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?	$750 member/$2,250 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?	Medical In-network $4,000 member/$8,000 family. Pharmacy $4,000 Individual /$8,000 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	$40 / visit Deductible does not apply	Not covered	None
	Specialist visit	$50 / 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)	20% coinsurance	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. Envision Imaging not subject to Deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medalistrx.com** or by calling 1-855-633-2579.	Preferred generic drugs	$15 retail / $30 mail order per prescription Maximum out-of-pocket $4,000 Individual / $8,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 25% coinsurance. Prescription benefits do not apply to medical only coverage.
	Preferred brand drugs	$45 retail / $90 mail order per prescription Maximum out-of-pocket $4,000 Individual / $8,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 25% coinsurance. Prescription benefits do not apply to medical only coverage.
	Non-preferred brand or generic drugs	$45 retail / $90 mail order per prescription Maximum out-of-pocket $4,000 Individual / $8,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 25% coinsurance. Prescription benefits do not apply to medical only coverage.

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)	
	Specialty drugs	$45 Copay for <$1,000 Maximum out-of-pocket $4,000 Individual / $8,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 30 day supply. Prescriptions costing $1,000 or more; 25% coinsurance. Prescription benefits do not apply to medical only coverage.
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	Copayment is waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$60 / 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 - $40 / 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.

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 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
	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	Inpatient - 20% coinsurance Outpatient - $50 / Visit Deductible does not apply to Outpatient Rehabilitation	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	Inpatient - 20% coinsurance Outpatient - $50 / Visit Deductible does not apply to Outpatient Rehabilitation	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.
	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	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.)		
• Acupuncture • Bariatric surgery • Children's glasses • Cosmetic surgery • Dental care (Adult)	• Dental care (Child) • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • 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 (Limited to one for each hearing impaired ear in any 48 month period.)

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** **$750**
- **Specialist copayment** **$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*
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$50**
- **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	$400
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,240**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$50**
- **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	$800
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

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?	Medical $250 member/$750 family in-network; Unlimited out-of-network.	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?	Medical In-network $2,000 member/$4,000 family, Out-of-Network Unlimited. Pharmacy $2,000 Individual / $4,000 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, balance-billing charges,Outpatient Prescription Drugs, penalties for failure to obtain pre-certification for out of network services, 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 for PCP Deductible does not apply	50% coinsurance	None
	Specialist visit	$25 / visit Deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	50% coinsurance	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)	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Requires preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medalistrx.com** or by calling 1-855-633-2579.	Preferred generic drugs	$5 retail / $10 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
	Preferred brand drugs	$35 retail / $70 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.

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)	
	Non-preferred brand or generic drugs	$35 retail / $70 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
	Specialty drugs	$35 Copay for <$1,000 Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 30 day supply. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Requires preauthorization.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Requires preauthorization.
If you need immediate medical attention	Emergency room care	10% coinsurance	50% coinsurance	None.
	Emergency medical transportation	10% coinsurance	50% coinsurance	None
	Urgent care	$50 / visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Requires preauthorization.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Requires preauthorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit Deductible does not apply	50% coinsurance	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)	
	Inpatient services	10% coinsurance	50% coinsurance	Requires preauthorization.
If you are pregnant	Office Visits	No charge Deductible does not apply	50% coinsurance	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	10% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	None
	Rehabilitation services	Inpatient - 10% coinsurance Outpatient - 10% coinsurance	50% coinsurance	Requires preauthorization. Up to 60 treatment days per disability, per calendar year.
	Habilitation services	Inpatient - 10% coinsurance Outpatient - 10% coinsurance	50% coinsurance	Requires preauthorization. Up to 60 treatment days per disability, per calendar year.
	Skilled nursing care	10% coinsurance	50% coinsurance	Up to 60 treatment days per disability, per calendar year.
	Durable medical equipment	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	Hospital stays require prior preauthorization.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	50% coinsurance.	Coverage is limited to one exam in 365 days.
	Children's glasses	Not covered	Not covered	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)	
	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.)		
• Acupuncture • Bariatric surgery • Children's glasses • Cosmetic surgery • Dental care (Adult)	• Dental care (Child) • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • 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 (Limited to one for each hearing impaired ear in any 48 month period.)	•

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 how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,040**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$30
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$530**

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

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?	Medical $250 member/$750 family in-network; Unlimited out-of-network.	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?	Medical In-network $2,000 member/$4,000 family, Out-of-Network Unlimited. Pharmacy $2,000 Individual / $4,000 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, balance-billing charges, Outpatient Prescription Drugs, penalties for failure to obtain pre-certification for out of network services, 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 for PCP Deductible does not apply	50% coinsurance	None
	Specialist visit	$25 / visit Deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	50% coinsurance	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)	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Requires pre-certification. Envision Imaging not subject to Deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medalistrx.com** or by calling 1-855-633-2579.	Preferred generic drugs	$5 retail / $10 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
	Preferred brand drugs	$35 retail / $70 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.

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)	
	Non-preferred brand or generic drugs	$35 retail / $70 mail order per prescription Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 90 day supply for retail and mail order at 2 copays. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
	Specialty drugs	$35 Copay for <$1,000 Maximum out-of-pocket $2,000 Individual / $4,000 Family	Covered upon request for reimbursement at appropriate pricing levels	Covers up to a 30 day supply. Prescriptions costing $1,000 or more; 20% coinsurance. Prescription benefits do not apply to medical only coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Requires pre-certification.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Requires pre-certification.
If you need immediate medical attention	Emergency room care	10% coinsurance	50% coinsurance	Benefits will be denied if not medically necessary.
	Emergency medical transportation	10% coinsurance	50% coinsurance	None
	Urgent care	$50 / visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Requires pre-certification.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Requires pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit Deductible does not apply	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	Requires pre-certification.

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 are pregnant	Office Visits	No charge Deductible does not apply	50% coinsurance	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	10% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	None
	Rehabilitation services	Inpatient - 10% coinsurance Outpatient - 10% coinsurance	50% coinsurance	Medical Review after 25 visits. Requires pre-certification.
	Habilitation services	Inpatient - 10% coinsurance Outpatient - 10% coinsurance	50% coinsurance	Medical Review after 25 visits. Requires pre-certification.
	Skilled nursing care	10% coinsurance	50% coinsurance	Up to 60 treatment days per disability, per calendar year. Requires pre-certification.
	Durable medical equipment	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	Requires pre-certification.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	50% coinsurance.	Coverage is 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.)		
• Acupuncture • Bariatric surgery • Children's glasses • Cosmetic surgery • Dental care (Adult)	• Dental care (Child) • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • 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 (Limited to one for each hearing impaired ear in any 48 month period.)

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** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,040**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$30
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$530**

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