



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, visit [oklahoma.gov/HealthChoice](https://oklahoma.gov/HealthChoice) or by calling 1-800-323-4314. 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 <https://www.Healthcare.gov/sbc-glossary/> or by calling 1-800-323-4314 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$750 person / \$2,000 family	Generally, you must pay all the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 person / \$300 family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,300 person / \$8,400 family <a href="#">network</a> medical \$3,800 person / \$9,900 family <a href="#">out-of-network</a> medical \$2,500 person / \$4,000 family <a href="#">network</a> pharmacy	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://oklahoma.gov/HealthChoice">oklahoma.gov/HealthChoice</a> or by calling 1-800-323-4314 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	<b>\$30 <a href="#">Copay</a></b> per visit; <a href="#">Deductible</a> Waived	50% <a href="#">Coinsurance</a>	Charges other than for an office visit apply to <a href="#">deductible</a> and coinsurance. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Specialist</a> visit	<b>\$50 <a href="#">Copay</a></b> per visit; <a href="#">Deductible</a> Waived	50% <a href="#">Coinsurance</a>	<a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Preventive care/ screening/ immunization</a>	No charge; <a href="#">Deductible</a> Waived	50% <a href="#">Coinsurance</a>	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Preauthorization is required for Myocardial PET scans. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">oklahoma.gov/HealthChoice</a>	Generic drugs (Tier 1)	<b>\$10 copay</b> 30-day supply / <b>\$25 copay</b> 31- to 90-day supply	50% <a href="#">Coinsurance</a>	Refer to <a href="#">plan</a> handbook for details.
	Preferred brand drugs (Tier 2)	<b>\$45 copay</b> 30-day supply / <b>\$90 copay</b> 31- to 90-day supply	50% <a href="#">Coinsurance</a>	
	Non-preferred brand drugs (Tier 3)	<b>\$75 copay</b> 30-day supply / <b>\$150 copay</b> 31- to 90-day supply	75% <a href="#">Coinsurance</a>	
	<a href="#">Specialty drugs</a> (Tier 4)	Generic - <b>\$10 copay</b> per 30-day supply. Preferred - <b>\$100 copay</b> per 30-day supply. Non-preferred - <b>\$200 copay</b> per 30-day supply.	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Preauthorization is required for certain procedures. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	<b>\$200 Copay</b> per visit 20% <a href="#">Coinsurance</a>	<b>\$200 Copay</b> per visit; 20% <a href="#">Coinsurance</a>	<a href="#">Copay</a> may be waived if admitted or if death occurs prior to admission
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> ground ambulance claims.
	<a href="#">Urgent care</a>	<b>\$30 Copay</b> per visit; <a href="#">Deductible</a> waived office visit; 20% <a href="#">Coinsurance</a> all other services	50% <a href="#">Coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">Coinsurance</a>	<b>\$300 Copay</b> per admission; 50% <a href="#">Coinsurance</a>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	Physician/surgeon fee	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Preauthorization is required after initial 20 visits. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	Inpatient services	20% <a href="#">Coinsurance</a>	<b>\$300 Copay</b> per admission; 50% <a href="#">Coinsurance</a>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
If you are pregnant	Office visits	No charge; <a href="#">Deductible</a> Waived	50% <a href="#">Coinsurance</a>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization may be required depending on the length of inpatient stay after delivery. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	Childbirth/delivery professional services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">Coinsurance</a>	<b>\$300 Copay</b> per admission; 50% <a href="#">Coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	100 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Rehabilitation services</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	60 Maximum visits per calendar year OT; 60 Maximum visits per calendar year PT; 60 Maximum visits per calendar year ST; Preauthorization is required after initial 20 visits for OT/PT. Preauthorization is required for ST for ages 17 & under. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Habilitation services for Learning Disabilities are not covered. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Habilitation services</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Skilled nursing care</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Preauthorization may be required. See <a href="#">plan</a> handbook for details. If you don't get preauthorization, benefits could be reduced by 10% or be denied. <a href="#">Balance billing</a> applies to non-emergency <a href="#">out-of-network provider</a> claims.
	<a href="#">Hospice services</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (only covered in lieu of anesthesia for surgery)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids (to age 18)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• CDC-recognized National Diabetes Prevention Program</li> </ul>

**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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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 to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://www.HealthCare.gov) and <http://cciio.cms.gov/programs/consumer/capgrants/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 Standard? 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.*

## 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 [provider](#) 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal 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>	\$800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,260</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>	\$850
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$30
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,800</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*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>	\$800
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>