



## 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 07/01/22 - 08/18/23. In accordance with your College/University, coverage may be purchased for varying periods of time.

All deductibles, out-of-pocket limits, and limits on benefits that are specified in the plan documents and the SBC, begin accruing on the first day of the earliest coverage period the student chooses below, and stop accruing on the last day of the latest coverage period the student chooses below. In instances where those periods are interrupted by coverage periods for which the student declines coverage, the deductibles, out-of-pocket limits, and limits on benefits do not reset when the student resumes coverage. The coverage periods for University of Oklahoma Self-funded Student Health Plan are listed below:

### Coverage Periods:

#### **OU-HSC Coverage Periods:**

Fall 1:	<u>07/01/22 - 12/31/22</u>
Fall 2:	<u>08/15/22 - 12/31/22</u>
Spring:	<u>01/01/23 - 05/31/23</u>
Spring/Summer:	<u>01/01/23 - 06/30/23</u>
Summer 1:	<u>06/01/23 - 06/30/23</u>

#### **Tulsa-Norman Coverage Periods:**

Annual:	<u>08/19/22 - 08/18/23</u>
Fall:	<u>08/19/22 - 01/16/23</u>
Spring:	<u>01/17/23 - 05/14/23</u>
Spring/Summer:	<u>01/17/23 - 08/18/23</u>
Summer:	<u>05/15/23 - 08/18/23</u>

#### **CESL Coverage Periods:**


Fall 1:	<u>08/19/22 - 10/16/22</u>
Fall 2:	<u>10/17/22 - 01/17/23</u>
Spring 1:	<u>01/18/23 - 03/20/23</u>
Spring 2:	<u>03/21/23 - 05/11/23</u>
Summer 1:	<u>05/12/23 - 06/29/23</u>
Summer 2:	<u>06/30/23 - 08/18/23</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 at <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.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 <u>deductible</u>?</b>	<u>In-Network/Out Network</u> with Referral: \$500 Individual <u>In-Network/Out Network</u> without Referral: \$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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. Annual \$100 <u>prescription drug deductible</u> . Annual \$75 Individual/\$225 Family <u>pediatric dental 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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care 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 <u>network provider</u>?</b>	Yes. See <a href="http://www.bcsok.com">www.bcsok.com</a> 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 charge</u> 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 <u>referral</u> to see a <u>specialist</u>?</b>	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
		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	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	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.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	
<b>If you have a test</b>	<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	
<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>	Generic drugs	\$15 <u>copay</u> /30-day supply	Not Covered	Must meet separate \$100 <u>prescription drug deductible</u> before <u>copays</u> apply. 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> /30-day supply	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> /30-day supply	Not Covered	
	<u>Specialty drugs</u>	\$15/\$50 <u>copay</u> /30-day supply	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)	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>	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit day plus 20% <u>coinsurance</u>	\$150 <u>copay</u> /visit day plus 20% <u>coinsurance</u>	<u>Copay</u> /visit per; 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	40% <u>coinsurance</u>	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> PCP/ \$50 <u>copay</u> SPC /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> other outpatient services	40% <u>coinsurance</u>	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.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	\$35 <u>copay</u> PCP/ \$50 <u>copay</u> SPC; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<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
	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 [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)	
				require a <u>referral</u> .
<b>If you need help recovering or have other special health needs</b>	<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	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not Covered	Outpatient: None 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>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>	<u>Medically necessary</u> rental or purchase at the <u>plan's</u> discretion.
	<u>Hospice services</u>	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.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge; Up to \$30 dollars	Refer to <u>Plan</u> document page 22-27
	Children's glasses	No Charge	No Charge; Up to \$75 dollars	Refer to <u>Plan</u> document page 22-27
	Children's dental check-up	20% <u>coinsurance</u>	40% <u>coinsurance</u> <u>deductible</u> does not apply	Refer to <u>Plan</u> document page 28-40

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com](http://www.bcbsok.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)
- Elective abortion (unless the life of the mother is endangered)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care (except 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
- 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 1-855-267-0214. 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 1-855-267-0214 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 1-855-267-0214.

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*)

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

<i>Cost sharing</i>	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,010</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>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost sharing</i>	
Deductibles*	\$600
Copayments	\$1,200
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,900</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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







**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>