BlueCross BlueShield of Oklahoma

Oklahoma Higher Education Employee Insurance Group

Benefit Summary 2014

	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)	$1,000 Ind. / $3,000 Family	$1,000 Ind. / $3,000 Family	$500 Ind. / $1,000 Family	$500 Ind. / $1,000 Family
Calendar Year Out-of-pocket Max (includes deductible)	$3,300 Ind. / $9,900 Family	$3,800 Ind. / $11,400 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	
Lifetime Max – Medical	Unlimited			
Lifetime Max – Pharmacy	Unlimited			
Primary Care Office Visit	$25 copay	50% after CYD	50% after CYD	
Specialist Office Visit	$40 copay	50% after CYD	50% after CYD	
Diagnostic X-ray/Lab	80% 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	
Well Baby Care	100%	50% after CYD	100%	50% after CYD
Adult Immunizations	100%	50% after CYD	100%	50% after CYD
Childhood Immunizations	100%			
Routine Health Exams	100%	50% after CYD	100%	50% after CYD
Routine Mammograms	100%			
Allergy Treatment/Testing (60 tests every 24 months)	80% after CYD	50% after CYD	50% after CYD	
Emergency Room	$100 copay; then 80% after CYD (copay waived if admitted)		50% after CYD	
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	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	
General Plan Information	80% after CYD	50% after CYD	50% after CYD	

Benefit Summary 2014 *(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 – 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
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	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	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	Member pays 50% up to $100 max	Member pays cost of Rx up to $125 max plus dispensing fee
Out-of-pocket Maximum	$2,500 per individual	No out-of-pocket maximum	$2,500 per individual	No out-of-pocket maximum
102 day supply limit or 300 quantity limit per copay				
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 Facilty (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	

*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.