


⚠️ 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-gpsh45bvpiokp-ok-2020.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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$1,200 Individual/\$3,600 Family Out-of-Network: \$3,600 Individual/\$10,800 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. In-Network Preventive Health, certain services with a copay, and some <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?	Network: \$8,150 Individual/\$16,300 Family Out-of-Network: 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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</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. For a list of <u>network providers</u> please call 1-866-520-2507 or see www.bcbsok.com .	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.
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
		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	\$25/visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual Visits are available. See your benefit booklet* for details.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	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)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	30% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	30% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the plan or policy document at www.bcsok.com/bb/ind/bb-gpsh45bvpiokp-ok-2020.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 you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsok.com/rx1.pdf	Preferred generic drugs	Retail - Preferred Participating - \$5/prescription Participating - \$10/prescription Mail - \$15/prescription; <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> limited to a 30-day supply. 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. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/ <u>coinsurance</u> . Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts.
	Non-preferred generic drugs	Retail - Preferred Participating - \$10/prescription Participating - \$20/prescription Mail - \$30/prescription; <u>deductible</u> does not apply	Retail - \$20/prescription, <u>deductible</u> does not apply	
	Preferred brand drugs	Preferred Participating - 30% <u>coinsurance</u> Participating - 35% <u>coinsurance</u>	Retail - 35% <u>coinsurance</u>	
	Non-preferred brand drugs	Preferred Participating - 35% <u>coinsurance</u> Participating - 40% <u>coinsurance</u>	Retail - 40% <u>coinsurance</u>	
	Preferred <u>specialty drugs</u>	45% <u>coinsurance</u>	45% <u>coinsurance</u>	
	Non-preferred <u>specialty drugs</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	\$1,500/visit plus 30% <u>coinsurance</u>	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	25% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$950/visit plus 25% <u>coinsurance</u>	\$950/visit plus 25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	25% <u>coinsurance</u>	30% <u>coinsurance</u>	Office visit <u>copayment</u> may apply instead of <u>coinsurance</u> .

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/bb/ind/bb-gpsh45bvpiokp-ok-2020.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 you have a hospital stay	Facility fee (e.g., hospital room)	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance	Preauthorization required. Preauthorization penalty: \$500. See your benefit booklet* for details.
	Physician/surgeon fees	25% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance for office visits; 15% coinsurance for other outpatient services	30% coinsurance	Outpatient: Preauthorization may be required; see your benefit booklet* for details. Inpatient: Preauthorization required. Preauthorization penalty:\$500
	Inpatient services	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance	
If you are pregnant	Office visits	Primary Care: \$25 Specialist: 25% coinsurance	30% coinsurance	Copay applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	30% coinsurance	30 visits/year. Preauthorization may be required.
	Rehabilitation services	25% coinsurance	30% coinsurance	Preauthorization may be required. Outpatient: Separate 25 visit limit per benefit period for Rehabilitation and Habilitation services, which includes physical, speech, occupational therapy and muscle manipulation. Inpatient: Separate 30 day maximum for Rehabilitation and Habilitation services per benefit period. Preauthorization penalty: \$500.
	Habilitation services	25% coinsurance	30% coinsurance	
	Skilled nursing care	25% coinsurance	30% coinsurance	
	Durable medical equipment	25% coinsurance	30% coinsurance	Preauthorization may be required.
	Hospice services	25% coinsurance	30% coinsurance	Preauthorization may be required. Inpatient Preauthorization penalty: \$500.
	If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	Not Covered
Children's glasses		No Charge; deductible does not apply	Not Covered	One pair of glasses per year. See your benefit booklet* 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.bcsok.com/bb/ind/bb-gpsh45bvpiokp-ok-2020.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 (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- 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 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)

- Chiropractic care (Limited to 25 visits per calendar year.)
- Hearing aids (Limited to one for 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 1-866-520-2507. You may also contact your state insurance department at 1-800-522-0071. 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: the Oklahoma Department of Insurance 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 1-800-522-0071 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

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 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): 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)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	25%
■ Hospital (facility) copay/coins.	\$400 + 25%
■ Other coinsurance	25%

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
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$400
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,360

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	25%
■ Hospital (facility) copay/coins.	\$400 + 25%
■ Other coinsurance	25%

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
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$400
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,960

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	25%
■ Hospital (facility) copay/coins.	\$400 + 25%
■ Other coinsurance	25%

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
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

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



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.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فليك الحق في الحصول بلع المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદ્મ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éi doodago la'da biká anánílwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóótí'í' t'áá níik'e níká a'doolwoł dóó bína'ídiłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'i'í' hodiílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاف، با شماره 855-710-6984 تماس حاصل نمایید.
PolSKI Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفہممد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.



Health care coverage is important for everyone.

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.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

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, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>