



## 2019 Benefit Summary



	Plan A	Plan B	Plan C	Plan D	Plan E
Network	Choice	Preferred & Choice	Preferred	Choice	Choice
General Plan Information					<b>HSA ELIGIBLE</b>
Calendar Year Deductible (CYD)	\$750 Ind / \$2250 Family	\$1250 Ind / \$3750 Family	\$1500 Ind / \$4000 Family	\$3000 Ind / \$9000 Family	\$1500 Ind / \$3000 Family
Calendar Year Out of Pocket Max <small>Includes deductible and pharmacy/medical copays</small>	\$3000 Ind / \$9000 Family	\$3500 Ind / \$10500 Family BP \$4000 Ind / \$12000 Family BC	\$4000 Ind / \$12000 Family	\$6350 Ind / \$13000 Family	\$3000 Ind / \$6000 Family
Member Coinsurance	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Primary Office Visit Copay	\$20 Copay	\$25 BP/\$35 BC Copay	\$35 Copay	\$35 Copay	20% after CYD
Specialty Office Visit Copay	\$40 Copay	\$40 BP/\$50 BC Copay	\$50 Copay	\$50 Copay	
Preventive Care Visits (Well Baby, Adult/Child Immunizations, Rou- tine Health Screenings)	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostics Lab/X-Ray	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
In-Patient Hospitalization	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Out-Patient Surgery	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Allergy Treatment/Testing	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Emergency Room	\$100 Copay; then 20% after CYD (waived if admitted)	\$150 Copay, then 20%/30% after CYD (waived if admitted)	\$150 Copay; then 20% after CYD (waived if admitted)	\$100 Copay; then 20% after CYD (waived if admitted)	20% after CYD
Urgent Care	\$40 Copay	\$40 BP / \$50 BC Copay	\$50 Copay	\$50 Copay	
Health Risk Assessment	HA deductible credit applies to 2019 plan year and must be completed between 01/01/2019 and 12/31/2019. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.				
<b>Mental Health/Substance Abuse</b>					
In-Patient	20% after CYD	20%/30% after CYD	20% after CYD	20% after CYD	20% after CYD
Out-Patient	\$20 Office Visit Copay 20% after CYD for other services	\$25 BP / \$35 BC Copay 20%/30% after CYD for other services	\$35 Office Visit Copay 20% after CYD for other ser- vices	\$35 Office Visit Copay 20% after CYD for other ser- vices	20% after CYD

# 2019 Benefit Summary *(continued)*



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Rehabilitation Services: Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Habilitation Services: Inpatient: 30 day limit per benefit period. PA required.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Physical and chiropractic Therapy (combined limited to 60 visits per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Durable Medical Equipment (DME)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Skilled Nursing Facility (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Home Health Care (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Hospice (PA Required)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
<b>Pharmacy</b>					
Generic Drugs	Retail: 25% of allowed amount; \$25 Min / \$50 Max Mail Order: \$75 Min / \$150 Max				20% after CYD
Preferred Brand Name Drugs	Retail: 25% of allowed amount; \$25 Min / \$50 Max Mail Order: \$75 Min / \$150 Max				20% after CYD
Non-Preferred Brand Name Drugs	Retail: 50% of allowed amount; \$50 Min / \$100 Max Mail Order: \$150 Min / \$300 Max				20% after CYD
Specialty Drugs	50% of allowed amount; \$50 Min / \$100 Max (Limited to 30 day supply Must be ordered through Prime Therapeutics (no mail order available)				20% after CYD
	30 Day Supply Limit retail. Up to 90 Day Supply of Maintenance drugs. Up to 90 Day Supply Mail, Network Only				

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.