BlueCross BlueShield of Oklahoma

Blue Preferred Silver PPO 003

Coverage Period: 01/01/2014-12/31/2014

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/coverage or by calling 1-866-520-2507.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$6,000** Individual/ **$12,700** Family. Out-of-Network: **$12,000** Individual/**$25,400** Family. Doesn't apply to services that charge a copay, certain preventive care, or prescription drugs.	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. Per occurrence: **$500** emergency room, **$250** Network/ **$350** Out-of-Network inpatient admission, **$200** Network/**$300** Out-of-Network outpatient surgery. There are no other specific **deductibles**.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. Network: **$6,000** Individual/ **$12,700** Family. Out-of-Network: **$12,000** Individual/**$25,400** 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, pre-authorization penalties, 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 **1-866-520-2507** 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 2 for how this plan pays different kinds of **providers**.
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 5. See your policy or plan document for additional information about **excluded services**.

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 1-866-520-2507 to request a copy.

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

- **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	$30 copay/visit	20% coinsurance	---none---
	Specialist visit	$50 copay/visit	20% coinsurance	
	Other practitioner office visit	$30 copay PCP/ $50 copay specialist	20% coinsurance	Acupuncture is not a covered benefit.
	Preventive care/screening/immunization	No Charge	20% 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)	No Charge	20% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	No Charge	20% coinsurance	
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	Preferred Generic Drugs	No Charge	No Charge	All Out-of-Network prescriptions subject to additional 50% penalty. Up to 30 day supply retail. Up to 90 day supply mail, Network only. Specialty drugs limited to 30 day supply. Prior authorization may be required. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	Non-Preferred Generic Drugs	$10 copay retail/ $20 copay mail	$10 copay retail	
	Preferred Brand Drugs	$50 copay retail/ $100 copay mail	$50 copay retail	
	Non-Preferred Brand Drugs	$100 copay retail/ $200 copay mail	$100 copay retail	
	Specialty Drugs	$150 copay	$150 copay	

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)	No Charge	20% coinsurance	Additional $200 Network/$300 Out-of-Network per occurrence deductible.
	Physician/surgeon fees	No Charge	20% coinsurance	---none---
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Additional $500 per occurrence deductible; waived if admitted.
	Emergency medical transportation	No Charge	No Charge	---none---
	Urgent care	No Charge	20% coinsurance	Copay may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Additional $250 Network/$350 Out-of-Network per occurrence deductible. $500 penalty for failure to preauthorize.
	Physician/surgeon fee	No Charge	20% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit or No Charge for other outpatient services	20% coinsurance	Outpatient: Preauthorization required for psychological testing, neuropsychological testing, electroconvulsive therapy, and intensive outpatient treatment; $500 penalty for failure to preauthorize. Inpatient: $500 penalty for failure to preauthorize. Additional $250 Network/$350 Out-of-Network per occurrence deductible.
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	
	Substance use disorder outpatient services	$30 copay/visit or No Charge for other outpatient services	20% coinsurance	
	Substance use disorder inpatient services	No Charge	20% coinsurance	
If you are pregnant	Prenatal and postnatal care	$30 copay/initial visit	20% coinsurance/ initial visit	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	No Charge	20% coinsurance	Additional $250 Network/$350 Out-of-Network per occurrence 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	No Charge	20% coinsurance	30 visit maximum per benefit period. $500 penalty for failure to preauthorize.
	Rehabilitation services	No Charge	20% coinsurance	Outpatient: Combined 25 visit limit per benefit period for physical, speech, and occupational therapy. Inpatient: 30 day maximum per benefit period. $500 penalty for failure to preauthorize.
	Habilitation services	No Charge	20% coinsurance	
	Skilled nursing care	No Charge	20% coinsurance	30 day inpatient maximum per benefit period. $500 penalty for failure to preauthorize.
	Durable medical equipment	No Charge	20% coinsurance	Medically necessary rental or purchase at the plan's discretion.
	Hospice service	No Charge	20% coinsurance	$500 penalty for failure to preauthorize.
If your child needs dental or eye care	Eye exam	No Charge	Covered	Reimbursed up to $30 Out-of-Network. One visit per calendar year. Ages 18 and under only.
	Glasses	No Charge	Covered	Reimbursed up to $30 frames/$25 single vision lenses Out-of-Network. One pair per calendar year. Ages 18 and under only.
	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 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)
- Hearing aids (Limited coverage for children)
- Infertility treatment
- Long-term care
- 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
- Non-emergency care when traveling outside the U.S. (With the exception of any services and supplies provided to a Subscriber incurred outside the United States if the Subscriber traveled to the location for the purposes of receiving medical services, supplies, or drugs)
- Private-duty nursing
- Routine foot care (Only for diabetic members)

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 1-800-522-0071.

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 (800) 522-0071 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** $1,040
- **Patient pays** $6,500

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	$6,300
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$6,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

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	$2,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,480**

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.