




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, [insert contact information]. 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 [HealthChoiceOK.com](http://HealthChoiceOK.com) or call 1-800-323-4314 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Combined medical and pharmacy <a href="#">deductible</a> of \$1,750 individual/ \$3,500 family must be met before benefits are paid. Does not apply to <a href="#">preventive care</a> .	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and two preventive service office visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network providers</a> and pharmacy combined <a href="#">out-of-pocket limit</a> \$6,000 individual/\$12,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Out-of-network provider</a> charges, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and amounts above maximum benefit limitations.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://HealthChoiceOK.com">HealthChoiceOK.com</a> or call 1-800-323-4314 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	100% until the <a href="#">deductible</a> is met. \$30 <a href="#">copay</a> /visit after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a>	Charges other than for an office visit apply to <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	<a href="#">Specialist</a> visit	100% until the <a href="#">deductible</a> is met. \$50/ <a href="#">copay</a> visit after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">HealthChoiceOK.com</a>	Generic drugs	\$10 <a href="#">copay</a> 30-day supply/ \$25 <a href="#">copay</a> 31- 90 day supply/ prescription)	50% prescription	See <a href="#">plan</a> handbook for details.
	Preferred brand drugs	\$45 <a href="#">copay</a> 30-day supply/ \$90 <a href="#">copay</a> 31-90 day supply/ prescription	50% prescription	See <a href="#">plan</a> handbook for details.
	Non-preferred brand drugs	\$75 <a href="#">copay</a> 30-day supply/ \$150 <a href="#">copay</a> 31-90 day supply/ prescription	75% prescription	See <a href="#">plan</a> handbook for details.
	<a href="#">Specialty drugs</a>	Generic - \$10 <a href="#">copay</a> * Preferred - \$100 <a href="#">copay</a> * Non- preferred - \$200 <a href="#">copay</a>	Not covered	*Specialty drugs are covered only up to a 30-day supply per <a href="#">copay</a> .

[\* For more information about limitations and exceptions, see the plan or policy document at [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)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims. \$200 <a href="#">copay</a> is waived if admitted to hospital or death occurs.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> 50% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> non-emergent hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limit of 20 visits per calendar year without certification. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
If you are pregnant	Office visits	100% until the <a href="#">deductible</a> is met. \$30 <a href="#">copay</a> /primary care visit after <a href="#">deductible</a> . 100% until the <a href="#">deductible</a> is met. \$50 <a href="#">copay</a> specialty visit after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> .

[\* For more information about limitations and exceptions, see the plan or policy document at [HealthChoiceOK.com](http://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)	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes one postpartum home visit, criteria must be met. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> , \$300 <a href="#">copay</a> (for each <a href="#">out-of-network provider</a> hospital stay)	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network provider</a> claims.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. (Up to 100 visits per calendar year.)
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. (Up to 60 visits per calendar year for each type of therapy including physical, occupational, and speech.)
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	<a href="#">Excluded services</a>
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details. (Up to 100 days per calendar year.)
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certification may be required. If certification is not obtained, a 10% penalty or denial of benefits may occur. See <a href="#">plan</a> handbook for details.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not Covered	<a href="#">Excluded services</a>
	Children's glasses	Not covered	Not Covered	<a href="#">Excluded services</a>
	Children's dental check-up	Not covered	Not Covered	<a href="#">Excluded services</a>

[\* For more information about limitations and exceptions, see the plan or policy document at [HealthChoiceOK.com](http://HealthChoiceOK.com).]

## 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.)

- |   |  |   |
|---|--|---|
| • Bariatric Surgery (Limited coverage for certain treatments) | • Hearing aids (under the age of 18, 1 every 48 months per hearing impaired ear)     | • CDC-recognized National Diabetes Prevention Program |
| • Chiropractic care (60 visits per calendar year)             | • 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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](http://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 on how 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 1-800-323-4314, TTY 711; 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 [www.ok.gov/oid/Consumers/Consumer\\_Assistance/index.html](http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html).

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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](#) \$1,750
- [Specialist \[cost sharing\]](#) \$50
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,000</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist \[cost sharing\]](#) \$50
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,600</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist \[cost sharing\]](#) \$50
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.