Blue Preferred Silver PPO℠ 101 - Three $0 PCP Visits

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

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 document at www.bcbsok.com/static/ok/pdf/policy-forms/2017/87571OK0320047-01.pdf or by calling 1-866-520-2507.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$3,250** Individual/ **$9,750** Family. Out-of-Network: **$9,750** Individual/**$29,250** Family. Doesn't apply to non-specialty prescription drugs, or the following In-Network services: preventive care, first three PCP office visits, or mental health/ substance use disorder office visits. Copays 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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Network: **$6,850** Individual/ **$13,700** Family. Out-of-Network: **Unlimited** Individual/**Unlimited** Family.	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, preauthorization penalties, balance-billed charges, Out-of-Network prescription drug 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**.
Does this plan use a network of providers?	Yes. For a list of Network providers please call **1-866-520-2507** 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 3 for how this plan pays different kinds of **providers**.

Questions: Call **1-866-520-2507** or visit us at www.bcbsok.com/coverage.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 7. 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 health 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.**)
- The 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	50% coinsurance	First three Network office visits are no charge; deductible and coinsurance apply for subsequent visits. First three Out-of-Network office visits are 30% coinsurance after deductible. Virtual visits may be available, please refer to your policy for more details.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Acupuncture is not covered.
	Preventive care/screening/immunization	No Charge	30% coinsurance	Annual mammography screening and childhood immunizations are covered at 100% of the allowable amount Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	Hospital – 40% coinsurance Non-Hospital - 20% coinsurance	50% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	Hospital – 40% coinsurance Non-Hospital - 20% coinsurance	50% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_OK_5T_EX.pdf	Preferred generic drugs	Retail – No Charge/ $5 copay/prescription Mail – No Charge	Retail – $5 copay/ prescription	Lower copay applies at preferred Network pharmacies. All non-specialty Out-of-Network prescriptions subject to 50% penalty. Up to 30 day supply retail. Up to 90 day supply mail, Network only. Specialty drugs limited to 30 day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Prior authorization may be required. Failure to preauthorize may result in claim denial.
	Non-preferred generic drugs	Retail – $10/$15 copay/prescription Mail – $30 copay/ prescription	Retail – $15 copay/ prescription	
	Preferred brand drugs	Retail – $50/$60 copay/prescription Mail – $150 copay/ prescription	Retail – $60 copay/ prescription	
	Non-preferred brand drugs	Retail – $100/$110 copay/prescription Mail – $300 copay/ prescription	Retail – $110 copay/ prescription	
	Specialty drugs	30% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital – $300 copay/procedure plus 40% coinsurance Non-Hospital - $300 copay/procedure plus 20% coinsurance	$1,500 copay/ procedure plus 50% coinsurance	Copay is charged in addition to the overall deductible. Elective abortion is not covered. $500 penalty for failure to preauthorize Out-of-Network.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$600 copay/visit plus 20% coinsurance	$600 copay/visit plus 20% coinsurance	Copay is charged in addition to the overall deductible and is waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	50% 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 have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/admit plus 20% coinsurance	$1,500 copay/admit plus 50% coinsurance	Copay is charged in addition to the overall deductible. $500 penalty for failure to preauthorize. Preauthorization requirement is waived if admitted from the emergency room.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge for office visits or 20% coinsurance for other outpatient services	30% coinsurance for office visits or 50% coinsurance for other outpatient services	Outpatient: Preauthorization required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment. Virtual visits may be available for Outpatient services, please refer to your policy for more details. Inpatient: Copay is charged in addition to the overall deductible.
	Mental/Behavioral health inpatient services	$400 copay/admit plus 20% coinsurance	$1,500 copay/admit plus 50% coinsurance	
	Substance use disorder outpatient services	No Charge for office visits or 20% coinsurance for other outpatient services	30% coinsurance for office visits or 50% coinsurance for other outpatient services	
	Substance use disorder inpatient services	$400 copay/admit plus plus 20% coinsurance	$1,500 copay/admit plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	First Network prenatal visit (per pregnancy) is no charge if one of the first three office visits per benefit period; deductible and coinsurance apply for subsequent visits. First Out-of-Network prenatal visit (per pregnancy) is 30% coinsurance after deductible if one of the first three office visits per benefit period.
	Delivery and all inpatient services	$400 copay/admit plus plus 20% coinsurance	$1,500 copay/admit plus 50% coinsurance	Copay is charged in addition to the overall deductible.

