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, www.ccok.com. For 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.ccok.com/pdf/SBC/SBCUniformGlossary-2017.pdf or call 1-800-777-4890 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 member/$1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and physician office visits 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. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network $3,500 Member/$7,000 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 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.ccok.com/directory or 1-800-777-4890 for a list of in-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
		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	$25 / visit Deductible does not apply	Not covered	None
	Specialist visit	$35 / visit Deductible does not apply	Not covered	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)	No charge Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ccok.com** or by calling 1-877-293-8628.	Preferred generic drugs	$15 retail / prescription $30 mail order / prescription	Not covered	Covers up to a 90 day supply at retail and mail order for maintenance drugs at a cost share equal to 2 retail copayments.
	Preferred brand drugs	$40 retail / prescription $80 mail order / prescription	Not covered	Covers up to a 90 day supply at retail and mail order for maintenance drugs at a cost share equal to 2 retail copayments.
	Non-preferred brand or generic drugs	$70 retail / prescription $140 mail order / prescription	Not covered	Covers up to a 90 day supply at retail and mail order for maintenance drugs at a cost share equal to 2 retail copayments.
	Specialty drugs	$160 retail / prescription	Not Covered	Covers up to a 30 day supply for retail. The difference between brand and generic pricing is not covered.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 / visit Deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician office visit - $25 / visit Other outpatient services - 20% coinsurance Deductible does not apply to physician office visits	Not covered	None
	Inpatient services	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you are pregnant	Office Visits	No charge Deductible does not apply	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	None

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)	
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Rehabilitation services	20% coinsurance	Not covered	Up to 60 treatment days per disability, per calendar year. Combination of physical, occupational, and speech therapy. Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	Not covered	Up to 60 treatment days per disability, per calendar year. Inpatient requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Durable medical equipment	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Hospice services	20% coinsurance Deductible does not apply	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	Not covered	Limited to one exam in 365 days.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)		
• Bariatric surgery	• Dental care (Child)	• Non-emergency care when traveling outside the U.S.
• Children's glasses	• Habilitation Services	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aids (Limited to one for each hearing impaired ear in any 48 month period.)	• Routine eye care (Adult) (limited to 1 visit per year)
• Chiropractic care		

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: CommunityCare at 1-800-777-4890 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: CommunityCare at 1-800-777-4890. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/healthreform, or the Oklahoma Insurance Department at 1-800-522-0071.

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 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 (Espanol): Para obtener asistencia en Espanol, llame al 1-800-777-4890.

To see examples of howthis 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 copayment** **$35**
- **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*
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$2,790**

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 copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Primary care physician office visits
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	$0
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,360**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Emergency room care (*including medical*
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	$40
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

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