



Oklahoma Baptist University

BENEFIT HIGHLIGHTS

PPO Network

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			
Program deductible does not apply to services that have a copayment.		\$5,000	\$7,500
Health Fund Amount (Amount contributed to the Fund by the Employer) <i>The family fund amount maximum is equal to 3 individual amounts.</i>		\$3,800 Individual	\$3,800 Individual
Family Coverage Deductible			
The family deductible maximum is equal to 3 individual deductibles.		\$15,000	\$22,500
Coinsurance		80%	60%
Individual Coverage Out-of-Pocket Expense (OPX) Limit			
The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit: <ul style="list-style-type: none"> • Deductibles • Copayments • Reductions in benefits due to non-compliance with utilization management program requirements • Charges that exceed the eligible charge or in-network service maximum 		\$3,000	\$9,000
Prescription Drug Card (Retail and Mail Service)			
Copay amounts paid at network pharmacies. See formulary for listings of generic, preferred and non-preferred brand and specialty prescription drugs.		\$15 copay for generic drugs \$35 copay for preferred drugs \$60 copay for non-preferred drugs	
Mail order (generic, preferred and non-preferred drugs)		2.5x copay for a 90-day supply of maintenance drugs	
Physician Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits			
One copayment per person per day. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance.		\$20 copay for Primary Care Physicians \$50 copay for Specialists	60% after deductible
Preventive Care			
Services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). Includes benefits for routine physical examinations, well child care and routine diagnostic tests including, but not limited to: PSA, Pap Smear, Bone Density, and Colonoscopy. Health Education and Counseling services including, but not limited to: Smoking Cessation and Obesity.		100% of allowed amount	70% of allowed amount
Mammograms		100%	100%
Immunizations – children under age 19		100%	100%
Maternity Services			
Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.		\$20 copay for Primary Care Physicians \$50 copay for Specialists	60% after deductible
Medical / Surgical Services			
Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.		80% after deductible	60% after deductible
Hospital Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Hospital Admission Deductible			
Per admission, per individual		\$0	\$300
Inpatient Hospital Services			
Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.		80% after deductible	60% after deductible



Oklahoma Baptist University

BENEFIT HIGHLIGHTS

PPO Network

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Hospital Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Outpatient Hospital Services			
Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.		80% after deductible	60% after deductible
Outpatient Emergency Care (Accident or Illness)			
Applies to both in- and out-of-network emergency room visits. The per-occurrence deductible is waived if the member is admitted to the hospital.		\$100 copay then 80% after annual deductible	
Mental Health & Chemical Dependency		PPO (In-Network)	Non-PPO (Out-of-Network)
Serious Mental Illness Treatment		80% after deductible	60% after deductible
Other Mental Health & Chemical Dependency Treatment Services		80% after deductible	60% after deductible
Additional Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Therapy Services – Occupational and Physical		80% after deductible	60% after deductible
Durable Medical Equipment		80% after deductible	60% after deductible
Orthotic Devices			
<ul style="list-style-type: none"> \$2,500 annual maximum 		80% after deductible	60% after deductible
Autism			
<ul style="list-style-type: none"> 390 visit annual maximum for combined Speech/Physical/Occupational Therapy up to age 6 Age 6 and over: Physical and Occupational Therapy include din above "Therapy Services" annual limit Other Medical Services apply same benefits, exclusions and limitations as any other diagnosis Speech therapy age 6 and over is a contract exclusion 		80% after deductible	60% after deductible
Home Health Care			
<ul style="list-style-type: none"> 30 visit annual maximum per calendar year 		80% after deductible	60% after deductible
Private Duty Nursing			
<ul style="list-style-type: none"> 85 visit annual maximum per calendar year 		80% after deductible	60% after deductible
Hospice		80% after deductible	60% after deductible

Discounts on Eye Exams, Prescription Lenses and Eyewear

Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at www.bcbsok.com/member and click on the **BlueExtras Discount Program** link.

Blue Care Connection (BCC)

When members receive covered inpatient hospital services, outpatient mental health and substance abuse services (MHSA), coordinated home care, skilled nursing facility or private duty nursing from a participating provider, the member will be responsible for contacting either the BCC or MHSA preauthorization line, as applicable. You must call one day prior to any hospital admission and/or outpatient MH/SA service or within 2 business days after an emergency medical or maternity admission. Please refer to your benefit booklet for information regarding benefit reductions based on failure to contact the applicable preauthorization line. **Note: Outpatient MHSA preauthorization is effective for services on or after January 1, 2011.**

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

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.