




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, call 1-888-348-9799 or at [www.bcbsok.com](http://www.bcbsok.com). 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Network</u> : \$3,000 Individual / \$3,000 Family <u>Out-of-Network</u> : \$6,000 Individual / \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : \$4,000 Individual / \$8,000 Family <u>Out-of-Network</u> : \$8,000 Individual / \$16,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, <u>preauthorization</u> penalties, and healthcare this <u>plan</u> doesn't cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsok.com">www.bcbsok.com</a> or call 1-888-348-9799 for a list of <u>Network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail (34 day supply): \$10 <u>copay</u> after <u>deductible</u> Mail (90 day supply): 20% after <u>deductible</u>	After <u>deductible</u> : 30% <u>coinsurance</u>	Retail limited to 34 day supply. Mail order limited to 90 day supply of maintenance drugs. For <u>out-of-network</u> drug <u>providers</u> , you are responsible for 30% of the eligible amount after you have met the <u>deductible</u> . Utilization Management Programs may apply.
	Preferred brand drugs	Retail (34 day supply): \$25 <u>copay</u> after <u>deductible</u> Mail (90 day supply): 20% after <u>deductible</u>	After <u>deductible</u> : 30% <u>coinsurance</u>	
	Non-preferred brand drugs	Retail (34 day supply): \$45 <u>copay</u> after <u>deductible</u> Mail (90 day supply): 20% after <u>deductible</u>	After <u>deductible</u> : 30% <u>coinsurance</u>	
	<u>Specialty drugs</u>	Mirror the applicable retail or mail <u>copay</u> tier.	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com](http://www.bcbsok.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Elective abortion is not covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com](http://www.bcbsok.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	45 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Outpatient: Combined 60 visit limit per benefit period for physical, speech, and occupational therapies. Inpatient: 30 day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	100 day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Medically necessary</u> rental or purchase at the <u>plan's</u> discretion. Precertification required if over \$4,000 for participating OK <u>providers</u> .
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com](http://www.bcbsok.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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 <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Elective abortion (unless the life of the mother is endangered)</li> <li>• Long-term care</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 <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (20 visits/year)</li> <li>• Chiropractic care (25 visits/year)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (up to the diagnosis of infertility only)</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsok.com">www.bcbsok.com</a></li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com](http://www.bcbsok.com).

**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: the plan at 1-888-348-9799, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or 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. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Oklahoma at 1-888-348-9799 or visit [www.bcbsok.com](http://www.bcbsok.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Insurance Department at 1-800-522-0071 or visit [www.ok.gov/oid/Consumers/Consumer\\_Assistance/](http://www.ok.gov/oid/Consumers/Consumer_Assistance/).

**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 1-888-348-9799.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-348-9799.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-348-9799.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-348-9799.

*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 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 <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost sharing</i>	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,070</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

#### 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:

<i>Cost sharing</i>	
Deductibles	\$3,000
Copayments	\$400
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,500</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*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:

<i>Cost sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>



BlueCross BlueShield of Oklahoma

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

Table with 2 columns: Language and Translation. Rows include Arabic, Burmese, Cherokee, Chinese, French, German, Hmong, Korean, Laotian, Navajo, Persian, Spanish, Tagalog, Thai, Urdu, and Vietnamese.



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>