




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 1-800-468-5744 or visit www.opehw1.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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-468-5744 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | For <u>Network</u> : \$750 Individual / \$1,500 Family For <u>Out-of-Network</u> : \$1,500 Individual / \$3,000 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> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , and <u>Network preventive care</u> , are 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 www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | Yes. \$50 <u>deductible</u> on brand-name prescriptions per individual. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For <u>Network</u> : \$5,000 Individual / \$10,000 Family For <u>Out-of-Network</u> : \$10,000 Individual / \$20,000 Family <u>Prescription drug limit</u> : \$2,000 Individual / \$4,000 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. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balanced-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> |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.bcbsok.com or call 1-800-942-5837 for a list of Blue Preferred <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 plan's <u>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. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | 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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | \$50 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | Specified services limited to one visit per benefit period. 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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Some exceptions and limitations apply. See the <u>Plan's</u> benefit book for additional information. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.opehw1.com . | Generic drugs | \$10 <u>copay</u> (30 day supply retail) | Reimbursed cost paid minus <u>copay</u> | \$50 <u>deductible</u> per person per plan year for Brand name drugs only. As of 10/1/17 the 90 day supply through Mail Order and retail will be: Generic- \$25 / Brand name \$112 A full list of exceptions, limitations & exclusions can be found on the Plan's website at www.opehw1.com . |
| | Preferred brand drugs | \$45 <u>copay</u> (30 day supply retail) | Reimbursed cost paid minus <u>copay</u> and brand name <u>deductible</u> | |
| | Non-preferred brand drugs | \$45 <u>copay</u> (30 day supply retail) | Reimbursed cost paid minus <u>copay</u> and brand name <u>deductible</u> | |
| | <u>Specialty drugs</u> | \$10 Generic <u>copay</u> (30 day supply, mail order only) \$60 Preferred Brands (30 day supply, mail order only) \$100 Non Preferred Brands (30 day supply, mail order only) | N/A mail order only | |

* For more information about limitations and exceptions, see the plan or policy document at www.opehw1.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) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need immediate medical attention | Emergency room care | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Additional \$50 <u>copay</u> per visit; waived if admitted. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services | 30% <u>coinsurance</u> | <u>Preauthorization</u> required for certain services. |
| | Inpatient services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| If you are pregnant | Office visits | \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | <u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <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 | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |

* For more information about limitations and exceptions, see the plan or policy document at www.opehw1.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 need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | 30 visit limit per benefit period. <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Outpatient: Combined 60 visit limit per benefit period for physical, speech, and occupational therapies. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Inpatient: 30 day limit per benefit period. <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | 30 day limit per benefit period. <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Medically necessary</u> rental or purchase at the <u>plan's</u> discretion. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> . |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | Not Covered under medical plan. |
| | Children's glasses | Not Covered | Not Covered | Not Covered under medical plan. |
| | Children's dental check-up | No Charge | No Charge | See the <u>Plan's</u> benefit book for additional information on coverage. |

* For more information about limitations and exceptions, see the plan or policy document at www.opehw1.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
- Bariatric surgery
- Cosmetic surgery
- Elective abortion (unless mother's life is endangered)
- Hearing aids (limited coverage for children)
- Infertility treatment
- Long-term care
- Routine eye care (Adult, unless offered by your employer)
- Routine foot care (only for diabetic members)
- Weight loss programs

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

- Chiropractic care
- Dental care (Adult & child, \$1,500 max/benefit period)
- Most coverage provided outside the United States. See www.bcbsok.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 1-800-468-5744, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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. 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 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 1-800-942-5837 or visit 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. 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/.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-942-5837.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-942-5837.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-942-5837.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-942-5837.

————— *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> | \$750 |
| ■ <u>Specialist</u> copayments | \$50 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$750 |
| <u>Copayments</u> | \$90 |
| <u>Coinsurance</u> | \$2,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,200 |

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> | \$750 |
| ■ <u>Specialist</u> copayments | \$50 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$800 |
| <u>Copayments</u> | \$1,200 |
| <u>Coinsurance</u> | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$2,260 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist</u> copayments | \$50 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$750 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,150 |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.



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, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: 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>