50%.	Fees.	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 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.	
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) | • Habilitation services | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care | • Private-duty nursing | • Weight loss programs |

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

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

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

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, 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.

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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](#) \$1,250
- [Specialist \[cost sharing\]](#) 50%
- [Hospital \(facility\) \[cost sharing\]](#) 50%
- [Other \[cost sharing\]](#) 50%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$0
Coinsurance	\$2,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,110

Managing Joe's type 2 Diabetes

(a year of routine in network care of a well controlled condition)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist \[cost sharing\]](#) 50%
- [Hospital \(facility\) \[cost sharing\]](#) 50%
- [Other \[cost sharing\]](#) 50%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$900
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,810

Mia's Simple Fracture

(in network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist \[cost sharing\]](#) 50%
- [Hospital \(facility\) \[cost sharing\]](#) 50%
- [Other \[cost sharing\]](#) 50%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

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.

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