



BlueCross BlueShield of Oklahoma

University of Oklahoma Self-funded
Student Health 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 Self-funded Student Health Plan covering plans purchased between 07/01/19 - 08/18/20. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for University of Oklahoma Self-funded Student Health Plan are listed below:

Coverage Periods:

OU-HSC Coverage Periods:

<u>Fall 1:</u>	<u>07/01/19 - 12/31/19</u>
<u>Fall 1 – A</u>	<u>07/01/19 – 08/31/19</u>
<u>Fall 2:</u>	<u>08/15/19 - 12/31/19</u>
<u>Spring:</u>	<u>01/01/20 - 05/31/20</u>
<u>Spring/Summer:</u>	<u>01/01/20 - 06/30/20</u>
<u>Summer 1:</u>	<u>06/01/20 - 06/30/20</u>

Tulsa-Norman Coverage Periods:

<u>Annual:</u>	<u>08/19/19 - 08/18/20</u>
<u>Fall:</u>	<u>08/19/19 - 01/12/20</u>
<u>Spring:</u>	<u>01/13/20 - 05/10/20</u>
<u>Spring/Summer:</u>	<u>01/13/20 - 08/18/20</u>
<u>Summer:</u>	<u>05/13/20 - 08/18/20</u>

CESL Coverage Periods:

<u>Fall 1:</u>	<u>08/19/19 - 10/10/19</u>
<u>Fall 2:</u>	<u>10/11/19 - 01/12/20</u>
<u>Spring 1:</u>	<u>01/13/20 - 03/12/20</u>
<u>Spring 2:</u>	<u>03/13/20 - 05/10/20</u>
<u>Summer 1:</u>	<u>05/11/20 - 06/25/20</u>
<u>Summer 2:</u>	<u>06/26/20 - 08/18/20</u>


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



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 1-855-267-0214 or visit <https://ou.myahpcare.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/ccio/resources/forms-reports-and-other-resources/downloads/uq-glossary-508-mm.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$500 Individual <u>Out-of-Network</u> : \$1,500 Individual	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.
Are there services covered before you meet your deductible?	Yes. Services at Student Health Center, <u>urgent care</u> , <u>prescription drugs</u> , ambulance, and <u>In-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 deductibles for specific services?	Yes. Annual \$100 <u>prescription drug deductible</u> . 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 out-of-pocket limit for this plan?	<u>In-Network</u> : \$6,600 Individual / \$13,200 Family <u>Out-of-Network</u> : \$15,000 Individual	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 out-of-pocket limit?	<u>Premiums</u> , <u>balanced-billed charges</u> , 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 network provider?	Yes. See www.bcbsok.com or call 1-855-267-0214 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.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		In-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	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center. 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. All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsok.com/member/prescriptiondrugs.html	Generic drugs	\$15 <u>copay</u>	Not Covered	Must meet separate \$100 prescription drug <u>deductible</u> before <u>copays</u> apply. <u>Copay</u> applies for up to a 30-day supply. Prescriptions limited to 90-day supply at retail pharmacies. At Student Health Center only: \$15 Generic and \$50 Brand. <u>Deductible</u> does not apply. No charge for birth control. Mail order is not covered. <u>Specialty drugs</u> must be obtained from Prime Specialty Pharmacy. Limited to 30-day supply.
	Preferred brand drugs	\$50 <u>copay</u>	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u>	Not Covered	
	<u>Specialty drugs</u>	\$15/\$50 <u>copay</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center. Elective abortion is not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at <https://ou.myahpcare.com>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> plus 20% <u>coinsurance</u>	\$150 <u>copay</u> plus 20% <u>coinsurance</u>	Emergency room <u>copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> other outpatient services	Office visit No Covered 40% <u>coinsurance</u> other outpatient services	Inpatient <u>preauthorization</u> required.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	<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). Inpatient <u>preauthorization</u> required. All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center. Pediatric and OB/GYN services do not require a <u>referral</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at <https://ou.myahpcare.com>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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>	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not Covered	Outpatient: Combined 25 visit limit per benefit period for physical and occupational therapies. Inpatient: <u>Preauthorization</u> required. All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Medically necessary, rental or purchase at the plan's discretion.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
If your child needs dental or eye care	Children's eye exam	Covered	Covered	Refer to benefits booklet for details.
	Children's glasses	Covered	Covered	Refer to benefits booklet for details.
	Children's dental check-up	Covered	Covered	Refer to benefits booklet for details.

* For more information about limitations and exceptions, see the plan or policy document at <https://ou.myahpcare.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
- Dental care (Adult and child)
- Elective abortion (unless the life of the mother is endangered)
- Infertility treatment
- Long-term care
- Routine eye care (Adult and child)
- Routine foot care (except with diagnosis of diabetes)
- 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
- Hearing aids (1 per ear per 48-month period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Network only)

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 1-866-520-2507. You may also contact your state insurance department at (405) 521-2991. 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: Oklahoma Department of Insurance at (405) 521-2991 or visit www.ok.gov/oid.

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 1-855-267-0214.

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, kwijigo holne' 1-855-267-0214.

————— *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>	\$500
■ <u>Specialist copay</u>	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

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>	\$500
■ <u>Specialist copay</u>	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$600
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,360

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

*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>