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?	**$500** person/**$1,500** 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 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. 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**.
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 cost of covered services. Be aware, your Network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term 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**.

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- **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	$30/visit	50% coinsurance	Charges other than an office visit apply to deductible and coinsurance. Balance billing applies to non-Network claims.
	Specialist visit	$50/visit		
	Other practitioner office visit	20% coinsurance		Balance billing applies to non-Network claims.
	Preventive care/screening/immunization	No charge		
If you have a test	Diagnostic test (x-ray, blood work)	20% 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		
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	$10/$25 copay/ prescription	50%/prescription	See plan handbook for details.
	Preferred brand drugs	$45/$90 copay/ prescription	50%/prescription	See plan handbook for details.
	Non-preferred brand drugs	$75/$150 copay/ prescription	75%/prescription	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
drug coverage is available at www.healthchoiceok.com	Specialty drugs	$100/$200 copay/ prescription	Not Covered	See plan handbook for details.
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			
If you need immediate medical attention	Emergency room services	20% coinsurance $100 copayment	20% coinsurance $100 copayment	Balance billing applies to non-Network claims.
	Emergency medical transportation	20% coinsurance	50% coinsurance	
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)		50% coinsurance $300 copayment	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 fee		50% coinsurance	

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	Limit of 15 visits per calendar year without certification. Balance billing applies to non-Network claims.
	Mental/Behavioral health inpatient services		50% coinsurance $300 copayment	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.
	Substance use disorder outpatient services		50% coinsurance	Limit of 15 visits per calendar year without certification. Balance billing applies to non-Network claims.
	Substance use disorder inpatient services		50% coinsurance $300 copayment	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	Prenatal and postnatal care		50% coinsurance	Includes one postpartum home visit, criteria must be met. Balance billing applies to non-Network claims.
	Delivery and all inpatient services		50% coinsurance $300 copayment	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.

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	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.
	Rehabilitation services			
	Habilitation services	Not Covered	Not Covered	Excluded service.
	Skilled nursing care	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.
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Excluded service.
	Glasses			
	Dental check-up			

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)
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids (adult)
- Infertility treatment
- 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.)**

- Chiropractic care
- 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/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
P.O. Box 24870
Oklahoma City, OK 73124-0870
1-405-416-1800 or toll-free 1-800-782-5218
TDD 1-405-416-1525 or toll-free 1-800-941-2160

If your claim remains denied after a claims review, you can appeal that decision to the Grievance Panel by writing to:

EGID Legal Grievance Department
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8701 or toll-free 1-800-543-6044
TDD 1-405-949-2281 or toll-free 1-866-447-0436

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.**

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

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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** $5,520
- **Patient pays** $2,020

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	$500
Copays	$20
Coinsurance	$1350
Limits or exclusions	$150
Total	**$2,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,900
- **Patient pays** $1,500

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	$500
Copays	$680
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,500**

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.