BlueCross BlueShield of Oklahoma

Oklahoma Higher Education Employee Insurance Group

Benefit Summary 2013

	BLUECHOICE PPO HIGH OPTION		BLUECHOICE PPO BASIC OPTION	
	In Network	Out of Network	In Network	Out of Network
General Plan Information			1st Dollar Coverge: Plan pays 100% of the first $500 of eligible charges for each individual then:	
Network	**BLUECHOICE**		**BLUECHOICE**	
Calendar Year Deductible (CYD)	$500 Ind. / $1,500 Family	$500 Ind. / $1,500 Family	$500 Ind. / $1,000 Family	$500 Ind. / $1,000 Family
Calendar Year Out-of-pocket Max (includes deductible)	$2,800 Ind. / $8,400 Family	$3,300 Ind. / $9,900 Family	$5,500 Ind. / $11,000 Family	$5,500 Ind. / $11,000 Family
Co-Insurance	Plan Pays 80% after CYD	Plan pays 50% after CYD	Plan Pays 50% after CYD	Plan pays 50% after CYD
Lifetime Max – Medical	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Max – Pharmacy	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Office Visit	$25 copay	50% after CYD	50% after CYD	50% after CYD
Specialist Office Visit	$40 copay	50% after CYD	50% after CYD	50% after CYD
Diagnostic X-ray/Lab	80% after CYD	50% after CYD	50% after CYD	50% after CYD
Inpatient Hospital*	80% 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	50% after CYD	50% after CYD
Well Baby Care	100%	50% after CYD	100%	50% after CYD
Adult Immunizations	100%	50% after CYD	100%	50% after CYD
Childhood Immunizations	100%	100%	100%	100%
Routine Health Exams	100%	50% after CYD	100%	50% after CYD
Routine Mammograms	100% Age 35-39 one baseline, age 40+ one per year	100% Age 35-39 one baseline, age 40+ one per year (max benefit $115)	100% Age 35-39 one baseline, age 40+ one per year	100% Age 35-39 one baseline, age 40+ one per year (max benefit $115)
Allergy Treatment/Testing (60 tests every 24 months)	80% after CYD	50% after CYD	50% after CYD	50% after CYD
Emergency Room	$100 copay; then 80% after CYD (copay waived if admitted)	$100 copay; then 80% after CYD (copay waived if admitted)	50% after CYD	50% after CYD
Mental Health and Substance Abuse				
Inpatient*	80% after CYD	Additional $300 deductible, then 50% after CYD	50% after CYD	Additional $300 deductible, then 50% after CYD
Outpatient	80 % after CYD	50% after CYD	50% after CYD	50% after CYD

Benefit Summary 2013 *(cont'd)*

BlueCross BlueShield of Oklahoma

	BLUECHOICE PPO HIGH OPTION		BLUECHOICE PPO BASIC OPTION	
	In Network	Out of Network	In Network	Out of Network
Pharmacy: Generic & Preferred Prescription Drugs				
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	Member pays lesser of $25 or actual cost	Member pays cost of Rx up to $75 max plus dispensing fee
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	Member pays 25% up to $50 max	Member pays cost of Rx up to $75 max plus dispensing fee
Out-of-pocket Maximum: Generic and Preferred Drugs	$2500 per individual	No out-of-pocket maximum	$2,500 per individual	No out-of-pocket maximum
Supply Limit (one month)	Greater of 34 days or 100 units			
Three month supply at retail or mail order for 1 copay (Specialty Pharmacy Program medications limited to a 30 day supply)				
Supply Limit (three month)	Greater of 102 days or 300 units			
Pharmacy: Non-Preferred Prescription Drugs				
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	Member pays lesser of $50 or actual cost	Member pays cost of Rx up to $125 max plus dispensing fee
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	Member pays 50% up to $100 max	Member pays cost of Rx up to $125 max plus dispensing fee
Out-of-pocket Maximum: Non-preferred Drugs	No out-of-pocket maximum	No out-of-pocket maximum	No out-of-pocket maximum	No out-of-pocket maximum
Supply Limit (one month)	Greater of 34 days or 100 units			
Three month supply at retail or mail order for 1 copay (Specialty Pharmacy Program medications limited to a 30 day supply)				
Supply Limit (three month)	Greater of 102 days or 300 units			
Other Covered Services				
Occupational & Speech Therapy (Each service limited to 60 visits per CY)	80% after CYD	50% 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	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	Covered as DME up to age 18	Covered as DME up to age 18	Covered as DME up to age 18
Durable Medical Equipment (DME), **Prosthetics and Orthotics**	80% after CYD	50% after CYD	50% after CYD	50% after CYD
Skilled Nursing Facilty (100 days per CY)*	80% after CYD	50% after CYD	50% after CYD	50% after CYD
Home Health Care (100 visits per CY)*	80% after CYD	50% after CYD	50% after CYD	50% after CYD
Hospice*	80% after CYD	50% after CYD	50% after CYD	50% after CYD

*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.