

 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.bcbsok.com/bb/ind/bb_bhse40baviokp_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. You can view 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?	\$7,500 Individual/\$15,000 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. Preventive health care, services with a <u>copayment</u> , and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	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 <u>preventive services</u> at 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?	\$9,200 Individual/\$18,400 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> , <u>balance billing</u> charges, 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.bcbsok.com/myblue or call 1-866-520-2507 for a list of <u>network 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?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		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	\$50/visit; <u>deductible</u> does not apply	Not Covered	Telemedicine Visits are available. See your benefit booklet* for details.
	<u>Specialist</u> visit	\$100/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<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)	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required; see your benefit booklet* for details.

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 Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsok.com/rx25/4T	Generic drugs	Retail: Preferred Participating - \$25/prescription Participating - \$25/prescription Mail - \$75/prescription; <u>deductible</u> does not apply	Not Covered	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. <u>Preauthorization</u> is required for certain drugs. 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.
	Brand drugs (Preferred)	Retail: Preferred Participating - \$50/prescription Participating - \$50/prescription Mail - \$150/prescription after <u>deductible</u>	Not Covered	
	Brand drugs (Non-Preferred)	Retail: Preferred Participating - \$100/prescription Participating - \$100/prescription Mail - \$300/prescription after <u>deductible</u>	Not Covered	
	<u>Specialty drugs</u>	\$500/prescription after <u>deductible</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required; See your benefit booklet* for details.
	Physician/surgeon fees	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.

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 Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50/office visit; <u>deductible</u> does not apply or 50% <u>coinsurance</u> for other outpatient services	Not Covered	Telemedicine Visits are available. <u>Preauthorization</u> required; see your benefit booklet* for details.
	Inpatient services	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required; see your benefit booklet* for details.
If you are pregnant	Office visits	Primary Care: \$50/initial visit Specialist: \$100/initial visit; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies to first prenatal visit only (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	50% <u>coinsurance</u>	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 facility services	50% <u>coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	Not Covered	30 visits/year. <u>Referral</u> required. <u>Preauthorization</u> required; see your benefit booklet* for details.
	<u>Rehabilitation services</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required; see your benefit booklet* for details. Outpatient: Separate 25-visit limit per benefit period for <u>Rehabilitation</u> and <u>Habilitation services</u> , which includes physical, speech, occupational therapy, and muscle manipulation. Inpatient: Separate 30-day maximum for <u>Rehabilitation</u> and <u>Habilitation services</u> per benefit period.
	<u>Habilitation services</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	Not Covered	30 days/year. <u>Referral</u> required. <u>Preauthorization</u> required; see your benefit booklet* for details.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	<u>Hospice services</u>	50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> required; See your benefit booklet* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/bb/ind/bb_bhse40baviokp_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 Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	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.)

- Abortion (except when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery (for treatment of obesity/weight reduction)
- Cosmetic surgery (Except when medically necessary)
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except when medically necessary)
- 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 (Chiropractic and Osteopathic manipulation combined with outpatient therapies limited to 25 visits per calendar year)
- Hearing aids (limited to one each ear every 48 months)
- Private-duty nursing (limited to 85 visits per year)

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: the plan at Blue Cross and Blue Shield of Oklahoma at 1-866-520-2507 or visit www.bcbsok.com. You may also contact your state insurance department at 1-405-521-2991 or the, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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 or state Health Insurance Marketplace or SHOP.

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: Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov.

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? Not Applicable.

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): Dinek'ehgo 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$7,500	■ The plan's overall deductible	\$7,500	■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$100	■ Specialist copayment	\$100	■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%	■ Other coinsurance	50%	■ Other coinsurance	50%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$7,500	<u>Deductibles</u>	\$900	<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$0	<u>Copayments</u>	\$1,100	<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$1,700	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$9,260	The total Joe would pay is	\$2,020	The total Mia would pay is	\$2,600

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/smartscreen/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	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، 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	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 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, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jì' hodíilni.
فارسی	برای دریافت کمک 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 مواصلت کی مدد موصول کرنے کے لیے، براہ 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.