BlueCross BlueShield of Oklahoma

University of Oklahoma
Student Health Insurance Plan

Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan.

Attached is the SBC for the University of Oklahoma Student Health Plan covering plans purchased between 07/01/16 - 08/18/17. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for University of Oklahoma are listed below:

Coverage Period	Norman Campus	Health Sciences Center
Annual	08/19/16 - 08/18/17	07/1/16 - 06/30/17 & 08/15/16 - 06/30/17
Fall	08/19/16 - 01/16/17	07/1/16 - 12/31/16 & 08/15/16 - 12/31/16
Spring	01/17/17 - 05/12/17	01/01/16 - 5/31/17
Spring/Summer	01/17/17 - 08/18/17	01/01/17 - 06/30/17
Summer	05/13/17 - 08/18/17	06/01/17 - 06/30/17 & 07/01/17 - 07/31/17

If you have any questions regarding your coverage or the length of time you purchased, please contact customer service at 855-267-0214.

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 by calling 1-855-267-0214 or at https://policy-srv.box.com/s/p0keu0i6npqd42xzwu6m68imhedskn6z

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per individual: **$500** Network/**$1,500** Out-of-Network Doesn't apply to services that charge a copay, prescription drugs, ambulance, or Network preventive care. Copays and per occurrence deductibles don't count toward the overall 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**.
Are there other deductibles for specific services?	Yes. $**100** prescription drug deductible. There are no other specific deductibles.	You must pay all the costs for these services up to the specific **deductible** amount before the plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. Network: **$6,600** Individual/**$13,200** Family Out-of-Network: **$15,000** Individual	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
Does this plan use a network of providers?	Yes. For a list of Network providers, please call 1-855-267-0214 or see www.bcbsok.com	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-of-network **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?	Yes. If a referral is not obtained from the Student Health Center, all services from other providers will be paid at the out-of-network cost sharing level. Pediatric and OB/GYN services do not require a referral.	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 5. 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 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	All services will be considered out-of-network unless referral is obtained from the Student Health Center. Acupuncture is not a covered benefit
	Specialist visit	20% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsok.com/member/prescriptiondrugs.html	Generic drugs	$15 copay	Not Covered	Must meet separate $100 prescription drug deductible before copays apply. Copay applies for up to a 30 day supply. Prescriptions limited to 90 day supply at retail pharmacies. At SHC only: $15 Generic and $50 Brand. Deductible does not apply. No charge for birth control.
	Preferred brand drugs	$50 copay	Not Covered	
	Non-preferred brand drugs	$50 copay	Not Covered	
	Specialty drugs	$50 copay	Not Covered	

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 you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay plus 20% coinsurance	$100 copay plus 20% coinsurance	$35 copay plus 20% coinsurance at Norman Regional. Non-emergent use of ER 40% coinsurance out-of-network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible does not apply.
	Urgent care	$35 copay/visit	$35 copay/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	Inpatient preauthorization required.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Inpatient preauthorization required. All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	

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 you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Rehabilitation services	20% coinsurance	Not Covered	Outpatient: Combined 25 visit limit per benefit period for physical and occupational therapies. Inpatient: Preauthorization required. All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Habilitation services	20% coinsurance	Not Covered	
	Skilled nursing care	20% coinsurance	Not Covered	All services will be considered out-of-network unless referral is obtained from the Student Health Center.
	Durable medical equipment	20% coinsurance	40% coinsurance	Medically necessary, rental or purchase at the plan's discretion.
	Hospice service	20% coinsurance	Not Covered	All services will be considered out-of-network unless referral is obtained from the Student Health Center.
If your child needs dental or eye care	Eye exam	Covered	Covered	Refer to benefit booklet for details.
	Glasses	Covered	Covered	Refer to benefit booklet for details.
	Dental check-up	Covered	Covered	Refer to benefit booklet for details.

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
- Bariatric surgery (For treatment of obesity/weight reduction)
- Cosmetic surgery (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental care (Adult and Child)
- Elective abortion (Unless the life of the mother is endangered)
- Infertility treatment
- Long-term care
- Routine foot care (Only for diabetic members)
- Routine eye care (Adult)
- Weight loss programs

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
- Non-emergency care when traveling outside the U.S. (With the exception of any services and supplies provided to a Subscriber incurred outside the U.S. if the Subscriber traveled to the location for the purposes of receiving medical services, supplies, or drugs)
- Private-duty nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-520-2507. You may also contact your state insurance department at (405) 521-2991.

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: Oklahoma Department of Insurance at (405) 521-2991 or visit www.ok.gov/oid.

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 1-855-267-0214.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-267-0214.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-267-0214.

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** $5,520
- **Patient pays** $2,020

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	$520
Copays	$0
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,740
- **Patient pays** $1,660

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	$600
Copays	$600
Coinsurance	$380
Limits or exclusions	$80
Total	**$1,660**

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 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.