

Benefit Summary for OKC Chamber Choice - 2008



Benefits	BlueOptions	BlueLincs HMO Value Option
1 <u>Selection of Physician</u>	The BluePreferred Provider Network provides the highest level of benefits. BluePreferred has nearly 1,100 doctors statewide. The BlueChoice Provider Network provides additional provider choices at a lower level of benefits than using the Blue Preferred network. BlueChoice has nearly 3,500 doctors statewide. The BlueTraditional Provider Network provides lesser benefits than Blue Preferred or BlueChoice networks. BlueTraditional has nearly 5,000 doctors statewide. Going out of network gives you total freedom to choose your own provider at the lowest level of benefits. Balance billing may occur on any charges above the BlueChoice allowable. To find the most current Provider Directories for all of our networks, please visit our website at www.bcsok.com.	Choose a Primary Care Physician as your personal health care coordinator. The PCP authorizes all referrals to specialists, testing and hospitalizations. To find the most current Provider Directories for all of our networks, please visit our website at www.bcsok.com.
2 <u>Deductible</u>	Your employer will choose from a \$500, \$750, \$1,000, \$1,500, or \$2,500 annual deductible per individual, three times per family, per calendar year.	Your employer will choose from no annual deductible or \$500 annual deductible per individual, three times per family, per calendar year.
3 <u>Co-Insurance</u>	You pay 20% of allowable amount for BluePreferred network provider. You pay 30% of allowable amount for BlueChoice network provider. You pay 40% of allowable amount for BlueTraditional network provider. You pay 50% of BlueChoice allowable amount for out-of-network providers. Amount above BlueChoice allowable will be subject to balance billing.	You pay 20% of allowable amount for diagnostic, radiology, laboratory, surgeon, and anesthesiologist services.
4 <u>Out-of-Pocket</u>	\$2,000 per family member for most in-network services at BluePreferred providers, plus deductible. \$3,000 per family member for most in-network services at BlueChoice providers, plus deductible. \$4,000 per family member for most in-network services at BlueTraditional providers, plus deductible. \$5,000 per family member for most services at out-of-network providers, plus deductible, plus charges above BlueChoice network allowable. The following do not apply to the out-of-pocket maximum: office visit co-payments, prescription drugs, additional per occurrence deductible on inpatient, outpatient, or ER, or psych/alcohol/drug related charges.	\$2,000 maximum per individual, \$6,000 maximum per family (three individuals must meet) per calendar year. This out-of-pocket maximum does not include co-payments for prescription drugs, inpatient mental health services or alcohol and drug abuse services.
5 <u>Office Visits</u>	You pay a \$30 co-payment for most office visits. Deductible and Coinsurance will be waived for the first 6 office visits each year.	\$20 co-payment.
6 <u>Office Visits (Children)</u>	You pay a \$30 co-payment for most office visits. Deductible and Coinsurance will be waived for children up to age 19.	No extra charge after \$20 co-payment up to age 19.
7 <u>Lab/X-ray</u>	Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans, & other excluded services).	Reference Other Physician & Medical Services
8 <u>Adult Preventive Care</u>	\$150 preventive care benefit, subject to \$30 office visit co-pay. Does not count toward 6 office visit maximum. Includes routine physicals, routine tests, tetanus shots.	\$20 co-payment, 20% coinsurance for diagnostic, radiology, and laboratory.
9 <u>Other Physician & Medical Services</u>	Annual deductible and coinsurance apply.	No extra charge after \$20 co-payment for most visits. 20% coinsurance for physical/speech therapy, surgery, anesthesia, lab, x-ray, durable medical equipment and ambulance. 50% coinsurance for allergy and infertility treatment.

