



# BlueCross BlueShield of Oklahoma



Oklahoma Higher Education  
Employee Insurance Group

## Benefit Summary 2017

Network	RED PLAN		WHITE PLAN				BLUE PLAN	
	Blue Choice PPO <sup>SM</sup>		BlueOptions <sup>SM</sup>				Blue Choice PPO <sup>SM</sup>	
	In Network	Out of Network	Blue Preferred PPO <sup>SM</sup>	Blue Choice PPO <sup>SM</sup>	Blue Traditional <sup>SM</sup>	Out of Network	In Network	Out of Network
<b>General Plan Information</b>							1st Dollar Coverage: Plan pays 100% of the first \$500 of eligible charges for each individual then:	
<b>General Payment Level</b>	80% after CYD	50% after CYD					50% after CYD	
<b>Calendar Year Deductible (CYD)</b>	\$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
<b>Calendar Year Out-Of-Pocket Max</b> <small>(Includes deductible and pharmacy/medical copays)</small>	\$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
<b>Coinsurance</b>	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	
<b>Lifetime Max – Medical</b>	Unlimited							
<b>Lifetime Max – Pharmacy</b>	Unlimited							
<b>Primary Care Office Visit</b>	\$25 copay	50% after CYD	\$25 copay	\$35 copay	60% after CYD	50% after CYD	50% after CYD	
<b>Specialist Office Visit</b>	\$40 copay	50% after CYD	\$40 copay	\$50 copay	60% after CYD	50% after CYD	50% after CYD	
<b>Diagnostic X-ray/Lab</b>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
<b>Inpatient Hospital*</b>	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
<b>Outpatient Surgery</b>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
<b>Well Baby Care</b>	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
<b>Adult Immunizations</b>	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
<b>Routine Health Exams</b>	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
<b>Childhood Immunizations</b>	100%							
<b>Routine Mammograms</b>	100%							
<b>Allergy Treatment/Testing</b> <small>(60 tests every 24 months)</small>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
<b>Emergency Room</b>	\$100 copay; then 80% after CYD (copay waived if admitted)		\$150 copay; then 80% after CYD (copay waived if admitted)				50% after CYD	
<b>Health Assessment (HA) - \$250</b> <small>deductible credit to employee, spouse, and dependents over age of 18.</small>	HA deductible credit applies to 2017 plan year and must be completed between 01/01/2017 and 12/31/2017. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.							
<b>Mental Health and Substance Abuse</b>								
<b>Inpatient*</b>	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
<b>Outpatient</b>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	

Other Covered Services	RED PLAN		WHITE PLAN				BLUE PLAN	
	Blue Choice PPO <sup>SM</sup>		BlueOptions <sup>SM</sup>				Blue Choice PPO <sup>SM</sup>	
	In Network	Out of Network	Blue Preferred PPO <sup>SM</sup>	Blue Choice PPO <sup>SM</sup>	Blue Traditional <sup>SM</sup>	Out of Network	In Network	Out of Network
<b>Occupational &amp; Speech Therapy</b> (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	
<b>Physical and Chiropractic Therapy</b> (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	
<b>Durable Medical Equipment (DME), Prosthetics and Orthotics</b>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
<b>Skilled Nursing Facility</b> (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	
<b>Home Health Care</b> (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	
<b>Hospice*</b>	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
<b>Hearing Screening</b> (limited to one per CY)	100% after copay	50% after CYD	100% after copay		60% after CYD	50% after CYD	50% after CYD	
<b>Hearing Aids</b>	Covered as DME up to age 18							

Pharmacy	RED, WHITE and BLUE PLANS	
	In Network	Out of Network
<b>Generic &amp; Preferred – Cost of Rx: \$100 or less</b>	Member pays lesser of \$25 or actual cost	Member pays cost of Rx up to \$75 max plus dispensing fee
<b>Generic &amp; Preferred – Cost of Rx: Greater than \$100</b>	Member pays 25% up to \$50 max	Member pays cost of Rx up to \$75 max plus dispensing fee
<b>Non-Preferred – Cost of Rx: \$100 or less</b>	Member pays lesser of \$50 or actual cost	Member pays cost of Rx up to \$125 max plus dispensing fee
<b>Non-Preferred – Cost of Rx: Greater than \$100</b>	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<sup>SM</sup> 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.