



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, WebTPA at 1-855-688-1208. 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.webtpa.com or call 1-855-688-1208 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For Connect Benefit providers : No deductible applies. For HCH Sync Network Providers : \$1,500 Individual/ \$3,000 Family per calendar year. For HCH Plus Network providers : \$2,000 Individual/ \$4,000 Family per calendar year. For out-of-network providers : \$4,000 Individual/ \$8,000 Family per calendar year.	Generally, you must pay all of 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. The deductibles for Sync and Plus cross accumulate so you will not pay more than \$2000 Individual/\$4000 Family in the calendar year.
Are there services covered before you meet your deductible ?	Yes. Preventive Care is 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For Connect Benefit providers : No OOP limit applies. For HCH Sync/ Plus network providers : \$5,400 Individual/ \$10,000 Family For out-of-network providers : Unlimited Individual/Family Pharmacy network: \$2,500 Individual/ \$5,000 Family Pharmacy out-of-network providers : Unlimited Individual/Family	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 , the overall family out-of-pocket limit must be met.

What is not included in the out-of-pocket limit?	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. For a list of network providers visit www.healthcarehighways.com or call 1-866-945-2292 for providers inside Oklahoma. For providers outside of Oklahoma, visit www.mycigna.com .	You pay the least if you use a provider in HCH Sync. You pay more if you use a provider in HCH Plus. 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?	Yes.	When using a Connect Benefit provider please contact 1-855-624-SAVE for voucher information.

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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

 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
		Connect Benefit Providers (You will pay the least)	Network Provider HCH Sync inside OK	Network Provider HCH Plus inside OK (CIGNA outside of OK)	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	No Charge	\$15 copayment	\$25 copayment	40% coinsurance after deductible	————None————
	Specialist visit	No Charge	\$30 copayment	\$50 copayment	40% coinsurance after deductible	————None————
	Preventive care/screening/immunization	No Charge	No Charge	No Charge	Not Covered	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. Out-of-network mammograms are covered at 100% after deductible
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Independent lab in conjunction w/ office visit and office visit lab covered 100% after deductible.
	Imaging (CT/PET scans, MRIs)	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required, unless using Connect Benefit.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Connect Benefit Providers (You will pay the least)	Network Provider HCH Sync inside OK	Network Provider HCH Plus inside OK (CIGNA outside of OK)	Out-of- Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.CerpassRx.com	Generic drugs	N/A	\$10 copayment (Retail 30-day) \$20 copayment (Mail Order 90-day)			The member will be responsible for the full retail cost of the brand name drug if the member chooses to fill a brand drug when a generic is available.
	Preferred brand drugs	N/A	\$70 copayment (Retail 30-day) \$140 copayment (Mail Order 90-day)			
	Non-preferred brand drugs	N/A	\$170 copayment (Retail 30-day) \$340 copayment (Mail Order 90-day)			
	Specialty drugs	N/A	Copayment is prorated according to the amount dispensed	Copayment is prorated according to the amount dispensed	Not Covered	Specialty drugs only available through Pharmacy Program www.CerpassRx.com and phone number 844-636-7506
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required for certain outpatient services.
	Physician/surgeon fees	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	————None————
If you need immediate medical attention	Emergency room care	Not Available	\$250 copay then 20% coinsurance after deductible	\$250 copay then 20% coinsurance after deductible	\$250 copay then 20% coinsurance after deductible	Copayment waived if admitted. Non-Emergent use of an Out-of-Network Emergency Room is covered at 60% coinsurance after deductible.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Connect Benefit Providers (You will pay the least)	Network Provider HCH Sync inside OK	Network Provider HCH Plus inside OK (CIGNA outside of OK)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Not Available	Not Available	20% coinsurance after deductible	20% coinsurance after deductible	Non-Emergency is subject to usual & customary allowance
	Urgent care	No Charge	\$15 copayment	\$25 copayment	40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required for certain outpatient services.
	Physician/surgeon fees	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	————None————

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Connect Benefit Providers (You will pay the least)	Network Provider HCH Sync inside OK	Network Provider HCH Plus inside OK (CIGNA outside of OK)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Available	Outpatient Physician \$15 Copay 15% coinsurance after deductible	Outpatient Physician \$25 Copay 20% coinsurance after deductible	40% coinsurance after deductible	\$0 Virtual Mental Health through Medefy www.medefy.com
	Inpatient services	Not Available	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Initial Office visit covered at 100% Deductible waived for Sync and Plus Providers. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Connect Benefit Providers (You will pay the least)	Network Provider HCH Sync inside OK	Network Provider HCH Plus inside OK (CIGNA outside of OK)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient Physical, Occupational and Speech therapy covered with no visit limits. Pre-authorization is required for Inpatient Rehabilitation and Habilitation Services.
	Habilitation services	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required.
	Durable medical equipment	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required for over \$2,000 dollars to determine medical necessity.
	Hospice services	No Charge	15% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	No coverage under the medical plan
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	No coverage under the medical plan
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	No coverage under the medical plan

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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, massage & herbal therapy | • Hearing aids (Adults) | • Massage Therapy |
| • Cosmetic surgery | • Infertility treatment | • Orthotics (Custom Molded) |
| • Dental Care – (Adult/Children) | • Long-term care | • Routine eye care (Adults/Children) |
| • Dependent Pregnancy | • Marriage Counseling | • Routine foot care |
| • Glasses | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|--|
| • Bariatric surgery (limited to 1 surgery per lifetime) | • Hearing aids (Limited coverage for children to age 18, limit to 1 per ear every 48 months.) | • Private-duty nursing (Limited to 60 visits per Calendar Year. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.) |
| • Chiropractic care (20 visits per year) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (Morbid obesity only) |

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-855-688-1208.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-688-1208.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-688-1208.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-688-1208

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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

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About these Coverage Examples: Utilizing Sync Network



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	\$1,500
■ Specialist copay	\$0
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$1700
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3270

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist copay	\$30
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$900
Copayments	\$400
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist copay	\$30
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1500
Copayments	\$100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$
The total Mia would pay is	\$1700