HEALTHCHOICE HIGH DEDUCTIBLE PLAN: OMES EGID

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 member-healthchoice.tpa.com 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 deductible?	Combined medical and pharmacy deductible of $1,750 person / $3,500 family must be met before copayments and coinsurance apply. Does not apply to preventive services.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000 person / $12,000 family network medical and pharmacy combined Unlimited Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, penalties, premiums, balance billing charges, and health care this plan doesn't cover.	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. See member-healthchoice.tpa.com or by calling 1-800-323-4314 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

	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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay per visit	50% Coinsurance	Charges other than for an office visit apply to deductible and coinsurance. Balance billing applies to non-emergency out-of-network provider claims.
	Specialist visit	$50 Copay per visit	50% Coinsurance	Balance billing applies to non-emergency out-of-network provider claims.
	Preventive care/ screening/ immunization	No charge; Deductible Waived	50% Coinsurance	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	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	Balance billing applies to non-emergency out-of-network provider claims.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	Preauthorization is required for Myocardial PET scans. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider 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)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at member-healthchoice.tpa.com	Generic drugs (Tier 1)	$10 copay 30-day supply / $25 copay 31- to 90-day supply	50% Coinsurance	Refer to plan handbook for details.
	Preferred brand drugs (Tier 2)	$45 copay 30-day supply / $90 copay 31- to 90-day supply	50% Coinsurance	
	Non-preferred brand drugs (Tier 3)	$75 copay 30-day supply / $150 copay 31- to 90-day supply	75% Coinsurance	
	Specialty drugs (Tier 4)	Generic - $10 copay per 30-day supply. Preferred - $100 copay per 30-day supply. Non-preferred - $200 copay per 30-day supply.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Preauthorization is required for certain procedures. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you need immediate medical attention	Emergency room care	$200 Copay per visit; 20% Coinsurance	$200 Copay per visit; 20% Coinsurance	Copay may be waived if admitted or if death occurs prior to admission
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Balance billing applies to out-of-network ground ambulance claims.
	Urgent care	$30 Copay per office visit; 20% Coinsurance all other services	50% Coinsurance	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% Coinsurance	$300 Copay per admission; 50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	50% Coinsurance	Preauthorization is required after initial 20 visits. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Inpatient services	20% Coinsurance	$300 Copay per admission; 50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance 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. Balance billing applies to non-emergency out-of-network provider claims.
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	$300 Copay per admission; 50% Coinsurance	

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	Home health care	20% Coinsurance	50% Coinsurance	100 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Rehabilitation services	20% Coinsurance	50% Coinsurance	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. Balance billing applies to non-emergency out-of-network provider claims.
	Habilitation services	20% Coinsurance	50% Coinsurance	
	Skilled nursing care	20% Coinsurance	50% Coinsurance	100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider claims.
	Hospice services	20% Coinsurance	50% Coinsurance	Preauthorization may be required. See plan handbook for details. If you don't get preauthorization, benefits could be reduced by 10% or be denied. Balance billing applies to non-emergency out-of-network provider 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)	
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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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.)

- Acupuncture (only covered in lieu of anesthesia for surgery)
- Bariatric surgery
- Chiropractic care
- Hearing aids (to age 18)
- Non-emergency care when traveling outside the U.S.
- CDC-recognized National Diabetes Prevention Program

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. 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. 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 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, 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.

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 plan's overall deductible	$1,750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,020

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 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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$700
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,560

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

The plan's overall deductible	$1,750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,050

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