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: **$3,000** Individual/ **$6,000** Family per calendar year. For out-of-network providers:$**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 $3,000 Individual/$6,000 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: **$4,400** Individual/**$9,000** 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(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	30% 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	30% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required, unless using Connect Benefit.

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

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.LucyRx.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.LucyRx.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	30% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required for certain outpatient services.
	Physician/surgeon fees	No Charge	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————None——————
If you need immediate medical attention	Emergency room care	Not Available	$250 copay then 30% coinsurance after deductible	$250 copay then 30% coinsurance after deductible	$250 copay then 30% coinsurance after deductible	Copayment waived if admitted. Non-Emergent use of an Out-of-Network Emergency Room is subject to Out-of-Network deductible and 40% coinsurance.

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

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	30% coinsurance after deductible	30% coinsurance after deductible	Non-Emergency is subject to usual & customary allowance
	Urgent care	No Charge	$15 copayment	$95 copayment	40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required for certain outpatient services.
	Physician/surgeon fees	No Charge	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————None————

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

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 30% coinsurance after deductible	40% coinsurance after deductible	$0 Virtual Mental Health through Medefy www.medefy.com
	Inpatient services	Not Available	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	No Charge	15% coinsurance after deductible	30% 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	30% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No Charge	15% coinsurance after deductible	30% 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	30% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required.

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

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	N/A	15% coinsurance after deductible	30% 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. *Physical Therapy is no longer available through Connect Benefit.
	Habilitation services	N/A	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	No Charge	15% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization is required.
	Durable medical equipment	No Charge	15% coinsurance after deductible	30% 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	30% 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

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.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, massage & herbal therapy
- Cosmetic surgery
- Dental Care – (Adult/Children)
- Dependent Pregnancy
- Glasses
- Hearing aids (Adults)
- Infertility treatment
- Long-term care
- Marriage Counseling
- Massage Therapy
- Orthotics (Custom Molded)
- Routine eye care (Adults/Children)
- Routine foot care

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)
- Chiropractic care (20 visits per year)
- Hearing aids (Limited coverage for children to age 18, limit to 1 per ear every 48 months.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Limited to 60 visits per Calendar Year. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.)
- 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, kwiijigo 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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* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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**

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**

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**

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**

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