



Benefit Summary 2018

RED PLAN			WHITE PLAN				BLUE PLAN	
Network	Blue Choice PPO SM		BlueOptions SM				Blue Choice PPO SM	
	In Network	Out of Network	Blue Preferred PPO SM	Blue Choice PPO SM	Blue Traditional SM	Out of Network	In Network	Out of Network
General Plan Information							1st Dollar Coverage: Plan pays 100% of the first \$500 of eligible charges for each individual then:	
Calendar Year Deductible (CYD)	\$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
General Payment Level	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Calendar Year Out-Of-Pocket Max (Includes deductible and pharmacy/medical copays)	\$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
Coinsurance	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	
Lifetime Max - Medical	Unlimited							
Lifetime Max - Pharmacy	Unlimited							
Primary Care Office Visit	\$25 copay	50% after CYD	\$25 copay	\$35 copay	60% after CYD	50% after CYD	50% after CYD	
Specialist Office Visit	\$40 copay	50% after CYD	\$40 copay	\$50 copay	60% after CYD	50% after CYD	50% after CYD	
Diagnostic X-ray/Lab	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Inpatient Hospital*	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
Outpatient Surgery	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Well Baby Care	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Adult Immunizations	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Routine Health Exams	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Childhood Immunizations	100%							
Routine Mammograms	100%							
Allergy Treatment/Testing (60 tests every 24 months)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Emergency Room	\$100 copay; then 80% after CYD (copay waived if admitted)		\$150 copay; then 80% after CYD (copay waived if admitted)				50% after CYD	
Health Assessment (HA) - \$250 deductible credit to employee, spouse, and dependents over age of 18.	HA deductible credit applies to 2018 plan year and must be completed between 01/01/2018 and 12/31/2018. 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	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
Outpatient	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	

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Occupational & Speech Therapy (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	
Physical and Chiropractic Therapy (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	
Durable Medical Equipment (DME), Prosthetics and Orthotics	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Skilled Nursing Facility (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	
Home Health Care (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	
Hospice*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Hearing Screening (limited to one per CY)	100% after copay	50% after CYD	100% after copay		60% after CYD	50% after CYD	50% after CYD	
Hearing Aids	Covered as DME up to age 18							

Pharmacy		RED, WHITE and BLUE PLANS	
	In Network	Out of Network	
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	
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	
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	
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	
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 PPOSM 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.