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	50% coinsurance	30 visit maximum per benefit period. $500 penalty for failure to preauthorize.
	Rehabilitation services	20% coinsurance	50% coinsurance	Outpatient: Combined 25 visit limit per benefit period for physical, speech, occupational therapy and muscle manipulation services. Inpatient: 30 day maximum per benefit period. Preauthorization required; $500 penalty if not preauthorized at least one business day prior to admission.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	30 visit maximum per benefit period. $500 penalty for failure to preauthorize.
	Durable medical equipment	20% coinsurance	50% coinsurance	Medically necessary rental or purchase at the plan's discretion.
	Hospice service	20% coinsurance	50% coinsurance	Inpatient copay may apply. $500 penalty if not preauthorized at least one business day prior to admission.
If your child needs dental or eye care	Eye exam	No Charge	No Charge	One visit per year. Reimbursed up to $30 Out-of-Network.
	Glasses	No Charge	No Charge	One pair of glasses per year. Up to $150 in-network. Reimbursed up to $75 frames/$25 single vision lenses Out-of-Network.
	Dental check-up	Not Covered	Not Covered	---none---

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 weight loss purposes)
- 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)
- Hearing aids (Limited to one for each ear every 48 months)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Private-duty nursing (Limited to 85 visits per year)
- Routine foot care (Except for diabetic subscribers)

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 1-405-521-2991.

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 1-405-521-2991 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-520-2507.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-520-2507.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-520-2507.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-520-2507.

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 the plan. The actual care you receive will be different from these examples, and the cost of that care also will 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** $4,040
- **Patient pays** $3,500

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	$3,300
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$3,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,020
- **Patient pays** $3,380

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	$3,300
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,380**

Questions and answers about 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 in-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.

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 talk to an interpreter, call 866-520-2507.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم .866-520-2507
မွန္မာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် 866-520-2507 သို့ ခေါ် ဆိုပါ။.
ᏣᎳᎩ Cherokee	ᏂᎯᏃ, ᎠᏎ ᏱᏣ ᏴᏫ Ꮎ ᎯᏍᏕᏢᏍᏗᎬᏱ, ᏣᏍᏛ Ꮫ Ꮬ ᏍᏕᏍ , Ꮒ Ꭿ Ꮳ Ꮷ Ꮎ ᏍᏆᏱ Ꭱ Ꮳ Ꮅ ᏍᏕᏍ Ꮧ Ꮧ Ꭰ Ꮄ Ꭱ Ꮳ Ꮓ Ꮞ Ꮧ Ꮳ̈ Ꮜ Ꮳ ᏡᏂ ᎯᏍᏗ Ꭼ ᏔᏅ Ᏹ Ꭰ Ꮞ ᏉᏉ. Ꭰ Ꮎ ᏁᏢ Ꮧ ᏍᏆᏱ ᏍᏓ Ꮌ Ꮓ Ꮕ Ꮧ Ꭲ , Ꮻ Ꮟ ᏔᏫ Ᏹ 866-520-2507.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 866-520-2507.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 866-520-2507.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 866-520-2507 an.
Hmoob Hmong	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug kwstxhais lus tham, hu rau 866-520-2507.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 866-520-2507 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 866-520-2507.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 866-520-2507.

فارسی Persian	اگر شما، یا کسی که شما به او کمک مي کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 866-520-2507 تماس حاصل نمایید.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 866-520-2507.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 866-520-2507.
ไทย Thai	**หากคุณ หรือคนทีคุณกาลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิทีจะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อที่หมายเลข** 866-520-2507.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، پر 866-520-2507 کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 866-520-2507.