BlueCross BlueShield of Oklahoma

2019 Benefit Summary

	Plan A	Plan B	Plan C	Plan D	Plan E
Network	Choice	**Preferred** & Choice	**Preferred**	Choice	Choice
General Plan Information					**HSA ELIGIBLE**
Calendar Year Deductible (CYD)	$750 Ind / $2250 Family	$1250 Ind / $3750 Family	$1500 Ind / $4000 Family	$3000 Ind / $9000 Family	$1500 Ind / $3000 Family
Calendar Year Out of Pocket Max Includes deductible and pharmacy/medical copays	$3000 Ind / $9000 Family	$3500 Ind / $10500 Family BP $4000 Ind / $12000 Family BC	$4000 Ind /$12000 Family	$6350 Ind / $13000 Family	$3000 Ind / $6000 Family
Member Coinsurance	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Primary Office Visit Copay Specialty Office Visit Copay	$20 Copay $40 Copay	$25 BP/$35 BC Copay $40 BP/$50 BC Copay	$35 Copay $50 Copay	$35 Copay $50 Copay	20% after CYD
Preventive Care Visits (Well Baby, Adult/Child Immunizations, Routine Health Screenings)	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostics Lab/X-Ray	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
In-Patient Hospitalization	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Out-Patient Surgery	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Allergy Treatment/Testing	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD	20% after CYD
Emergency Room Urgent Care	$100 Copay; then 20% after CYD (waived if admitted) $40 Copay	$150 Copay, then 20%/30% after CYD (waived if admitted) $40 BP / $50 BC Copay	$150 Copay; then 20% after CYD (waived if admitted) $50 Copay	$100 Copay; then 20% after CYD (waived if admitted) $50 Copay	20% after CYD
Health Risk Assessment	HA deductible credit applies to 2019 plan year and must be completed between 01/01/2019 and 12/31/2019. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.				
Mental Health/Substance Abuse					
In-Patient	20% after CYD	20%/30% after CYD	20% after CYD	20% after CYD	20% after CYD
Out-Patient	$20 Office Visit Copay 20% after CYD for other services	$25 BP / $35 BC Copay 20%/30% after CYD for other services	$35 Office Visit Copay 20% after CYD for other services	$35 Office Visit Copay 20% after CYD for other services	20% after CYD

2019 Benefit Summary *(continued)*

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Rehabilitation Services: Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Habilitation Services: Inpatient: 30 day limit per benefit period. PA required.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Physical and chiropractic Therapy (combined limited to 60 visits per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Durable Medical Equipment (DME)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Skilled Nursing Facility (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Home Health Care (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Hospice (PA Required)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD	20% after CYD
Pharmacy					
Generic Drugs	Retail: 25% of allowed amount; $25 Min / $75 Max Mail Order: $75 Min / $150 Max				20% after CYD
Preferred Brand Name Drugs	Retail: 25% of allowed amount; $25 Min / $75 Max Mail Order: $75 Min / $150 Max				20% after CYD
Non-Preferred Brand Name Drugs	Retail: 50% of allowed amount; $50 Min / $100 Max Mail Order: $150 Min / $300 Max				20% after CYD
Specialty Drugs	50% of allowed amount; $50 Min / $100 Max (Limited to 30 day supply Must be ordered through Prime Therapeutics (no mail order available)				20% after CYD
	30 Day Supply Limit retail. Up to 90 Day Supply of Maintenance drugs. Up to 90 Day Supply Mail, Network Only				

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 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 t o the benefits shown. Full information can be found only in the group Contract and Certificate of Benefits.