

 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 general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and physician office visits are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network \$3,500 Member/\$7,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 / visit <u>Deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$35 / visit <u>Deductible</u> does not apply	Not covered	None
	<u>Preventive care/ screening/ immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>Deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.ccok.com</u> or by calling 1-877-293-8628.	Preferred generic drugs	\$15 retail \$30 mail order per prescription	Not covered	Covers up to a 30 day supply for retail, a 90 day supply for maintenance drugs and a 90 day supply for mail order.
	Preferred brand drugs	\$40 retail \$80 mail order per prescription	Not covered	Covers up to a 30 day supply for retail, a 90 day supply for maintenance drugs and a 90 day supply for mail order. 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)	
	Non-preferred brand or generic drugs	\$70 retail \$140 mail order per prescription	Not covered	Covers up to a 30 day supply for retail, a 90 day supply for maintenance drugs and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.
	<u>Specialty drugs</u>	\$160 retail per prescription	Not Covered	Covers up to a 30 day supply for retail. The difference between brand and generic pricing is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 / visit <u>Deductible</u> does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> 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% <u>coinsurance</u> <u>Deductible</u> does not apply to physician office visits	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)	
	Inpatient services	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you are pregnant	Office Visits	No charge <u>Deductible</u> does not apply	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Up to 60 treatment days per disability, per calendar year. Combination of physical, occupational, and speech therapy. Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Up to 60 treatment days per disability, per calendar year. Inpatient requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Hospice services</u>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply	Not covered	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.)

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|-----------------------|-------------------------|--|
| • 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.)

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|---------------------|---|--|
| • 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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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.

Multi-Language Interpreter Services - Taglines for Notices

Spanish Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.

Vietnamese Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.

Chinese 本通知有重要的訊息。本通知有關於您透過 CommunityCare 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字1-800-777-4890]

Korean 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.

German Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.

Arabic يحوي هذا الاعتراف معلومات هامة. يحوي هذا الاعتراف معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال CommunityCare. ابحث عن التواريخ الهامة في هذا الاعتراف. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب 1-800-777-4890

Burmese ဤစာ၌ ဝေအရီးသင်္ကဏ်းဝေ သာ အြကအလက ပါဝင်ပါသည်။ ။ ဤစာ၌ သင် အြကလက တသသ မဟုတ် CommunityCare င သင်္ကဏ်း ဝေ သာ သင် ပြစားခြင်း အြကအလကမီးပါဝင်ပါသည်။ ။ အသေကရကစေ ကသ ဤစာ၌ တဝေ ခဖပါ။ သတတဝ်တီးဝေ သာ ဝေ နာကဝ်ဝ် ဝီးရက မတ္တုဗေ ကန် ဝီးမာဝေ ရိုးပြစားခြင်း သသ မဟုတ် စရသတိပြစားခြင်း ဆကလကရရ သေဝေစရရ ဝေ ဆာငရကစရာရ သသသ ကသ ဝေ ဆာငရကပါ။ ဤကသစဝ င ပတု ချ မန္တ ဝေ သာ အြကအလကမီးရရ သရန် ကန္တရသတုံ ဝေ ပရန္တလသုတ် မသမသတာသစကဏ်း ဖြစ်အကူအညီရယူ သ ှု။ 1-800-777-4890။

Hmong Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyooq los yog tej hnuv tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas pab kom koj ua tsis pub dhau cov caij nyooq uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom

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CommunityCare™

CommunityCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CommunityCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact CommunityCare's Senior Manager of Quality Improvement. If you believe that CommunityCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CommunityCare
Attn: Senior Manager Quality Improvement
P.O. Box 3249 Tulsa, Oklahoma 74101
(918) 594-5303 (phone)
(918) 594-5250 (Fax)
CustomerServiceReview@ccok.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CommunityCare's Senior Manager of Quality Improvement is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

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