### General Plan Information

**In Network**

- **1st Dollar Coverage:** Plan pays 100% of the first $500 of eligible charges for each individual then:
  - **Network**: BLUECHOICE
  - **BlueChoice PPO High Option**
    - **Calendar Year Deductible (CYD)**: $1,000 Ind. / $3,000 Family
    - **Calendar Year Out-of-pocket Max (Includes deductible and pharmacy/medical copays)**: $3,300 Ind. / $9,900 Family
  - **Inpatient Hospital**
    - 80% after CYD
    - Additional $300 deductible per admit, then 50% after CYD
  - **Outpatient Surgery**
    - 80% after CYD
    - 50% after CYD
  - **Well Baby Care**: 100%
  - **Adult Immunizations**: 100%
  - **Routine Health Exams**: 100%
  - **Routine Mammograms**: 100%
  - **Allergy Treatment/Testing (60 tests every 24 months)**: 80% after CYD
  - **Emergency Room**: $100 copay; then 80% after CYD (copay waived if admitted)
  - **Health Assessment (HA)**: $250 deductible credit to employee, spouse, and dependents over age of 18. (HA deductible credit applies to 2015 plan year and must be completed between 01/01/15 and 12/31/15. 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
    - **Outpatient**
      - 80% after CYD
  - **In Network**:
    - **Plan Pays 80% after CYD**
  - **Out of Network**:
    - **Plan Pays 50% after CYD**

**Out of Network**

- **Calendar Year Deductible (CYD)**: $1,000 Ind. / $1,000 Family
- **Calendar Year Out-of-pocket Max (Includes deductible and pharmacy/medical copays)**: $5,500 Ind. / $11,000 Family
- **Co-Insurance**
  - **Plan Pays 80% after CYD**

### Out of Network

- **Network**: BLUECHOICE
- **BlueChoice PPO High Option**
  - **Calendar Year Deductible (CYD)**: $1,000 Ind. / $3,000 Family
  - **Calendar Year Out-of-pocket Max (Includes deductible and pharmacy/medical copays)**: $3,800 Ind. / $11,400 Family
  - **Inpatient Hospital**
    - 80% after CYD
    - 50% after CYD
  - **Outpatient Surgery**
    - 80% after CYD
    - 50% after CYD
  - **Well Baby Care**: 100%
  - **Adult Immunizations**: 100%
  - **Routine Health Exams**: 100%
  - **Routine Mammograms**: 100%
  - **Allergy Treatment/Testing (60 tests every 24 months)**: 80% after CYD
  - **Emergency Room**: $100 copay; then 80% after CYD (copay waived if admitted)
  - **Mental Health and Substance Abuse**
    - **Inpatient**
      - 80% after CYD
    - **Outpatient**
      - 80% after CYD
  - **In Network**:
    - **Plan Pays 50% after CYD**
  - **Out of Network**:
    - **Plan Pays 50% after CYD**
<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>BLUECHOICE PPO HIGH OPTION</th>
<th>BLUECHOICE PPO BASIC OPTION</th>
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<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
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<tr>
<td><strong>Generic &amp; Preferred –</strong></td>
<td>Member pays lesser of $25 or actual cost</td>
<td>Member pays cost of Rx up to $75 max plus dispensing fee</td>
</tr>
<tr>
<td>Cost of Rx: $100 or less</td>
<td></td>
<td></td>
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<tr>
<td><strong>Generic &amp; Preferred –</strong></td>
<td>Member pays 25% up to $50 max</td>
<td>Member pays cost of Rx up to $75 max plus dispensing fee</td>
</tr>
<tr>
<td>Cost of Rx: Greater than $100</td>
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<tr>
<td><strong>Non-Preferred –</strong></td>
<td>Member pays lesser of $50 or actual cost</td>
<td>Member pays cost of Rx up to $125 max plus dispensing fee</td>
</tr>
<tr>
<td>Cost of Rx: $100 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred –</strong></td>
<td>Member pays 50% up to $100 max</td>
<td>Member pays cost of Rx up to $125 max plus dispensing fee</td>
</tr>
<tr>
<td>Cost of Rx: Greater than $100</td>
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102 day supply limit or 300 quantity limit per copay

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>BLUECHOICE PPO HIGH OPTION</th>
<th>BLUECHOICE PPO BASIC OPTION</th>
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<tbody>
<tr>
<td></td>
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<td>Out of Network</td>
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<tr>
<td><strong>Occupational &amp; Speech Therapy</strong> (Each service limited to 60 visits per CY)</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
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<tr>
<td><strong>Physical and Chiropractic Therapy</strong> (Services combined limited to 60 visits per CY)</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
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<tr>
<td><strong>Hearing Screening</strong> (limited to one per CY)</td>
<td>100%</td>
<td>50% after CYD</td>
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<tr>
<td><strong>Hearing Aids</strong></td>
<td>Covered as DME up to age 18</td>
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<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetics and Orthotics</strong></td>
<td>80% after CYD</td>
<td>50% after CYD</td>
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<tr>
<td><strong>Skilled Nursing Facility (100 days per CY)</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Home Health Care (100 visits per CY)</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
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<tr>
<td><strong>Hospice</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
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*Requires Pre-Authorization

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 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.