### Benefit Summary 2014

#### BLUECHOICE PPO HIGH OPTION

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic &amp; Preferred — Cost of Rx: $100 or less</strong></td>
<td><strong>Member pays lesser of $25 or actual cost</strong></td>
<td><strong>Member pays cost of Rx up to $75 max plus dispensing fee</strong></td>
</tr>
<tr>
<td><strong>Generic &amp; Preferred — Cost of Rx: Greater than $100</strong></td>
<td><strong>Member pays 25% up to $50 max</strong></td>
<td><strong>Member pays cost of Rx up to $75 max plus dispensing fee</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred — Cost of Rx: $100 or less</strong></td>
<td><strong>Member pays lesser of $50 or actual cost</strong></td>
<td><strong>Member pays cost of Rx up to $125 max plus dispensing fee</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred — Cost of Rx: Greater than $100</strong></td>
<td><strong>Member pays 50% up to $100 max</strong></td>
<td><strong>Member pays cost of Rx up to $125 max plus dispensing fee</strong></td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum</strong></td>
<td><strong>$2,500 per individual</strong></td>
<td><strong>No out-of-pocket maximum</strong></td>
</tr>
</tbody>
</table>

#### Other Covered Services

- **Occupational & Speech Therapy** (Each service limited to 60 visits per CY)
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

- **Physical and Chiropractic Therapy** (Services combined limited to 60 visits per CY)
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

- **Hearing Screening** (limited to one per CY)
  - 100%
  - 50% after CYD
  - 100%
  - 50% after CYD

- **Hearing Aids**
  - Covered as DME up to age 18

- **Durable Medical Equipment (DME), Prosthetics and Orthotics**
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

- **Skilled Nursing Facility (100 days per CY)**
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

- **Home Health Care (100 visits per CY)**
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

- **Hospice**
  - 80% after CYD
  - 50% after CYD
  - 50% after CYD

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*Requires Pre-Authorization

This benefit summary is a Non-Grandfathered health plan. Benefits assume, and are subject to the use of BCBSOK's administrative policies, procedures, and medical policies. Out of network charges are paid utilizing the Blue Choice allowable amount. Members may be balanced billed by the provider. This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations, and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.
## Benefit Summary 2014

### General Plan Information

<table>
<thead>
<tr>
<th></th>
<th>In Network</th>
<th>Out of Network</th>
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<tbody>
<tr>
<td><strong>Network</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year Deductible (CYD)</strong></td>
<td>$1,000 Ind. / $3,000 Family</td>
<td>$1,000 Ind. / $3,000 Family</td>
<td>$500 Ind. / $1,000 Family</td>
<td>$500 Ind. / $1,000 Family</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-pocket Max</strong></td>
<td>$3,300 Ind. / $9,900 Family</td>
<td>$3,800 Ind. / $11,400 Family</td>
<td>$5,500 Ind. / $11,000 Family</td>
<td>$5,500 Ind. / $11,000 Family</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td>Plan Pays 80% after CYD</td>
<td>Plan pays 50% after CYD</td>
<td>Plan Pays 50% after CYD</td>
<td>Plan Pays 50% after CYD</td>
</tr>
<tr>
<td><strong>Lifetime Max – Medical</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Lifetime Max – Pharmacy</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### Network and Benefits

- **In Network**
  - **primary care office visit**: $25 copay
  - **Diagnostic X-ray/Lab**: 80% after CYD
  - **Inpatient Hospital**: 80% after CYD
  - **Outpatient Surgery**: 80% after CYD
  - **Well Baby Care**: 100%
  - **Adult Immunizations**: 100%
  - **Routine Health Exams**: 100%
  - **Routine Mammograms**: 100%
  - **Allergy Treatment/Testing**: 80% after CYD
  - **Emergency Room**: $100 copay; then 80% after CYD (copay waived if admitted)

- **Out of Network**
  - **Primary Care Office Visit**: 50% after CYD
  - **Specialist Office Visit**: 50% after CYD
  - **Diagnostic X-ray/Lab**: 50% after CYD
  - **Inpatient Hospital**: 50% after CYD
  - **Outpatient Surgery**: 50% after CYD
  - **Well Baby Care**: 100%
  - **Adult Immunizations**: 100%
  - **Routine Health Exams**: 50% after CYD
  - **Routine Mammograms**: 100%
  - **Allergy Treatment/Testing**: 50% after CYD
  - **Emergency Room**: 50% after CYD

### Network Coverage

- **In Network**: Plan pays 100% of the first $500 of eligible charges for each individual then:
  - 50% after CYD
- **Out of Network**: Plan pays 80% after CYD

### Deductibles

- **In Network**: $500 Ind. / $1,000 Family
- **Out of Network**: $5,500 Ind. / $11,000 Family

### Additional Information

- **Well Baby Care**
  - Health Assessment (HA) — $250 deductible credit to employee or spouse (no children) upon completion
  - HA deductible credit applies to 2014 plan year and must be completed between 01/01/14 and 12/31/14.
  - HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.

- **Mental Health and Substance Abuse**
  - Inpatient: 80% after CYD
  - Outpatient: 80% after CYD
  - General Plan Information: 80% after CYD

- **Denial of Benefits**
  - Benefits may be denied if: the non-emergency nature of a service is not appropriate; services are not considered medically necessary; services are not covered by the plan; services were not rendered in accordance with accepted standards of medical practice; services were not rendered by a provider in good standing; services were not rendered in accordance with the plan's authorization requirements.