Blue Cross and Blue Shield: Qualified Health Plans
2026

Small Group Size 1-50

Health Plan Name	**BCBSOK Blue Preferred PPO $600/$1,500 Blue Preferred Platinum PPO 401 P710PFR**
O-EPIC Health Plan ID	**H02314**
Individual Annual Deductible (in-network)	$600
Individual Annual Out-of-Pocket maximum (in-network)	$1,500 – includes deductible and RX
Office Visit Copay	$35 Specialist $60
Pharmacy	$5/$10/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Advantage PPO $600/$1,500 Blue Advantage Platinum PPO 101 P710ADT**
O-EPIC Health Plan ID	**H02315**
Individual Annual Deductible (in-network)	$600
Individual Annual Out-of-Pocket maximum (in-network)	$1,500 – includes deductible and RX
Office Visit Copay	$35 Specialist $60
Pharmacy	$5/$10/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Preferred PPO $750/$2,250 Blue Preferred Platinum PPO 416 P8E1PFR**
O-EPIC Health Plan ID	**H02316**
Individual Annual Deductible (in-network)	$750
Individual Annual Out-of-Pocket maximum (in-network)	$2,250 - includes deductible and RX
Office Visit Copay	$30 Specialist $45
Pharmacy	$0/$10/$35/$75/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Advantage PPO $750/$2,250 Blue Advantage Platinum PPO 116 P8E1ADT**
O-EPIC Health Plan ID	**H02317**
Individual Annual Deductible (in-network)	$750
Individual Annual Out-of-Pocket maximum (in-network)	$2,250 - includes deductible and RX
Office Visit Copay	$30 Specialist $45
Pharmacy	$0/$10/$35/$75/$250/$350 Pref. RX copay

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Health Plan Name	**BCBSOK Blue Advantage PPO $1,100/$1,750 Blue Advantage Platinum PPO 118 P8J6ADT**
O-EPIC Health Plan ID	**H02318**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$1,750 - includes deductible and RX
Office Visit Copay	$30 Specialist $55
Pharmacy	$10/$20/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Options PPO $1,100 Blue Options Platinum PPO 311 P8J7OPT**
O-EPIC Health Plan ID	**H02308**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$1,750 Blue Preferred - includes deductible and RX $3,000 Blue Choice - includes deductible and RX
Office Visit Copay	$35 Specialist $65
Pharmacy	$10/$20/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Choice PPO $1,100/$1,750 Blue Choice Platinum PPO 208 P8J1CHC**
O-EPIC Health Plan ID	**H02309**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$1,750 – includes deductible and RX
Office Visit Copay	$30 Specialist $55
Pharmacy	$10/$20/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Advantage PPO $1,000/$2,250 Blue Advantage Platinum PPO 122 P8K1ADT**
O-EPIC Health Plan ID	**H02310**
Individual Annual Deductible (in-network)	$1,000
Individual Annual Out-of-Pocket maximum (in-network)	$2,250 – includes deductible and RX
Office Visit Copay	$25 Specialist $45
Pharmacy	$0/$10/$35/$75/$250/$350 Pref. RX copay

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Health Plan Name	**BCBSOK Blue Preferred PPO $1,100/$1,750 Blue Preferred Platinum PPO 420 P8K4PFR**
O-EPIC Health Plan ID	**H02311**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$1,750 – includes deductible and RX
Office Visit Copay	$30 Specialist $55
Pharmacy	$10/$20/$50/$100/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Preferred PPO $1,000/$2,250 Blue Preferred Platinum PPO 421 P8K1PFR**
O-EPIC Health Plan ID	**H02312**
Individual Annual Deductible (in-network)	$1,000
Individual Annual Out-of-Pocket maximum (in-network)	$2,250 – includes deductible and RX
Office Visit Copay	$25 Specialist $45
Pharmacy	$0/$10/$35/$75/$250/$350 Pref. RX copay

Health Plan Name	**BCBSOK Blue Solutions Platinum PPO 501 P8J7BSL $1,100/$1,750**
O-EPIC Health Plan ID	**H02348**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$1,750
Office Visit Copay	$35 Specialist $65
Pharmacy	$10/$20/$30/$50/$70/$100/$120

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Blue Cross and Blue Shield: Qualified Health Plans
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Mid-Market Group 51 - 150

Health Plan Name	**BCBSOK Blue Choice PPO $1,000/$3,000 Blue Choice PPO MOBCH0046**
O-EPIC Health Plan ID	**H02334**
Individual Annual Deductible (in-network)	$1,000
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and Rx
Office Visit Copay	$25 Specialist $30
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Options PPO $500/$2,750 Blue Options PPO MOOPT0016**
O-EPIC Health Plan ID	**H02335**
Individual Annual Deductible (in-network)	$500
Individual Annual Out-of-Pocket maximum (in-network)	$2,750 Blue Preferred/$3,750 Blue Choice Includes deductible and Rx
Office Visit Copay (OVC)	$35 Specialist $40
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Options PPO $1,100/$3,000 Blue Options PPO MOOPT0056**
O-EPIC Health Plan ID	**H02336**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Blue Preferred/$4,250 Blue Choice Includes deductible and Rx
Office Visit Copay	$35 Specialist $40
Pharmacy	$0/$10/$35/$75/$250/$350 Preferred Rx copay

