

 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, visit www.bcbsook.com/bb/mm/bb_mobap0015_ok_2025.pdf or by calling 1-866-520-2507. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$1,350 Individual/\$4,050 Family Out-of-Network: \$2,700 Individual/\$8,100 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. In-network preventive health, certain services with a copayment, prescription drugs, ambulance and diagnostic test 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. ER \$500; Inpatient \$200; Outpatient Surgery Facility \$150. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: \$3,000 Individual/\$9,000 Family Out-of-Network: \$9,000 Individual/\$27,000 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, preauthorization penalties, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsook.com/blueadvantage or call 1-866-520-2507 for a list of 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
		Network Provider (You will pay the least)	Out-of-Network (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; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Telemedicine Visits are available. See your benefit booklet* for details.
	<u>Specialist</u> visit	\$70/visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	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	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsok.com/rx-drugs/drug-lists/drug-lists	Generic drugs (Preferred)	Retail: Preferred - No Charge Participating - \$10/prescription Mail: No Charge; <u>deductible</u> does not apply	Retail: \$10/prescription; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Your cost for a covered insulin drug will not exceed \$30 per 30-day supply or \$90 per 90-day supply.
		Retail: Preferred - \$10/prescription Participating - \$20/prescription Mail: \$30/prescription; <u>deductible</u> does not apply	Retail: \$20/prescription; <u>deductible</u> does not apply	
	Generic drugs (Non-Preferred)			
	Brand drugs (Preferred)	Retail: Preferred - \$50/prescription Participating - \$70/prescription Mail - \$150/prescription; <u>deductible</u> does not apply	Retail: \$70/prescription; <u>deductible</u> does not apply	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/bb/mm/bb_mobap0015_ok_2025.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	
	Brand drugs (Non-Preferred)	Retail: Preferred - \$100/prescription Participating - \$120/prescription Mail: \$300/prescription; <u>deductible</u> does not apply	Retail: \$120/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Preferred)	\$250/prescription; <u>deductible</u> does not apply	\$250/prescription; <u>deductible</u> does not apply plus 50% additional charge	
	<u>Specialty drugs</u> (Non-Preferred)	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply plus 50% additional charge	
	Facility fee (e.g., ambulatory surgery center)	\$150/visit plus 30% <u>coinsurance</u>	\$250/visit plus 40% <u>coinsurance</u>	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
If you have outpatient surgery	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
If you need immediate medical attention	<u>Emergency room care</u>	\$500/visit plus 30% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	Per occurrence <u>deductible</u> waived if admitted. Out of network cost share is subject to <u>Network deductible</u> .
	<u>Emergency medical transportation</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$50/visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200/visit plus 30% coinsurance	\$300/visit plus 40% coinsurance	Preauthorization required. \$500 penalty for failure to preauthorize. See your benefit booklet* for details.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Preauthorization required. See your benefit booklet* for details.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40/office visit; deductible does not apply or 30% coinsurance for other outpatient services	30% coinsurance for office visits or 40% coinsurance for other outpatient services	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	\$200/visit plus 30% coinsurance	\$300/visit plus 40% coinsurance	Preauthorization required. \$500 penalty for failure to preauthorize.
If you are pregnant	Office visits	Primary Care: \$40/initial visit Specialist: \$70/visit; deductible does not apply	30% coinsurance	Copayment applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for preventive services. 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	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	\$200/visit plus 30% coinsurance	\$300/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	30 visits per benefit period. \$500 penalty for failure to preauthorize.
	Rehabilitation services	30% coinsurance	40% coinsurance	Outpatient: Separate 25-visit limit per benefit period for Rehabilitation and Habilitation Services, which includes physical, speech, occupational therapy and muscle manipulation.
	Habilitation services	30% coinsurance	40% coinsurance	Inpatient: Separate 30-day maximum for Rehabilitation and Habilitation Services per benefit period. \$500 penalty for failure to preauthorize.
	Skilled nursing care	30% coinsurance	40% coinsurance	30-day inpatient maximum per benefit period. \$500 penalty for failure to preauthorize.
	Durable medical equipment	30% coinsurance	40% coinsurance	Medically necessary rental or purchase at the plan's discretion.
	Hospice services	30% coinsurance	40% coinsurance	\$500 penalty for failure to preauthorize.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)		
<ul style="list-style-type: none">• Abortion (Unless the life of the mother is endangered)• Acupuncture• Bariatric surgery (For treatment of obesity/weight reduction)• Cosmetic surgery (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)	<ul style="list-style-type: none">• Dental care (Adult and Child)• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Routine eye care (Adult and Child)• Routine foot care (Except for diabetic subscribers)• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Chiropractic care (25 visit maximum per benefit period combined with outpatient therapies)• Hearing aids (One hearing aid per ear every 48 months)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. (With the exception of any services and supplies provided to a Subscriber incurred outside the United States if the Subscriber traveled to the location for the purposes of receiving medical services, supplies, or drugs)	<ul style="list-style-type: none">• Private-duty nursing (Limited to 85 visits per benefit 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: For group health coverage contact the [plan](#), Blue Cross and Blue Shield of Oklahoma at 1-866-520-2507 or visit www.bcbsok.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 on how 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: For group health coverage subject to ERISA: the [plan](#) at 1-866-520-2507 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, the [plan](#) at 1-866-520-2507 or www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

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 the 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 1-866-520-2507.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-520-2507.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-520-2507.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-520-2507.

To see examples of how this 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 \$1,350
- Specialist copayment \$70
- Hospital (facility) copay/coins \$200+30%
- Other coinsurance 30%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,350
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,010

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,350
- Specialist copayment \$70
- Hospital (facility) copay/coins \$200+30%
- Other coinsurance 30%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

- The plan's overall deductible \$1,350
- Specialist copayment \$70
- Hospital (facility) copay/coins \$200+30%
- Other coinsurance 30%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019

TTY/TDD:

800-537-7697

Complaint Portal: <https://ocrportal.hhs.gov/ocr/main.jsf>

Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.	
Español	Udámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لنطق المساعدة اللغوية أو التراسل ميلاً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભૂતપૂર્ણ સહાયતા મેળવવા માટે, કૃપા કરીને 855-710-6984 નંબર પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiama il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná : Doo bilagáana bizaad dinit'sá'góó, shá ata' hodooni ninizingo, t'áájiik'eh bee náhaz'á. 1-866-560-4042 ji' hodiilni.
فارسی	برای دریافت کمک و زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلات کی مدد موسوں کرنے کے لیے، براؤ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

