This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.healthsmart.com** or by calling **1-800-825-3540**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO providers: **$500*** Individual **/ $1,000** Family For Non-PPO providers: **$750*** Individual **/ $1,500** Family PPO doesn't apply to Preventive Care. Copayments don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. *Effective 01/01/2017
Are there other deductibles for specific services?	Yes. **$100** per confinement for Non-PPO hospital (waived if lifethreatening). There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. For PPO providers: **$5,000** Individual **/ $10,000** Family For Non-PPO providers: **$6,850*** Individual **/ $13,700*** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. *Effective 01/01/2017
What is not included in the out–of–pocket limit?	Amounts in excess of reasonable & appropriate, balanced-billed charges, Non-PPO deductibles, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Is there an overall annual limit on what the plan pays?	No.	This chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **PPO providers**, see www.healthsmart.com or call **1-800-825-2540**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-ofnetwork **provider** for some services. Plans use the term in-network, **preferred**, or participating
		for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-ofNetwork Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% coinsurance	——————none——————
	Specialist visit	$50 copay/visit	40% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractor.	40% coinsurance for chiropractor.	Coverage is limited to $2,500 calendar year maximum. No coverage for acupuncture.
	Preventive care/screening/immunization	No charge	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	With LabCard - 0%/test Without LabCard - 20% coinsurance/test	40% coinsurance/test	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance/test	40% coinsurance/test	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-ofNetwork Provider	Limitations & Exceptions

If you need drugs to treat your illness or condition **All coinsurance and copayments apply to the in network out of pocket maximum** More information about **prescription drug coverage** is available at www.maxcarerx.com.	Generic drugs	Retail - $10 copay/prescription; Mail - $30 copay/prescription	-Same copayment and min/max (if applicable) for Innetwork but based on the **allowed amount**.	-Covers up to a 30-day supply (retail prescription); 31-90 day supply of maintenance medications. -If you purchase a brand-name drug when a generic equivalent is available, you will pay the brand coinsurance *plus* the difference in cost between the brand and generic, unless "dispensed as written" is indicated by your provider..
	Preferred brand drugs	Retail - 35% coinsurance or $125 copay, whichever is less/prescription; Mail Order - $150 copay/prescription	Same as above.	-Preferred brand drug category includes compound medications, which are limited to a 30-day supply. -Other Limitations & Exceptions are the same as above.
	Non-preferred brand drugs	Retail - 40% coinsurance or $150 copay, whichever is less/prescription; Mail Order - $200 copay/prescription	Same as above.	Same as above.

	Specialty drugs	Generic - 20% coinsurance or $100 copay, whichever is less; Brand Name – 20% coinsurance or $150 copay, whichever is less	Same as above.	Limited to a 30-day supply. Requires Prior Authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-ofNetwork Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay/visit; 20% coinsurance after deductible	$150 copay/visit; 20% coinsurance after deductible	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$25 copay/visit	40% coinsurance	——————none——————

If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Requires Case Management. Out-ofNetwork additional deductible waived if life-threatening
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Requires Case Management.
	Substance use disorder outpatient services	$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Requires Case Management.
If you are pregnant	Prenatal and postnatal care	$0 with BabyLinks Program participation or 20% coinsurance	40% coinsurance	BabyLinks Program requires Case Management.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——————none——————
Common Medical Event	**Services You May Need**	**Your Cost If You**	**Your Cost If You**	**Limitations & Exceptions**

		Use an In-Network Provider	Use an Out-ofNetwork Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Requires Case Management.
	Rehabilitation services	20% coinsurance	40% coinsurance	Requires Case Management.
	Habilitation services	20% coinsurance	40% coinsurance	Requires Case Management.
	Skilled nursing care	20% coinsurance	40% coinsurance	Requires Case Management.
	Durable medical equipment	20% coinsurance	40% coinsurance	Requires Case Management for expenses in excess of $500.
	Hospice service	20% coinsurance	40% coinsurance	Requires Case Management.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Assessment Only
	Glasses	Not Covered	Not Covered	
	Dental check-up	No Charge	40% coinsurance	Assessment Only

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture Dental care (Adult) Private-duty nursing
- Bariatric surgery Infertility treatment Routine eye care (Adult)
- Cosmetic surgery Long-term care Routine foot care
- Non-emergency care when traveling outside the U.S. Weight loss programs

Questions: Call **1-800-825.3540** or visit us at **www.healthsmart.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-800-825-3540 to request a copy.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
□ Chiropractic care	□ Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 405-848-1975 / 800-825-3540. You may also contact your state insurance department or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: HealthSmart Benefit Solutions, Inc. at 405-848-1975 / 800-825-3540 or Fax 405-607-2626.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **800-825-3540**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **800-825-3540.**

Chinese (中文): 如果需要中文的帮助, **请拨打这个号码 800-825-3540**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **800-825-3540.**

Questions: Call **1-800-825.3540** or visit us at **www.healthsmart.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-800-825-3540 to request a copy.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to

estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Questions and answers about the Coverage Examples:

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,720
- **Patient pays** $1,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$20
Coinsurance	$1,370
Limits or exclusions	$30
Total	**$1,820**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$580
Coinsurance	$260
Limits or exclusions	$40
Total	**$1,280**

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

× **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

× **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.