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10 <u>Prescription Drugs</u>	You pay 50% of the discounted price of the drug at a network pharmacy. Prescriptions drugs are not subject to deductible or out-of-pocket maximum. \$10,000 stop-loss. Plan pays 100% after stop-loss is reached.	Deductible: \$300 per subscriber per calendar year Generic Drug: 30% of the allowable charge with a minimum co-pay of \$12. Preferred Drug: \$25 co-pay Other Drug: 30% of the allowable charge with a minimum co-pay of \$25. (See BCBSOK Preferred Drug List.)
11 <u>Routine Gynecological Examination</u>	You pay a \$30 office visit co-pay for an annual visit.	\$20 co-payment. Annual self-referral benefit included, contact Members Services to arrange. 20% coinsurance for lab fees.
12 <u>Routine Pap Smear</u>	Included in routine gynecological exam.	20% coinsurance for lab fees.
13 <u>Routine DRE (Digital Rectal Exam) & PSA Test</u>	You pay a \$30 co-payment for the first 6 office visits. Annual screening for early detection of prostate cancer in males age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening exam per benefit period, not to exceed \$65 per screening.	No extra charge after \$20 co-payment. Annual screening for early detection of prostate cancer in males age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening exam per benefit period.
14 <u>Immunizations</u>	\$30 co-payment for the first 6 office visits. Co-payment waived for covered childhood immunizations up to age 19.	\$20 co-pay, includes well baby care and required immunizations, up to age 19.
15 <u>Mammography</u>	Paid at 100% up to a \$115 benefit per year for one baseline routine mammogram between the ages of 35 - 39, then once annually at age 40 and older. Diagnostic mammograms are subject to deductible and coinsurance.	Routine mammograms received in-network with PCP referral are covered at 100% up to \$115 for one baseline routine mammogram between the ages of 35-39, then once annually at age 40 and older. Diagnostic mammograms are subject to deductible and 20% coinsurance.
16 <u>Maternity</u>	\$30 co-payment for initial visit only, then no office visit co-pay for additional visits. May count as one of 6 deductible/coinsurance-free visits per year. Annual deductibles and coinsurance may apply for all other maternity charges. Maternity hospital services same as other hospital services.	20% coinsurance for prenatal, postnatal, and diagnostic lab services.
17 <u>Inpatient Care</u>	Annual deductible and coinsurance apply. Additional per occurrence deductible of 50% of the annual deductible.	20% coinsurance for surgeon, anesthesiologist, and hospital services.
18 <u>Outpatient Care/Hospital Services</u>	Annual deductible and coinsurance apply. Additional per occurrence deductible of \$200 for facility outpatient surgical procedures.	20% coinsurance for diagnostic, radiology, laboratory, surgeon, and anesthesiologist services.
19 <u>Emergency Care</u>	Annual deductible and coinsurance apply. Additional per occurrence deductible of \$100 for each emergency room visit, waived if admitted.	Must be authorized by your Primary Care Physician within 48 hours. \$125 co-payment in or out of the service area. \$75 co-payment for participating Minor Emergency Care Centers.
20 <u>Psychiatric Care/Alcoholism/Drug Abuse</u>	Subject to deductible, then: Inpatient: Benefits are provided at 50% for 30 days. Outpatient: Benefits are provided at 50% for 20 visits per calendar year. Coinsurance does not count toward the out-of-pocket maximum.	Mental Health Outpatient: 50% coinsurance, max of 20 visits per calendar year. Inpatient: 50% coinsurance up to 7 days per calendar year. Alcoholism and Drug Abuse not covered except for detoxification. Emergency room \$125 per visit. Inpatient hospital \$125 per day first 10 days.

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21	<u>Lifetime Maximum</u>	\$2,000,000	Unlimited.
22	<u>Age Limit for Dependent Children</u>	To the end of year reaching age 19 or to 23rd birthday if full time student.	To the end of year reaching age 19 or to the end of month following 23rd birthday if full time student.

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 which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.

For groups with more than 50 employees, please see your Group Contract and/or Certificate of Benefits for information about certain state-mandated benefits.

You may not change benefit options until your group's renewal.

You cannot choose more than one deductible option.

For applicable deductible credit you must submit a recent EOB from your group's previous carrier with your application. For pre-ex credit, see your account representative.