# COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **Calendar Year Deductible** | No deductible | No deductible | No deductible |
| **Calendar Year Out-of-Pocket Maximum** | $4,000 individual<br>$12,000 family<br>Includes medical and pharmacy | $4,000 individual<br>$8,000 family<br>Includes medical and pharmacy | $4,000 individual<br>$12,000 family<br>Includes medical and pharmacy |
| **Office Visit** | $25 copay/PCP<br>$50 copay/specialist | $35 copay/PCP<br>$50 copay/specialist | $0 copay/PCP<br>$50 copay/specialist |

This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| **Calendar Year Deductible (for pharmacy deductible, refer to Page 29)** | High plan<br>$750 individual<br>$2,000 family<br>High Alternative plan<br>$1,000 individual<br>$2,750 family<br>Copays do not apply to deductible<br>Separate pharmacy deductible<br>A family is three or more covered individuals | $1,750 individual<br>$3,500 family<br>One member may be responsible for up to the full family deductible<br>The combined medical and pharmacy deductible must be met before benefits are paid<br>A family is two or more covered individuals | Medical First-Dollar Coverage<br>Plan pays first $500 (Basic) or $250 (Basic Alternative) per covered family member for covered expenses<br>Medical Deductible<br>After first-dollar coverage, you pay the deductible for covered expenses<br>Basic: $1,000 individual or $1,500 family<br>Basic Alternative: $1,250 individual or $1,750 family<br>A family is two or more covered individuals<br>Medical Coinsurance (Basic and Basic Alternative)<br>After medical deductible, you pay 50% and plan pays 50% for covered expenses until your out-of-pocket maximum is reached<br>Medical Calendar Year Out-of-Pocket Maximum (Basic and Basic Alternative)<br>$4,000 maximum per member, no more than $9,000 per family<br>Deductible and coinsurance apply to maximums. Once your maximum limit is met, the plan pays 100% of allowable amounts for covered services<br>For pharmacy deductible, refer to Page 29 |
| **Calendar Year Out-of-Pocket Maximum** | High plan<br>$3,300 individual<br>$8,400 family<br>High Alternative plan<br>$3,550 individual<br>$8,400 family<br>For both plans: Deductible, coinsurance and copays apply; excludes pharmacy expenses | $6,000 individual<br>$12,000 family<br>Deductible, coinsurance and copays apply; includes pharmacy expenses | |
| **Office Visit** | $30 copay/general physician<br>$50 copay/specialist | You pay 100% of allowable amounts until deductible is met<br>$30 copay/general physician<br>$50 copay/specialist | First-dollar coverage, then 50% of allowable amounts after deductible |

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| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **X-Ray and Lab** | $25 copay for X-ray and lab<br>$250 copay per scan or procedure for FOCUS Procedures (MRI, CT, PET, EEG, ECG, MPS and similar); and pathology and lab under CPT codes of cytogenetic studies, surgical pathology or transcutaneous procedures | $0 copay for routine X-ray and lab<br>$200 copay per scan<br>Specialty scans: MRI, CT, MRA and PET scans<br>(May be subject to prior authorization) | $10 copay for X-ray and lab<br>For MRI, MRA, PET, CAT and nuclear scans:<br>$250 copay per scan in a preferred facility<br>$750 copay per scan in a non-preferred facility |
| **Allergy Testing and Treatment** | $25 copay/PCP<br>$50 copay/specialist<br>Serum and shots including a 6-week supply of antigen | $35 copay/PCP<br>$50 copay/specialist<br>$30 serum and shots including a 6-week supply of antigen | $0 copay/PCP<br>$50 copay/specialist<br>$30 serum and shots including a 6-week supply of antigen and administration |
| **Preventive Services** | $0 copay (PCP or specialist)<br>$0 copay per OB/GYN visit, no referral required for annual routine services | $0 copay (PCP or specialist)<br>$0 copay for well-woman visit, no PCP referral required | $0 copay PCP/routine physical exam<br>$0 copay well-woman exam and preventive services |
| **Well-Child Care** | $0 copay | $0 copay | $0 copay per well-child visit |
| **Immunizations** | $0 copay | $0 copay birth through age 20 years<br>$0 copay ages 21 and older when following the recommendation of ACIP | $0 copay when following the recommendation of ACIP |

