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 are the SBC for the University of Oklahoma Self-funded Student Health Plan covering plans purchased between 6/1/2025 - 08/14/2026. 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:

| **OU-HSC Coverage Periods** | |
|---|---|
| Summer | 6/1/2025 – 7/31/2025 |
| Fall I | 6/1/2025 – 12/31/2025 |
| Fall II | 7/1/2025 – 12/31/2025 |
| Fall III | 8/15/2025 – 12/31/2025 |

| **Tulsa-Norman Coverage Periods** | |
|---|---|
| Fall | 8/15/2025 – 8/14/2026 |
| Spring | 1/12/2026 – 5/10/2026 |
| Spring/Summer | 1/12/2026 – 8/14/2026 |
| Summer | 5/11/2026 – 8/14/2026 |

| **CESL Coverage Periods** | |
|---|---|
| Fall I | 8/15/2025 – 10/17/2025 |
| Fall II | 10/18/2025 – 1/11/2026 |
| Spring I | 1/12/2026 – 3/15/2026 |
| Spring II | 3/16/2026 – 5/10/2026 |
| Summer I | 5/11/2026 – 6/28/2026 |
| Summer II | 6/29/2026 – 8/14/2026 |

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://ousystem.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/ or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $500 Individual<br>Out Network: $1,500 Individual | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Services at Student Health Center, urgent care, prescription drugs, ambulance, and In-Network preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.<br>For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Annual $100 prescription drug deductible. Annual $75 Individual/$225 Family pediatric dental deductible. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: $6,600 Individual / $13,200 Family<br>Out-of-Network: $15,000 Individual / Unlimited Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **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 network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | $35 copay/visit; deductible does not apply | 40% coinsurance | None |
| | Specialist visit | $50 copay/visit; deductible does not apply | 40% coinsurance | None |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | Preauthorization may be required; see your policy* for details. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.bcbsok.com/member/prescriptiondrugs.html | Generic drugs | $15 copay/30-day supply | Not Covered | Must meet separate $100 prescription drug deductible before copays apply.<br>ESN limited to 90-day supply.<br>At Student Health Center only: $15 Generic and $50 Brand. Deductible does not apply. No charge for birth control.<br>Mail order is not covered.<br>Specialty drugs must be obtained from Prime Specialty Pharmacy. Limited to 30-day supply. |
| | Preferred brand drugs | $50 copay/30-day supply | Not Covered | |
| | Non-preferred brand drugs | $50 copay/30-day supply | Not Covered | |
| | Specialty drugs | $15/$50 copay/30-day supply | Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at https://ousystem.myahpcare.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% coinsurance | 40% coinsurance | Preauthorization may be required; see your policy* for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit day plus 20% coinsurance | $150 copay/visit day plus 20% coinsurance | Copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | None |
| | Urgent care | $60 copay/visit; deductible does not apply | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required; see your policy* for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copay PCP/ $50 copay SPC/office visit; deductible does not apply 20% coinsurance other outpatient services | 40% coinsurance | Preauthorization may be required; see your policy* for details. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization is required; see your policy* for details. |
| **If you are pregnant** | Office visits | $35 copay PCP/ $50 copay SPC; deductible does not apply | 40% coinsurance | Copayment applies to the first prenatal visit (per pregnancy); deductible and coinsurance apply for subsequent visits. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Inpatient preauthorization required. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at https://ousystem.myahpcare.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** | Home health care | 20% coinsurance | Not Covered | Preauthorization is required; see your policy* for details. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Outpatient: None<br>Inpatient: Preauthorization required. |
| | Habilitation services | 20% coinsurance | Not Covered | |
| | Skilled nursing care | 20% coinsurance | Not Covered | Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Medically necessary rental or purchase at the plan's discretion. |
| | Hospice services | 20% coinsurance | Not Covered | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | No Charge; Up to $30 | Refer to plan policy for details. |
| | Children's glasses | No Charge | No Charge; Up to $100 | Refer to plan policy for details. |
| | Children's dental check-up | 20% coinsurance; deductible does not apply | 40% coinsurance; deductible does not apply | Refer to plan policy for details. |

* For more information about limitations and exceptions, see the plan or policy document at https://ousystem.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
- Elective abortion (unless the life of the mother is endangered)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Dental care (Adult)
- Hearing aids (1 per ear per 48-month period)
- 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: For group health coverage contact the plan, Blue Cross and Blue Shield of Oklahoma at 1-855-267-0214 or visit www.bcbsok.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Oklahoma at 1-855-267-0214 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-800-522-0071 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Oklahoma at 1-855-267-0214 or visit www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html

**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, kwiijigo 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 plan's overall deductible** | **$500** |
| **Specialist copay** | **$50** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $50 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,010** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copay** | **$50** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost sharing* | |
|---|---|
| Deductibles* | $600 |
| Copayments | $1,200 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,900** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copay** | **$50** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,100** |

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

**Health care coverage is important for everyone.**

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 talk to an interpreter, call 855-710-6984. 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, sexual orientation, health status or disability. 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

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/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

| | **To receive language or communication assistance free of charge, please call us at 855-710-6984.** |
|---|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |