



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\\_gpsa30bvpikoko\\_ok\\_2025.pdf](http://www.bcbsok.com/bb/ind/bb_gpsa30bvpikoko_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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Network</u> : \$1,100 Individual/\$2,200 Family <u>Out-of-Network</u> : \$3,300 Individual/\$6,600 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In-Network Preventive Health care, primary care services, 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>Network</u> : \$7,850 Individual/\$15,700 Family <u>Out-of-Network</u> : Unlimited Individual/Unlimited 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.
<u>What is not included in the out-of-pocket limit?</u>	<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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.bcbsok.com/blueadvantageppo">www.bcbsok.com/blueadvantageppo</a> 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 charge</u> 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.
<u>Do you need a referral to see a specialist?</u>	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
		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	No Charge; <b>deductible</b> does not apply	30% <b>coinsurance</b>	Telemedicine Visits are available. See your benefit booklet* for details.
	<u>Specialist</u> visit	30% <b>coinsurance</b>	50% <b>coinsurance</b>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <b>deductible</b> does not apply	30% <b>coinsurance</b>	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)	Freestanding Facility: 20% <b>coinsurance</b> Hospital: 30% <b>coinsurance</b>	50% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: 20% <b>coinsurance</b> Hospital: 30% <b>coinsurance</b>	50% <b>coinsurance</b>	Preauthorization is 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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsok.com/rx25/6T">www.bcbsok.com/rx25/6T</a>	Generic drugs (Preferred)	Retail: Preferred Participating - No Charge Participating - \$10/prescription Mail: No Charge; <u>deductible</u> does not apply	Retail: \$10/prescription; <u>deductible</u> does not apply plus 50% additional charge	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>Prauthorization</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.
	Generic drugs (Non-Preferred)	Retail: Preferred Participating - \$5/prescription Participating - \$20/prescription Mail: \$15/prescription; <u>deductible</u> does not apply	Retail: \$20/prescription; <u>deductible</u> does not apply plus 50% additional charge	
	Brand drugs (Preferred)	Retail: Preferred Participating - 30% <u>coinsurance</u> Participating - 35% <u>coinsurance</u>	Retail: 35% <u>coinsurance</u> plus 50% additional charge	
	Brand drugs (Non-Preferred)	Retail: Preferred Participating - 35% <u>coinsurance</u> Participating - 40% <u>coinsurance</u>	Retail: 40% <u>coinsurance</u> plus 50% additional charge	
	<u>Specialty drugs</u> (Preferred)	45% <u>coinsurance</u>	45% <u>coinsurance</u> plus 50% additional charge	
	<u>Specialty drugs</u> (Non-Preferred)	50% <u>coinsurance</u>	50% <u>coinsurance</u> plus 50% additional charge	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Freestanding Facility: 20% <u>coinsurance</u> Hospital: 30% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	<u>Prauthorization</u> is required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$950/visit plus 30% <u>coinsurance</u>	\$950/visit plus 30% <u>coinsurance</u>	Copayment waived if admitted. Out-of-network <u>cost share</u> is subject to Network deductible.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com/bb/ind/bb\\_gpsa30bvpioko\\_ok\\_2025.pdf](http://www.bcbsok.com/bb/ind/bb_gpsa30bvpioko_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)	
	<u>Emergency medical transportation</u>	30% coinsurance	30% coinsurance	None
	<u>Urgent care</u>	30% coinsurance	50% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400/visit plus 30% coinsurance	\$2,000/visit plus 50% coinsurance	<u>Prauthorization</u> is required. Facility: <u>Prauthorization</u> penalty: \$500. See your benefit booklet* for details.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	<u>Prauthorization</u> is required. See your benefit booklet* for details.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% coinsurance for office visit or 20% coinsurance for other outpatient services	50% coinsurance	Telemedicine Visits are available. <u>Prauthorization</u> is required; see your benefit booklet* for details.
	Inpatient services	\$400/visit plus 30% coinsurance	\$2,000/visit plus 50% coinsurance	<u>Prauthorization</u> is required; see your benefit booklet* for details. <u>Prauthorization</u> penalty: \$500.
<b>If you are pregnant</b>	Office visits	Primary Care: No Charge/initial visit; <u>deductible</u> does not apply <u>Specialist</u> : 30% coinsurance	Primary Care: 30% coinsurance <u>Specialist</u> : 50% coinsurance	No Charge for initial visit, or 30% coinsurance for initial visit. 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	50% coinsurance	
	Childbirth/delivery facility services	\$400/visit plus 30% coinsurance	\$2,000/visit plus 50% coinsurance	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% coinsurance	50% coinsurance	30 visits/year. <u>Prauthorization</u> is required.
	<u>Rehabilitation services</u>	30% coinsurance	50% coinsurance	

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com/bb/ind/bb\\_gpsa30bvpioko\\_ok\\_2025.pdf](http://www.bcbsok.com/bb/ind/bb_gpsa30bvpioko_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)	
<b>If your child needs dental or eye care</b>	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	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>Preatuthorization</u> is required. Preatuthorization penalty: \$500.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30 days/year. <u>Preatuthorization</u> is required. Inpatient <u>Preatuthorization</u> penalty: \$500.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	Inpatient: \$400/visit plus 30% <u>coinsurance</u> Outpatient: 30% <u>coinsurance</u>	Inpatient: \$2,000/visit plus 50% <u>coinsurance</u> Outpatient: 50% <u>coinsurance</u>	<u>Preatuthorization</u> is required. Inpatient <u>Preatuthorization</u> penalty: \$500.
	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

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsok.com/bb/ind/bb\\_gpsa30bvpioko\\_ok\\_2025.pdf](http://www.bcbsok.com/bb/ind/bb_gpsa30bvpioko_ok_2025.pdf)

## **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 (unless 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.bcbso.com](http://www.bcbso.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](http://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](http://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](http://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 a'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)

■ <u>The plan's overall deductible</u>	\$1,100
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) copayment/coinsurance</u>	\$400+30%
■ <u>Other coinsurance</u>	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**

#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$3,200

#### What isn't covered

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,760</b>

### Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$1,100
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) copayment/coinsurance</u>	\$400+30%
■ <u>Other coinsurance</u>	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**

#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$30

#### What isn't covered

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,550</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$1,100
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) copayment/coinsurance</u>	\$400+30%
■ <u>Other coinsurance</u>	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**

#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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., 35<sup>th</sup> 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	للتلقى المساعدة اللغوية أو التواصل مجاناً، 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 મફુતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिन्दी	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 dinit'sá'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 ji' hodilni.
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 помошь 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 لئے، براہ کرم بیٹھن 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.