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| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| **X-Ray and Lab** | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Allergy Testing and Treatment** | 20% of allowable amounts after deductible<br>Limit of 60 tests every 24 months | 20% of allowable amounts after deductible<br>Limit of 60 tests every 24 months | First-dollar coverage, then 50% of allowable amounts after deductible<br>Limit of 60 tests every 24 months |
| **Preventive Services** (for full list, refer to HealthChoiceOK.com) | $0 copay; no deductible or coinsurance<br>Includes two preventive office visits per calendar year for members and dependents ages 18 and older | $0 copay; no deductible or coinsurance<br>Includes two preventive office visits per calendar year for members and dependents ages 18 and older | $0 copay; no deductible or coinsurance<br>Includes two preventive office visits per calendar year for members and dependents ages 18 and older |
| **Well-Child Care** | $0 copay; no deductible or coinsurance | $0 copay; no deductible or coinsurance | $0 copay; no deductible or coinsurance |
| **Immunizations** | No charge for well-child and adult immunizations and administration<br>$30/$50 office visit copay may apply | No charge for well-child and adult immunizations and administration<br>$30/$50 office visit copay may apply | No charge for well-child and adult immunizations and administration<br>Office visit: First-dollar coverage, then 50% of allowable amounts after deductible |

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| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **Hearing Screening and Hearing Aid** | Hearing screening<br>$0 copay<br>Limit of one per year<br>Hearing aids<br>20% coinsurance | Hearing screening<br>$0 copay when performed by PCP<br>Limit of one per year<br>Hearing aids<br>20% coinsurance | Hearing screening<br>$0 copay<br>Limit of one per year<br>Hearing aids<br>20% coinsurance |
| **Hospital Inpatient** | $1,000 copay per day<br>$3,000 maximum per admission | $350 copay per day<br>$1,750 maximum per admission | $300 copay per day<br>$900 maximum per admission |
| **Hospital Outpatient** | $750 copay per day | $300 copay per visit | $300 copay in a preferred facility<br>$800 copay in a non-preferred facility |
| **Emergency Room** | $300 copay; waived if admitted | $200 copay; waived if admitted | $400 copay for facility charge; waived if admitted |
| **Urgent Care** | $50 copay for outpatient or professional urgent care facility per visit | $50 copay per visit | $25 copay per visit |
| **Maternity Prenatal and Postnatal Care** | $0 copay for prenatal and postnatal care<br>$2,000 copay per admission | $0 copay for preventive prenatal and postnatal care<br>$35 copay/PCP $50 copay/ specialist for confirmation visit<br>$350 copay per day<br>$1,750 maximum per admission | $0 copay for prenatal and postnatal care<br>$500 per hospital admission |

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| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| **Hearing Screening and Hearing Aid** | Hearing screening<br>$30/$50 copay unless preventive<br>Limit of one per year<br>Hearing aids<br>Covered as durable medical equipment for children ages 17 and younger<br>Certification required | Hearing screening<br>$30/$50 copay after deductible unless preventive<br>Limit of one per year<br>Hearing aids<br>Covered as durable medical equipment for children ages 17 and younger<br>Certification required | Hearing screening<br>Limit of one per year<br>Hearing aids<br>Covered as durable medical equipment for children ages 17 and younger<br>Certification required<br>First-dollar coverage, then 50% of allowable amounts after deductible |
| **Hospital Inpatient** | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Hospital Outpatient** | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible. | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Emergency Room** | $200 copay – waived if admitted<br>20% of allowable amounts after deductible | $200 copay – waived if admitted<br>20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Urgent Care** | $30 office visit copay<br>20% of allowable amounts after deductible | $30 office visit copay after deductible<br>20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Maternity Prenatal and Postnatal Care** | Prenatal: $0 copay<br>Postnatal: 20% of allowable amounts after deductible<br>Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits) | Prenatal: $0 copay<br>Postnatal: 20% of allowable amounts after deductible<br>Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits) | Prenatal: $0 copay<br>Postnatal: First-dollar coverage, then 50% of allowable amounts after deductible<br>Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits) |

