

**Oklahoma Temporary High Risk Pool  
Health Insurance Summary of Benefits –  
2012 Plan Year**



**Calendar Year Deductible: \$2,000 Medical / \$200 Rx**

**BENEFIT HIGHLIGHTS**

**Blue Preferred PPO  
Network**

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

<b>Program Basics</b>		<b>Plan Benefits</b>	
		<b>PPO (In-Network)</b>	<b>Non-PPO (Out-of-Network)</b>
<b>Lifetime Benefit Maximum</b>			
Per individual		\$1,000,000	
<b>Individual Medical Deductible</b>			
Per individual		\$2,000	
<b>Individual Prescription Drug Deductible</b>			
Per individual		\$200	
<b>Individual Medical Coverage Out-of-Pocket Expense (OPX) Limit</b>			
The amount of money that an individual will pay toward covered health care expenses during any one calendar year.		\$4,350 per individual member (includes deductible and coinsurance)	
<b>Individual Prescription Drug Coverage Out-of-Pocket Expense (OPX) Limit</b>			
The amount of money that an individual will pay toward covered outpatient prescription drug expenses during any one calendar year.		\$1,600 per individual member (includes deductible and copays)	
<b>Co-Insurance</b>			
*All out-of-network charges that exceed the Blue Traditional allowable amount will be subject to balance billing.		80% - of the Blue Preferred allowable amount	60% - of the Blue Traditional allowable amount*
<b>Physician Services</b>		<b>Plan Benefits</b>	
<b>Well Care</b>			
Routine physical exams, immunizations, routine diagnostic tests		100% no deductible	100% no deductible
Maternity Services		80% after deductible	60% after deductible
Medical/Surgical Services		80% after deductible	60% after deductible
<b>Hospital Services</b>		<b>Plan Benefits</b>	
<b>Outpatient Hospital Services</b> 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, including mental health and substance abuse services.		80% after deductible	60% after deductible
<b>Inpatient Hospital Services (includes inpatient rehabilitation care)</b> Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.		80% after deductible	60% after deductible
<b>Outpatient Emergency Care (Accident or Illness)</b> – Maximum benefit of 180 days per calendar year		80% after deductible	
<b>Extended Care Expenses</b>		<b>Plan Benefits</b>	
<b>Skilled Nursing Facilities</b> (Maximum benefit – 180 days per calendar year)		80% after deductible	60% after deductible
<b>Hospice Care</b> (Lifetime Maximum benefit – \$10,000)		80% after deductible	60% after deductible
<b>Home Health Care</b> (Maximum benefit – the lesser of 60 days or \$5,000 per calendar year)		80% after deductible	60% after deductible
<b>Special Provision Expenses</b>		<b>Plan Benefits</b>	
<b>Treatment of Chemical Dependency</b>		80% after deductible	60% after deductible
<b>Mental Health Care – Inpatient and Outpatient</b>		80% after deductible	60% after deductible
<b>Additional Services</b>		<b>Plan Benefits</b>	

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 Benefit Booklet.

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		<b>PPO (In-Network)</b>	<b>Non-PPO (Out-of-Network)</b>
<b>Therapy Services</b>			
	<b>Speech, Occupational and Physical</b> (Combined Maximum benefit - \$2,000 per calendar year)	80% after deductible	60% after deductible
	<b>Temporomandibular Joint Dysfunction (TMJ) and Related Disorders</b>	80% after deductible	60% after deductible
<b>Other Covered Services</b>			
	<b>Ambulance Services, Medical Supplies, Durable Medical Equipment</b>	80% after deductible	60% after deductible
<b>Outpatient Prescription Drugs</b>		<b>Plan Benefits</b>	
<b>Administered by MaxCare Prescription Benefit Services</b>			
<b>Retail</b>			
Copay amounts paid at retail network pharmacies for up to a 30 day supply. See formulary for listings of generic, formulary brand, non-formulary brand, and specialty/biotech prescription drugs. Specialty/Biotech drugs available only at specialty network pharmacies for up to a 30 day supply.			
	<b>Generic</b>	\$10 copay after deductible	
	<b>Formulary Brands</b>	\$35 copay after deductible (plus cost difference if generic available)	
	<b>Non-Formulary Brands</b>	\$60 copay after deductible (plus cost difference if generic available)	
	<b>Specialty/Biotech Drugs</b>	\$150 copay	
<b>Mail-At-Retail</b>			
Copay amounts paid for at Mail-At-Retail network pharmacies for up to a 90 day supply of maintenance drugs (generic, formulary brand, and non-formulary brand drugs). No Specialty/Biotech Drugs.			
	<b>Generic</b>	\$30 copay after deductible	
	<b>Formulary Brands</b>	\$105 copay after deductible (plus cost difference if generic available)	
	<b>Non-Formulary Brands</b>	\$180 copay after deductible (plus cost difference if generic available)	

To Locate a Participating Provider: Visit our Web site at [www.bcbsoh.com](http://www.bcbsoh.com) and use our Provider Finder® tool.  
To contact MaxCare: Visit their Web site at [www.maxcarerx.com](http://www.maxcarerx.com) or call 1-800-259-7765.