Health Plan Name	**BCBSOK Blue Preferred PPO $500/$2,500 Blue Preferred PPO MOBPF0013 (MOBPF0012 MOBPF0010)**
O-EPIC Health Plan ID	**H02099**
Individual Annual Deductible (in-network)	$500
Individual Annual Out-of-Pocket maximum (in-network)	$2,500 Includes deductible and Rx
Office Visit Copay	$20 Specialist $20
Pharmacy	$0/$10/$35/$75/$150/$250 Preferred RX copay

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Health Plan Name	**BCBSOK Blue Preferred PPO $1,000/$3,000 Blue Preferred PPO MOBPF0046**
O-EPIC Health Plan ID	**H02338**
Individual Annual Deductible (in-network)	$1,000
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and Rx
Office Visit Copay	$25 Specialist $30
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred Rx copay

Health Plan Name	**BCBSOK Blue Preferred PPO $1,600/$3000 Blue Preferred PPO MOBPF0236**
O-EPIC Health Plan ID	**H02339**
Individual Annual Deductible (in-network)	$1,600
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and RX
Office Visit Copay	$25 Specialist $30
Pharmacy	$0/$10/$35/$75/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Preferred PPO $2,100/$3,000 Blue Preferred PPO MOBPF0246**
O-EPIC Health Plan ID	**H02340**
Individual Annual Deductible (in-network)	$2,100
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and RX
Office Visit Copay	$25 Specialist $30
Pharmacy	$0/$10/$35/$75/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Advantage PPO $1,350 /$3000 Blue Advantage PPO MOBAP0016**
O-EPIC Health Plan ID	**H02331**
Individual Annual Deductible (in-network)	$1,350
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and RX
Office Visit Copay	$40 Specialist $70
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred RX copay

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Blue Cross and Blue Shield: Qualified Health Plans
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Health Plan Name	**BCBSOK Blue Options PPO $2,100/$3,000 Blue Options PPO MOOPT0086**
O-EPIC Health Plan ID	**H02337**
Individual Annual Deductible (in-network)	$2,100
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Blue Preferred/$4,250 Blue Choice Includes deductible and Rx
Office Visit Copay	$40 Specialist $45
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred Rx copay

Health Plan Name	**BCBSOK BlueLincs HMO $500/$1,250 BlueLincs HMO MOHMO0043 (MOHMO0040)**
O-EPIC Health Plan ID	**H02256**
Individual Annual Deductible (in-network)	$500
Individual Annual Out-of-Pocket maximum (in-network)	$1,250 Includes deductible and Rx
Office Visit Copay	$25 Specialist $45
Pharmacy	$0/$10/$35/$75/$150/$250 Preferred Rx copay

Health Plan Name	**BCBSOK Blue Advantage PPO $500 $1500 Blue Advantage PPO MOBAP0076**
O-EPIC Health Plan ID	**H02332**
Individual Annual Deductible (in-network)	$500
Individual Annual Out-of-Pocket maximum (in-network)	$1,500 Includes deductible and Rx
Office Visit Copay	$30 Specialist $55
Pharmacy	$0/$10/$50/$100/$250/$350 Preferred Rx copay

Health Plan Name	**BCBSOK Blue Advantage PPO $1,000/$3,000 Blue Advantage PPO MOBAP0086**
O-EPIC Health Plan ID	**H02333**
Individual Annual Deductible (in-network)	$1,000
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and Rx
Office Visit Copay	$25 Specialist $30
Pharmacy	$0/$10/$35/$75/$250/$350 Preferred RX copay

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Blue Cross and Blue Shield: Qualified Health Plans
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Health Plan Name	**BCBSOK Blue Solutions- Blue Advantage $1,100/$3,000 MOBSL0026**
O-EPIC Health Plan ID	**H02354**
Individual Annual Deductible (in-network)	$1,100
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and Rx
Office Visit Copay	$35 Specialist $40
Pharmacy	$0/$10/$35/$75/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Solutions- Blue Advantage $500/$2,750 MOBSL0016**
O-EPIC Health Plan ID	**H02356**
Individual Annual Deductible (in-network)	$500
Individual Annual Out-of-Pocket maximum (in-network)	$2,750 Includes deductible and Rx
Office Visit Copay	$35 Specialist $40
Pharmacy	$0/$20/$50/$100/$250/$350 Preferred RX copay

Health Plan Name	**BCBSOK Blue Solutions- Blue Advantage $2,100/$3,000 MOBSL0046**
O-EPIC Health Plan ID	**H02355**
Individual Annual Deductible (in-network)	$2,100
Individual Annual Out-of-Pocket maximum (in-network)	$3,000 Includes deductible and Rx
Office Visit Copay	$40 Specialist $45
Pharmacy	$0/$20/$50/$100/$250/$350 Preferred RX copay

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