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| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| **Mental Health or Substance Use Disorder Inpatient** | $1,000 copay per day<br>$3,000 maximum per admission | $350 copay per day<br>$1,750 maximum per admission | Residential Treatment Center or medical detox<br>$300 copay per day<br>$900 maximum per admission |
| **Mental Health or Substance Use Disorder Outpatient** | $25 copay/PCP<br>$50 copay/specialist | $35 copay/physician office<br>$0 copay/facility<br>$0 copay/Applied Behavioral Analysis | $0 copay per visit |
| **Occupational or Speech Therapy Visit** | $0 copay inpatient<br>$50 copay per outpatient therapy<br>Limit of 60 visits combined for all therapies per year | Inpatient $350 copay per day<br>$1,750 maximum per admission<br>(May be subject to prior authorization)<br>$50 copay per outpatient therapy visit<br>Up to 60 days treatment per disability | $0 copay inpatient<br>$35 copay per outpatient visit<br>Limit of 60 treatment days per course of therapy |
| **Physical Therapy or Physical Medicine Visit** | | | |

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| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| **Durable Medical Equipment** | 20% of allowable amounts after deductible for purchase, rental, repair or replacement | 20% of allowable amounts after deductible for purchase, rental, repair or replacement | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Mental Health or Substance Use Disorder Inpatient** | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| **Mental Health or Substance Use Disorder Outpatient** | 20% of allowable amounts after deductible<br>Limit: 20 services/year without certification | 20% of allowable amounts after deductible<br>Limit: 20 services/year without certification | First-dollar coverage, then 50% of allowable amounts after deductible<br>Limit: 20 services/year without certification |
| **Occupational or Speech Therapy Visit** | 20% of allowable amounts after deductible; 60 visits/ year maximum<br>Occupational therapy<br>Limit: 20 visits/year without certification<br>Speech therapy<br>For ages 17 and younger, certification required | 20% of allowable amounts after deductible; 60 visits/ year maximum<br>Occupational therapy<br>Limit: 20 visits/year without certification<br>Speech therapy<br>For ages 17 and younger, certification required | First-dollar coverage, then 50% of allowable amounts after deductible; 60 visits/ year maximum<br>Occupational therapy<br>Limit: 20 visits/year without certification<br>Speech therapy<br>For ages 17 and younger, certification required |
| **Physical Therapy or Physical Medicine Visit** | 20% of allowable amounts after deductible<br>Limits: 20 visits/year without certification; 60 visits/year maximum | 20% of allowable amounts after deductible<br>Limits: 20 visits/year without certification; 60 visits/year maximum | First-dollar coverage, then 50% of allowable amounts after deductible<br>Limits: 20 visits/year without certification; 60 visits/year maximum |

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| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **Chiropractic and Manipulative Therapy Visit** | $50 copay<br>Included under physical and occupational therapy, no separate visit limit per year | $50 copay<br>No visit limits | $25 copay<br>Limit 15 visits per year |
| **Bariatric Surgery** | $1,000 copay per day<br>$3,000 maximum per admission | $350 copay per day<br>$1,750 maximum per admission | $300 per day<br>$900 maximum per admission |
| **National Diabetes Prevention Program** | Covered at 100% | Covered at 100% | Covered at 100% |
| **Telehealth/ Telemedicine** | Covered services are covered at regular plan provisions<br>MDLIVE covered at 100% | $35 copay/PCP<br>$50 copay/Specialist<br>$0 copay/Preventive | Covered same as office visit if provider offers telehealth/telemedicine services |

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| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| **Chiropractic and Manipulative Therapy Visit** | Chiropractic therapy<br>20% of allowable amounts after deductible<br>$50 specialist office visit copay may apply<br>Limits: 20 visits/year without certification; 60 visits/year maximum<br>Manipulative therapy<br>Included within physical or chiropractic therapy limits | Chiropractic therapy<br>20% of allowable amounts after deductible<br>$50 specialist office visit copay may apply<br>Limits: 20 visits/year without certification; 60 visits/year maximum<br>Manipulative therapy<br>Included within physical or chiropractic therapy limits | Chiropractic therapy<br>First-dollar coverage, then 50% of allowable amounts after deductible<br>Limits: 20 visits/year without certification; 60 visits/year maximum<br>Manipulative therapy<br>Included within physical or chiropractic therapy limits |
| **Bariatric Surgery** | 20% of allowable amounts after deductible; some limitations and exclusions apply | 20% of allowable amounts after deductible; some limitations and exclusions apply | First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply |
| **National Diabetes Prevention Program** | $0 copay for preventive service | $0 copay for preventive service | $0 copay for preventive service |
| **Telehealth/ Telemedicine** | 20% of allowable amounts after deductible; some limitations and exclusions apply<br>$30/$50 office visit copay may apply<br>SwiftMD: $0 fee and no coinsurance | 20% of allowable amounts after deductible; some limitations and exclusions apply.<br>$30/$50 office visit copay may apply<br>SwiftMD: $45 fee until deductible is met. $0 fee and no coinsurance after meeting deductible | First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply<br>SwiftMD: $0 fee and no coinsurance |

