

BENEFIT HIGHLIGHTS

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics		PPO		Non-PPO	
		(In-Network)		(Out-of-Network)	
Lifetime Maximum		Unlimited			
Individual Coverage Deductible		\$1,150		\$400	
Family Coverage Deductible		\$2,300		\$800	
Program deductible does not apply to services that have a copayment unless otherwise noted					
Health Care Account (HCA)					
Health Care Account will apply toward the first portion of your annual In-Network Deductible.		Individual	\$1,000	N/A	
		Family	\$2,000	N/A	
Coinsurance			90%	70%	
Medical & RX Out-of-Pocket Expense (OPX) Limit					
The out-of-pocket limit is the most you could pay in a year for covered services. The following expenses do not apply to the out-of-pocket limit: premiums, balance-billed charges, penalties and health care this plan does not cover.		Individual	\$3,175	Unlimited	
		Family	\$6,350	Unlimited	
Prescription Drug Card (Retail and Mail Service)		Rx Deductible			
			N/A	\$50	
		Generic	\$10		
		Preferred Brand	\$25		
		Non Preferred Brand	\$45		
		Mail Order / Extended Supply Network (ESN) - 90-day supply maintenance drugs (specialty drugs not available thru mail order)	2 times retail copay		
Out of Network Member cost share: 30% after deductible.					
Physician Services		PPO (In-Network)		Non-PPO	
		Copay	Coinsurance	(Out-of-Network)	
Physician Office Visits					
This benefit applies to charges which are billed as part of your Physician's office or telemedicine visit. This benefit does not apply to the following services: Surgical Services, Physical Therapy and Occupational Therapy, Chemotherapy, Allergy Testing and Injections, Covered Immunizations, Durable Medical Equipment, Sleep Study, CT Scan, PET Scan, and MRI.		PCP	\$25	N/A	70% of allowable charge*after deductible
		Specialist	\$25	N/A	
Virtual Visits through MDLIVE (PEPM Administration Fee Applies)		Medical	\$0	N/A	N/A
		Behavioral Health	\$0	N/A	N/A
Preventive Care					
Included Benefits: Routine Physical, Well Baby exam, Routine Gynecological exam, Routine Breast exam, Immunizations, ACA Preventative Lab, Routine Bone Density test, Routine Pap Smear, Routine Prostate test, Routine Digital Rectal exam, Routine Colorectal Cancer screening lab, Routine Colonoscopy, Health Education/Counseling services, and Smoking Cessation (excluding prescription drugs), Women's Preventative Care (including, but not limited to: well-woman visits, certain FDA-approved contraception methods for women, female sterilization, breast feeding support, supplies and counseling). The electric breast pump is limited to 1 per benefit period.		N/A	100% (deductible waived)	70% of allowable charge*after deductible	
Routine Mammograms, Routine Immunizations (children under age 19), Routine Diagnostic Medical Procedure, Routine EKG, Routine X-Ray, Routine Colorectal Cancer Screening X-Ray & Routine Lab.		N/A	100% (deductible waived)	70% (deductible waived)	
Diagnostic Lab and X-Ray		N/A	90% after deductible	70% of allowable charge*after deductible	
Complex Imaging (MRI, CT, PET, etc.)		N/A	90% after deductible	70% of allowable charge*after deductible	
Medical / Surgical Services					
Coverage for surgical procedures, anesthesia, inpatient medical care visits, outpatient medical care visits as well as other physician services.		N/A	90% after deductible	70% of allowable charge*after deductible	

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<i>Hospital Services</i>		<i>PPO (In-Network)</i>		<i>Non-PPO</i>
		<i>Copay</i>	<i>Coinsurance</i>	<i>(Out-of-Network)</i>
<i>Inpatient Hospital Services</i>				
Coverage includes benefits for average semi-private room and board and ancillary charges in a Hospital and Skilled Nursing Facility (extended care facility), preadmission testing, care in a Hospice program, and well-baby newborn care.		N/A	90% after deductible	70% of allowable charge*after deductible
<i>Outpatient Hospital Services</i>				
Coverage includes benefits for surgery, diagnostic services, physical therapy, occupational therapy, radiation therapy, chemotherapy, and renal dialysis treatments. For therapy specific services, please see the Outpatient Therapy Services section for benefit maximums and payment levels.		N/A	90% after deductible	70% of allowable charge*after deductible
<i>Outpatient Emergency Care (Accident or Illness)</i>				
Applies to both in- and out-of-network emergency room visits. In addition to the deductible and coinsurance, a \$100 Copay will apply for Non-Emergency use of the Emergency Room. The per-occurrence copay is waived if the member is admitted to the hospital.		N/A	90% after deductible	
<i>Ambulance Services - Ground</i>		N/A	90% after deductible	70% of allowable charge*after deductible
<i>Ambulance Services - Air</i>		N/A	90% after deductible	
<i>Urgent Care</i>		\$25	N/A	70% of allowable charge*after deductible
<i>Mental Health & Substance Use Disorder Services</i>		Covered as any other Medical Service		
<i>Additional Services</i>		<i>PPO (In-Network)</i>		<i>Non-PPO</i>
		<i>Copay</i>	<i>Coinsurance</i>	<i>(Out-of-Network)</i>
<i>Outpatient Therapy Services</i>				
· Physical Therapy	no annual visit limit	N/A	90% after deductible	70% of allowable charge*after deductible
· Occupational Therapy	no annual visit limit	N/A	90% after deductible	
· Speech Therapy	no annual visit limit	N/A	90% after deductible	
· Chiropractic Medical Services / Muscle Manipulations	\$500 annual max benefit	\$25	N/A	
<i>Durable Medical Equipment</i> (Preauthorization required if over \$4,000)		N/A	90% after deductible	70% of allowable charge*after deductible
<i>Home Health Care Services</i>		no annual visit limit	N/A	90% after deductible
<i>Skilled Nursing Facility (Extended Care Facility)</i>		no annual visit limit	N/A	90% after deductible
<i>Hospice Care</i>		no annual visit limit	N/A	90% after deductible

To locate an in-network provider: <https://www.bcbsok.com/find-a-doctor-or-hospital>

*Allowable charge for non-contracting providers for covered services will be the lesser of the provider's billed charges or the Plan's non-contracting allowable charge. The non-contracting allowable charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate.

This is not a contract. 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 that apply to the benefits shown. Full information can be found in the Certificate of Benefits.