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 $12,000 family Includes medical and pharmacy	$4,000 individual $8,000 family Includes medical and pharmacy	$4,000 individual $12,000 family Includes medical and pharmacy
Office Visit	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist (PCP referral is not required to see most specialists)	$0 copay/PCP $50 copay/specialist

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

Bold text indicates significant plan changes. 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.

HEALTH PLANS 2024 Health Plan Comparison 2

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
X-Ray and Lab	$25 copay for X-ray and lab $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 $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	$10 copay for X-ray and lab For MRI, MRA, PET, CAT and nuclear scans: $250 copay per scan in a preferred facility $750 copay per scan in a non-preferred facility
Allergy Testing and Treatment	$25 copay/PCP $50 copay/specialist Serum and shots including a 6-week supply of antigen	$35 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen	$0 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen and administration
Preventive Services	$0 copay (PCP or specialist) $0 copay per OB/GYN visit, no referral required for annual routine services	$0 copay (PCP or specialist) $0 copay for well-woman visit, no PCP referral required	$0 copay PCP/routine physical exam $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 $0 copay ages 21 and older when following the recommendation of ACIP	$0 copay when following the recommendation of ACIP

Bold text indicates significant plan changes. 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
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 Limit of 60 tests every 24 months	20% of allowable amounts after deductible Limit of 60 tests every 24 months	First-dollar coverage, then 50% of allowable amounts after deductible Limit of 60 tests every 24 months
Preventive Services (for full list, refer to HealthChoiceOK.com)	$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older	$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older	$0 copay; no deductible or coinsurance 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 $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration Office visit: First-dollar coverage, then 50% of allowable amounts after deductible

Bold text indicates significant plan changes. 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.

HEALTH PLANS

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Hearing Screening and Hearing Aid	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance
Hospital Inpatient	$1,000 copay per day $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$300 copay per day $900 maximum per admission
Hospital Outpatient	$750 copay per day	$300 copay per visit	$300 copay in a preferred facility $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 $2,000 copay per admission	$0 copay for preventive prenatal and postnatal care $35 copay/PCP $50 copay/ specialist for confirmation visit $350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$0 copay for prenatal and postnatal care $500 per hospital admission

Bold text indicates significant plan changes. 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
Hearing Screening and Hearing Aid	Hearing screening $30/$50 copay unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening $30/$50 copay after deductible unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required 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 20% of allowable amounts after deductible	$200 copay – waived if admitted 20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Urgent Care	$30 office visit copay 20% of allowable amounts after deductible	$30 office visit copay after deductible 20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Maternity Prenatal and Postnatal Care	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: First-dollar coverage, then 50% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)

Bold text indicates significant plan changes. 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.

HEALTH PLANS 2024 Health Plan Comparison 6

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 $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	Residential treatment center or medical detox $300 copay per day $900 maximum per admission
Mental Health or Substance Use Disorder Outpatient	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $0 copay/facility $0 copay/Applied Behavioral Analysis	$0 copay per visit
Occupational or Speech Therapy Visit	$0 copay inpatient $50 copay per outpatient therapy Limit of 60 visits combined for all therapies per year	Inpatient $350 copay per day $1,750 maximum per admission (May be subject to prior authorization) $50 copay per outpatient therapy visit Up to 60 days treatment per disability	$0 copay inpatient $35 copay per outpatient visit Limit of 60 treatment days per course of therapy
Physical Therapy or Physical Medicine Visit			

Bold text indicates significant plan changes. 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
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 Limit: 20 services/year without certification	20% of allowable amounts after deductible Limit: 20 services/year without certification	First-dollar coverage, then 50% of allowable amounts after deductible Limit: 20 services/year without certification
Occupational or Speech Therapy Visit	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	First-dollar coverage, then 50% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required
Physical Therapy or Physical Medicine Visit	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	First-dollar coverage, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum

Bold text indicates significant plan changes. 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.

HEALTH PLANS

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Chiropractic and Manipulative Therapy Visit	$50 copay Included under physical and occupational therapy, no separate visit limit per year	$50 copay No visit limits	$25 copay Limit 15 visits per year
Bariatric Surgery	$1,000 copay per day $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$300 per day $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 MDLIVE covered at 100%	$35 copay/PCP $50 copay/Specialist $0 copay/Preventive	Covered same as office visit if provider offers telehealth/telemedicine services

Bold text indicates significant plan changes. 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 NetworkServices	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Chiropractic and Manipulative Therapy Visit	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy First-dollar coverage, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy 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 $30/$50 office visit copay may apply SwiftMD: $0 fee and no coinsurance	20% of allowable amounts after deductible; some limitations and exclusions apply. $30/$50 office visit copay may apply 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 SwiftMD: $0 fee and no coinsurance

Bold text indicates significant plan changes. 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.

HEALTH PLANS 2024 Health Plan Comparison 10

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	Retail or Mail Order (30-day supply) Preferred generic: $5 Non-preferred generic: $15 Preferred brand: $40 Non-preferred brand: $80 Insulin*: No more than $30 (90-day supply) Preferred generic: $10 Non-preferred generic: $30 Preferred brand: $80 Non-preferred brand: $160 Insulin*: No more than $90 Specialty Preferred: $100 Non-preferred: $200 **Drug formulary has changed to the BCBSOK Performance Drug List.** *Only insulin included on current drug list.	Retail (30-day supply) Select generic: $0 Preferred generic/Tier 1: $15 Preferred brand/Tier 2: $40* Non-preferred brand or generic/Tier 3: $70* Specialty/Tier 4: $160* Member cost share will not exceed $30 for a 30-day supply of insulin. Mail Order (90-day supply) Select generic: $0 Preferred generic/Tier 1: $45 Preferred brand/Tier 2: $120* Non-preferred brand or generic/Tier 3: $210* Mail Order (30-day supply) Specialty/Tier 4: $160* *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 (30-day supply) Tier 1 generic: $20 Preferred brand: $65 Non-preferred drugs: $90 Insulin: No more than $30 (90-day supply) Tier 1 generic: $40 Preferred brand: $130 Non-preferred drugs: $180 Insulin: No more than $90 Specialty (30-day supply) Preferred: $200 Non-preferred: $400

Bold text indicates significant plan changes. 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, High Alternative, Basic, Basic Alternative and HDHP Plans 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 $100 for individual $300 for family	HealthChoice HDHP Medical and pharmacy combined $1,750 for individual $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 Preferred drugs – $100 copay Non-preferred drugs – $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.

HEALTH PLANS