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| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| **Pharmacy Benefits** | Retail or Mail Order<br>(30-day supply)<br>Preferred generic: $5<br>Non-preferred generic: $15<br>Preferred brand: $40<br>Non-preferred brand: $80<br>Insulin: No more than $30<br><br>(90-day supply)<br>Preferred generic: $10<br>Non-preferred generic: $30<br>Preferred brand: $80<br>Non-preferred brand: $160<br>Insulin: No more than $90<br>Specialty<br>Preferred: $100<br>Non-preferred: $200 | Retail or Mail Order<br>(30-day supply)<br>Select generic: $0<br>Preferred generic: $15<br>Preferred brand: $40*<br>Non-preferred brand or generic: $70*<br>Insulin: No more than $30<br><br>(90-day supply)<br>Select generic: $0<br>Preferred generic: $45<br>Preferred brand: $120*<br>Non-preferred brand or generic: $210*<br>Insulin: No more than $90<br>Specialty<br>(30-day supply)<br>$160<br><br>*If you choose to obtain a brand-name drug when a generic is available, you pay the applicable copay or coinsurance for the brand-name drug, plus the difference in cost between the brand-name drug and its generic equivalent. The difference in cost between the brand-name drug and its generic equivalent will not count toward your annual out-of- pocket maximum. | Retail or Mail Order<br>(30-day supply)<br>Tier 1 generic: $20<br>Preferred brand: $65<br>Non-preferred drugs: $90<br>Insulin: No more than $30<br><br>(90-day supply)<br>Tier 1 generic: $40<br>Preferred brand: $130<br>Non-preferred drugs: $180<br>Insulin: No more than $90<br>Specialty<br>(30-day supply)<br>Preferred: $200<br>Non-preferred: $400 |

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| Your Costs for Network Services | HealthChoice High, High Alternative, Basic, Basic Alternative and HDHP Plans<br>The applicable pharmacy or, for HDHP, combined deductible must be met before pharmacy copays apply. | |
|---|---|---|
| **Pharmacy Deductible** | HealthChoice High, High Alternative, Basic and Basic Alternative<br>$100 for individual<br>$300 for family | HealthChoice HDHP<br>Medical and pharmacy combined<br>$1,750 for individual<br>$3,500 for family |
| **Prescription Medications** | **30-Day Supply** | **90-Day Supply** |
| **Generic Drugs** | Up to $10 | Up to $25 |
| **Preferred Drugs** | Up to $45 | Up to $90 |
| **Non-Preferred Drugs** | Up to $75 | Up to $150 |
| **Specialty Drugs** | Generic – $10 copay<br>Preferred – $100 copay<br>Non-preferred – $200 copay | 30-day copays apply to each additional 30-day supply |
| **Insulin** | No more than $30 | No more than $90 |

**Note:** Only FDA-approved drugs and drugs with FDA Emergency Use Authorizations are covered. Experimental treatments and unapproved drugs and drugs not approved or not authorized for emergency use by the FDA are not covered under this plan.

**HealthChoice Preventive Medication List** – These medications are not subject to pharmacy deductible on the High, High Alternative, Basic or Basic Alternative plans, or the combined medical/pharmacy deductible on the HDHP.

All plan provisions apply. Some medications are subject to prior authorization and/or quantity limits. If you choose a brand-name medication when a generic is available, you are responsible for the difference in the cost in addition to the copay.

HealthChoice covers **up to a 168-day supply** of tobacco cessation medications at 100% when filled at a network pharmacy. Visit the **HealthChoice Be Tobacco Free page** for details.

CDC-recommended vaccinations, such as for shingles, are covered at 100% when using a network pharmacy. **Note:** These can also be covered under the health benefit if provided by a recognized network health provider, such as a physician or health department.

Amounts paid by copay assistance programs, manufacturer copay cards or other third parties do not apply toward deductibles or out-of-pocket maximums.