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?	$750 person/$2,000 family. 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?	For Network Providers $3,300 person/$8,400 family; For non-Network providers $3,800 person/$9,900 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	$30 copayment/visit	50% coinsurance	Charges other than for an office visit apply to deductible and coinsurance. Balance billing applies to non-Network claims.
	Specialist visit	$50 copayment/visit	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	Balance billing applies to non-Network 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 non-Network 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.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 copayment.
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 non-Network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate	Emergency room care	$200 copayment	$200 copayment	Balance billing applies to non-Network claims.

[* 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)	
medical attention		20% coinsurance	20% coinsurance	$200 copayment is waived if admitted to hospital or death occurs.
	Emergency medical transportation	20% coinsurance	50% coinsurance	
	Urgent care	$30 copayment 20% coinsurance	$30 copayment 50% coinsurance	Balance billing applies to non-Network claims.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance $300 copayment (for each non-network 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 non-Network 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. Balance billing applies to non-Network claims.
	Inpatient services	20% coinsurance	50% coinsurance $300 copayment (for each non-network 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 non-Network claims.
If you are pregnant	Office visits	$30 copayment/ Primary care visit $50 copayment/ Specialist visit	50% coinsurance	Balance billing applies to non-Network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Includes one postpartum home visit, criteria must be met. Balance billing applies to non-Network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance $300 copayment (for each non-network 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 non-Network claims.
If you need help recovering or have other special health needs	Home health 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 visits per calendar year)

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)	
	Rehabilitation services	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 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	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 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 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

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

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.

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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	$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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,310

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

The plan's overall deductible	$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*	$850
Copayments	$1,200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,510

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

The plan's overall deductible	$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	$750
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,250

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.

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