



**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.bcbsok.com/coverage](http://www.bcbsok.com/coverage) or by calling 1-855-609-5684.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. <b>\$4,000</b> Individual/ <b>\$8,000</b> Family.	The <b>out-of-pocket limit</b> 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.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Does this plan use a <b>network of providers</b> ?	Yes. For a list of Network providers please call 1-855-609-5684 or see <a href="http://www.bcbsok.com/state">www.bcbsok.com/state</a> .	If you use an in-network doctor or other health care <b>provider</b> , 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-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	Yes.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
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 <b>excluded services</b> .

**Questions:** Call 1-855-609-5684 or visit us at [www.bcbsok.com/coverage](http://www.bcbsok.com/coverage).

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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-609-5684 to request a copy.



- **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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 copay/visit	Not Covered	---none---
	Specialist visit	\$50 copay/visit	Not Covered	
	Other practitioner office visit	\$35 copay/visit	Not Covered	Acupuncture is not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	No Charge if billed with office visit.
	Imaging (CT/PET scans, MRIs)	\$200 copay/scan	Not Covered	---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.bcbsok.com/member/prescriptiondrugs.html">www.bcbsok.com/member/prescriptiondrugs.html</a>	Preferred generic drugs	No Charge	Not Covered	Up to 30 day supply retail. Up to 90 day supply of maintenance drugs mail. Specialty drugs limited to 30 day supply. Prior authorization may be required.
	Non-preferred generic drugs	\$10 copay retail/ \$25 copay mail	Not Covered	
	Preferred brand drugs	\$40 copay retail/ \$100 copay mail	Not Covered	
	Non-preferred brand drugs	\$80 copay retail/ \$200 copay mail	Not Covered	
	Specialty drugs	\$100 copay	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200 copay/visit	Not Covered	Elective abortion is not covered.
	Physician/surgeon fees	No Charge	Not Covered	

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Your Cost If You Use a Network Provider</b>	<b>Your Cost If You Use an Out-of-Network Provider</b>	<b>Limitations &amp; Exceptions</b>
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay/visit	\$200 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	---none---
	Urgent care	\$50 copay/visit	Not Covered	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 copay/admission	Not Covered	\$100 copay per day for the first 8 days.
	Physician/surgeon fee	No Charge	Not Covered	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$35 copay/visit	Not Covered	Outpatient: Preauthorization may be required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment. Inpatient: \$100 copay per day for the first 8 days.
	Mental/Behavioral health inpatient services	\$100 copay/admission	Not Covered	
	Substance use disorder outpatient services	\$35 copay/visit	Not Covered	
	Substance use disorder inpatient services	\$100 copay/admission	Not Covered	
<b>If you are pregnant</b>	Prenatal and postnatal care	\$35 copay/visit	Not Covered	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	\$100 copay/admission	Not Covered	\$100 copay per day for the first 8 days.
<b>If you need help recovering or have other special health needs</b>	Home health care	No Charge	Not Covered	---none---
	Rehabilitation services	\$35 copay/visit	Not Covered	Outpatient: Combined 60 visit limit per calendar year for chiropractic, physical, occupational, and speech therapies.
	Habilitation services	\$35 copay/visit	Not Covered	
	Skilled nursing care	\$100 copay/admission	Not Covered	\$100 copay per day for the first 8 days. Limited to 100 visits per calendar year.
	Durable medical equipment	20% coinsurance	Not Covered	Medically necessary rental or purchase at the plan's discretion.
	Hospice service	No Charge	Not Covered	----none---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

### 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <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>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care (Only for diabetic members)</li> </ul>

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.)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>

## 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 1-855-609-5684. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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 Blue Cross and Blue Shield of Oklahoma at 1-855-609-5684 or visit [www.bcbsok.com](http://www.bcbsok.com), or contact 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 Department of Insurance at (405) 521-2991 or visit [www.ok.gov/oid/Consumers/Consumer\\_Assistance/index.html](http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html).

## 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 1-855-609-5684.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-609-5684.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-609-5684.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-609-5684.

---

*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.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,040
- Patient pays \$500

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$350
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$500</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,570
- Patient pays \$830

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$750
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$830</b>

## Questions and answers about the Coverage Examples:

### 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 in-network 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.

**Questions:** Call 1-855-609-5684 or visit us at [www.bcbsok.com/coverage](http://www.bcbsok.com/coverage).

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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-609-5684 to request a copy.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association