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.ccok.com or by calling 1-800-777-4890.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 person/$4,000 family. Doesn't apply to preventive care or pharmacy.	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?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network $6,000 person/$12,000 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.ccok.com or call 1-800-777-4890.	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 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.

- 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 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.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-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 / visit	Not covered	----------none----------
	Specialist visit	$50 / visit	Not covered	----------none----------
	Other practitioner office visit	$30 / visit	Not covered	Deductible application and co-payment may vary based on provider type and/or place of service.
	Preventive care/ screening/ immunization	No charge	Not covered	Not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	$25/visit for x-ray and No charge on blood work	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$200 / visit	Not covered	Requires pre-authorization. Failure to receive pre-authorization 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.	Preferred generic drugs	$15 retail / $30 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. Some preferred generic drugs have no charge.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preferred brand drugs	$60 retail / $120 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order.
	Non-preferred brand or generic drugs	$85 retail / $170 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order.
	Specialty drugs	$120 per prescription	Not covered	Covers up to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 / visit	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Physician/surgeon fees	No charge	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
If you need immediate medical attention	Emergency room services	$150 / visit	$150 / visit	Co-payment is waived if admitted to the hospital.
	Emergency medical transportation	$50.00 / transport	$50.00 / transport	----------none----------
	Urgent care	$50 / visit	Not covered	Not subject to the deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200/day not to exceed 1,000.00	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Physician/surgeon fees	No charge	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 / visit	Not covered	----------none----------
	Mental/Behavioral health inpatient services	$200/day not to exceed $1,000.00	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	$30.00 / visit	Not covered	----------none----------
	Substance use disorder inpatient services	$200.00/day not to exceed $1,000.00	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Not subject to the deductible.
	Delivery and all inpatient services	$200/day not to exceed $1,000.00	Not covered	----------none----------
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Rehabilitation services	Inpatient - $100/day. Outpatient - $50/visit.	Not covered	Up to 60 treatment days per disability, per calendar year. Combination of physical, occupational, and speech therapy. Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	$25 / day	Not covered	Up to 60 treatment days per disability, per calendar year. Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Durable medical equipment	20% co-insurance	Not covered	Out-of-pocket limits do not apply. Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits.
	Hospice service	No charge	Not covered	Requires pre-authorization. Failure to receive pre-authorization will result in non-payment of benefits. Not subject to the deductible.
If your child needs dental or eye care	Eye Exam	No charge	Not covered	Limited to one exam in 365 days. Not subject to the deductible.
	Glasses	Not covered	Not covered	Not covered

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not covered	Not covered	Not covered

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.)

- Bariatric surgery
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care (Limited to 12 visits per month and 30 visits per year. Chiropractic maintenance therapy not covered.)
- Hearing aids (Except age 19 and over)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-777-4890. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov or the Oklahoma State Department of Insurance 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: CommunityCare at 1-800-777-4890. You may also contact the Department of Labor's Employee Benefits Security Admnistration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Oklahoma Insurance Department at 1-800-522-0071.

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.

Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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 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 this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,990
- **Patient Pays:** $2,550

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	$2,000
Copays	$400
Coinsurance	$0
Limits or exclusions	$150
Total	$2,550

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

- **Amount owed to providers:** $5,400
- **Plan Pays:** $3,510
- **Patient Pays:** $1,890

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	$1,300
Copays	$590
Coinsurance	$0
Limits or exclusions	$0
Total	$1,890

Questions and answers about the 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.