Blue Preferred PPO HDHP
$3,000 Deductible
Embedded Deductible / Embedded OPX

BlueCross BlueShield of Oklahoma

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 (In-Network)*	*Non-PPO (Out-of-Network)*
Lifetime Maximum			*Unlimited*	
Individual Coverage Deductible			$3,000	$6,000
Family Coverage Deductible			$6,000	$12,000
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, penaliltes and health care this plan does not cover.	Individual	$6,000	Unlimited
		Family	$12,000	Unlimited
Prescription Drug Card (Retail and Mail Service)				
		Generic	90%, after deductible	70%, after deductible
		Preferred Brand	90%, after deductible	70%, after deductible
		Non Preferred Brand	90%, after deductible	70%, after deductible
		Mail Order / Extended Supply Network (ESN) - 90-day supply maintenance drugs (specialty drugs not available thru mail order)	90%, after deductible	70%, 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 Therap and Occupational Therapy, Chemotherapy, Allergy Testing and Injections, Covered Immunizations, Durable Medical Equipment, Sleep Study, CT Scan, PET Scan, and MRI.	PCP	N/A	90% after deductible	*70% of allowable charge*after deductible*
		Specialist	N/A	90% after deductible	
Virtual Visits through MDLIVE		Medical	N/A	90% after deductible	*N/A*
		Behavioral Health	N/A	90% after deductible	*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)	*100%*
Diagnostic Lab and X-Ray			N/A	90% after deductible	*70% of allowable charge*after deductible*
Complex Imaging (MRI, CT, PET)			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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Hospital Services		*PPO (In-Network)*		*Non-PPO*
		Copay	*Coinsurance*	*(Out-of-Network)*
Inpatient Hospital Services				
	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*
Outpatient Hospital Services				
	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*
Outpatient Emergency Care (Accident or Illness)				
	Applies to both in- and out-of-network emergency room visits. The per-occurrence copay is waived if the member is admitted to the hospital.	N/A	90% after deductible	
Ambulance Services - Ground		90% after deductible		*70% of allowable charge*after deductible*
Ambulance Services - Air		90% after deductible		
Urgent Care		N/A	90% after deductible	*70% of allowable charge*after deductible*
Mental Health & Substance Use Disorder Services		**Covered same as any other illness**		

Additional Services			*PPO (In-Network)*		*Non-PPO*
			Copay	*Coinsurance*	*(Out-of-Network)*
Outpatient Therapy Services					
	· 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	N/A	90% after deductible	
Durable Medical Equipment (Preauthorization required if over $4,000)			N/A	90% after deductible	*70% of allowable charge*after deductible*
Home Health Care Services		no annual visit limit	N/A	90% after deductible	*70% of allowable charge*after deductible*
Skilled Nursing Facility (Extended Care Facility)		no annual visit limit	N/A	90% after deductible	*70% of allowable charge*after deductible*
Hospice Care		no annual visit limit	N/A	90% after deductible	*70% of allowable charge*after deductible*

To Locate a Participating Provider: Visit our Web site at www.bcbsok.com/providers and use our Provider Finder® tool.

*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.