BlueCross BlueShield of Oklahoma

Benefit Summary 2018

	RED PLAN		WHITE PLAN				BLUE PLAN	
Network	Blue Choice PPO℠		BlueOptions℠				Blue Choice PPO℠	
	In Network	Out of Network	Blue Preferred PPO℠	Blue Choice PPO℠	Blue Traditional℠	Out of Network	In Network	Out of Network
General Plan Information							1st Dollar Coverage: Plan pays 100% of the first $500 of eligible charges for each individual then:	
Calendar Year Deductible (CYD)	$1,000 Ind. / $3,000 Family	$1,000 Ind. / $3,000 Family	$1,250 Ind. / $3,750 Family				$500 Ind. / $1,000 Family	$500 Ind. / $1,000 Family
General Payment Level	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Calendar Year Out-Of-Pocket Max (Includes deductible and pharmacy/medical copays)	$3,300 Ind. / $9,900 Family	$3,800 Ind. / $11,400 Family	$3,500 Ind. / $10,500 Family	$4,000 Ind. / $12,000 Family	$4,500 Ind. / $13,500 Family	$6,500 Ind. /$13,000	$5,500 Ind. / $11,000 Family	$5,500 Ind. / $11,000 Family
Coinsurance	Plan Pays 80% after CYD	Plan pays 50% after CYD	Plan Pays 80% after CYD	Plan Pays 70% after CYD	Plan Pays 60% after CYD	Plan Pays 50% after CYD	Plan Pays 50% after CYD	
Lifetime Max - Medical	Unlimited							
Lifetime Max - Pharmacy	Unlimited							
Primary Care Office Visit	$25 copay	50% after CYD	$25 copay	$35 copay	60% after CYD	50% after CYD	50% after CYD	
Specialist Office Visit	$40 copay	50% after CYD	$40 copay	$50 copay	60% after CYD	50% after CYD	50% after CYD	
Diagnostic X-ray/Lab	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Inpatient Hospital*	80% after CYD	Additional $300 deductible per admit, then 50% after CYD	80% after CYD	70% after CYD	60% after CYD	Additional $300 deductible per admit, then 50% after CYD	50% after CYD	Additional $300 deductible per admit, then 50% after CYD
Outpatient Surgery	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Well Baby Care	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Adult Immunizations	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Routine Health Exams	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Childhood Immunizations	100%							
Routine Mammograms	100%							
Allergy Treatment/Testing (60 tests every 24 months)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Emergency Room	$100 copay; then 80% after CYD (copay waived if admitted)		$150 copay; then 80% after CYD (copay waived if admitted)				50% after CYD	
Health Assessment (HA) - $250 deductible credit to employee, spouse, and dependents over age of 18.	HA deductible credit applies to 2018 plan year and must be completed between 01/01/2018 and 12/31/2018. 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	Additional $300 deductible, then 50% after CYD	80% after CYD	70% after CYD	60% after CYD	Additional $300 deductible per admit, then 50% after CYD	50% after CYD	Additional $300 deductible, then 50% after CYD
Outpatient	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	

Benefit Summary 2018 *(cont'd)*

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	In Network	Out of Network	Blue Preferred PPO℠	Blue Choice PPO℠	Blue Traditional℠	Out of Network	In Network	Out of Network
Occupational & Speech Therapy (Each service limited to 60 visits per CY)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% 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	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Durable Medical Equipment (DME), Prosthetics and Orthotics	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Skilled Nursing Facility (100 days per CY)*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Home Health Care (100 visits per CY)*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Hospice*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Hearing Screening (limited to one per CY)	100% after copay	50% after CYD	100% after copay		60% after CYD	50% after CYD	50% after CYD	
Hearing Aids	Covered as DME up to age 18							

Pharmacy	RED, WHITE and BLUE PLANS	
	In Network	Out of Network
Generic & Preferred – Cost of Rx: $100 or less	Member pays lesser of $25 or actual cost	Member pays cost of Rx up to $75 max plus dispensing fee
Generic & Preferred – Cost of Rx: Greater than $100	Member pays 25% up to $50 max	Member pays cost of Rx up to $75 max plus dispensing fee
Non-Preferred – Cost of Rx: $100 or less	Member pays lesser of $50 or actual cost	Member pays cost of Rx up to $125 max plus dispensing fee
Non-Preferred – Cost of Rx: Greater than $100	Member pays 50% up to $100 max	Member pays cost of Rx up to $125 max plus dispensing fee
102 day supply limit or 300 quantity limit per copay		

*Requires pre-certification

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 PPO℠ 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.