

Benefit Summary for Tulsa Chamber Choice - 2008



10/24/2006

Benefits	BlueOptions PPO \$500, \$1,000, \$1,500, or \$2,500 Deductible	BlueLincs HMO Special Option \$500 Deductible	BlueLincs HMO Value Option No Deductible
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.bcbsok.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.bcbsok.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.bcbsok.com .
2 <u>Deductible</u>	Your employer will choose from a \$500, \$1,000, \$1,500, or \$2,500 annual deductible per individual, three times per family per calendar year.	\$500 per individual and \$1,500 per family. If the copayment is based on a percentage, then the deductible applies before the copayment. If the copayment is a dollar amount, then the deductible applies after the copayment.	No deductible.
3 <u>Co-Insurance</u>	Plan pays 80% of allowable amount for BluePreferred network provider. Plan pays 70% of allowable amount for BlueChoice network provider. Plan pays 60% of allowable amount for BlueTraditional network provider. Plan pays 50% of BlueChoice allowable amount for out-of-network providers. Amount above BlueChoice allowable will be subject to balance billing.	No co-insurance (copayment for some services.)	No co-insurance (copayment for some 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: office visit copayments, prescription drugs, additional per occurrence deductible on inpatient, outpatient, ER or psych/alcohol/drug related charges.	\$3,000 maximum per individual per year. This out-of-pocket maximum does not include copayments for prescription drugs, certain inpatient mental health services, self-referral services, or alcohol and drug abuse services.	\$2,000 maximum per individual per year. This out-of-pocket maximum does not include copayments for prescription drugs, certain inpatient mental health services, self-referral services, or alcohol and drug abuse services.
5 <u>Office Visits</u>	You pay a \$30 copayment for most office visits. Deductible and Coinsurance will be waived for the first 6 office visits each year.	\$20 copayment. (PCP) \$30 copayment. (Specialists)	\$20 copayment.
6 <u>Office Visits (Children)</u>	You pay only a \$30 copayment for most office visits for children up to age 19. Deductible and Coinsurance will be waived.	No extra charge after \$20 copayment up to age 18 for routine services in PCP's office.	No extra charge after \$20 copayment up to age 18 for routine services in PCP's office.
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	Reference Other Physician & Medical Services
8 <u>Adult Preventive Care</u>	\$150 preventive care benefit, subject to \$30 office visit copay. Does not count toward 6 office visit maximum. Includes routine physicals, routine tests, tetanus shots.	No extra charge after office visit copayment for most visits.	No extra charge after \$20 copayment for most visits.

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9	<u>Other Physician & Medical Services</u>	Annual Deductible and Coinsurance apply.	No extra charge after office visit copayment for most visits. 30% copayment for diagnostic testing. 30% copayment for physical, speech, or occupational therapy. (Maximum 60 consecutive calendar days per condition). 30% copayment for durable medical equipment. (\$1,000 maximum benefit per calendar year for DME). 50% copayment for allergy treatment and infertility treatment.	No extra charge after \$20 copayment for most visits. 20% copayment for diagnostic testing. 20% copayment for physical, speech, or occupational therapy. (Maximum 60 consecutive calendar days per condition). 20% copayment for durable medical equipment. (\$1,000 maximum benefit per calendar year for DME). 50% copayment for allergy treatment and infertility treatment.
10	<u>Prescription Drugs</u>	50% coinsurance applies at network pharmacies. Prescriptions drugs are not subject to deductible or out-of-pocket maximum. \$10,000 stop-loss. Plan pays 100% after stop-loss is reached.	50% coinsurance applies at network pharmacies. Prescriptions drugs are not subject to deductible or out-of-pocket maximum. \$10,000 stop-loss. Plan pays 100% after stop-loss is reached.	50% coinsurance applies at network pharmacies. Prescriptions drugs are not subject to deductible or out-of-pocket maximum. \$10,000 stop-loss. Plan pays 100% after stop-loss is reached.
11	<u>Routine Gynecological Examination</u>	You pay a \$30 office visit copay for an annual visit.	No extra charge after office visit copayment. Annual self-referral benefit included. (At BlueLincs doctors).	No extra charge after \$20 copayment. Annual self-referral benefit included. (At BlueLincs doctors).
12	<u>Routine Pap Smear</u>	Included in routine gynecological exam.	30% copayment	20% copayment
13	<u>Routine DRE (Digital Rectal Exam) & PSA Test</u>	You pay only a \$30 copayment for the first 6 office visits. Annual screening for early detection of prostate cancer in male Subscribers 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 office visit copayment. Must meet criteria noted in member handbook. 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.	No extra charge after \$20 copayment. Must meet criteria noted in member handbook. 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.
14	<u>Immunizations</u>	You pay only a \$30 copayment for the first 6 office visits. Copayment waived for covered childhood immunizations up to age 19.	No extra charge up to age 18. 30% copayment age 19 and older.	No extra charge up to age 18. 20% copayment age 19 and older.
15	<u>Mammography</u>	Deductible and coinsurance will be waived up to a \$115 benefit per year for one baseline routine mammogram between the ages of 35 - 39 and one routine mammogram per year at age 40 and above. Diagnostic mammograms are subject to deductible and coinsurance.	Copayment will be waived up to a \$115 benefit per year for one baseline routine mammogram between the ages of 35 - 39 and one routine mammogram per year at age 40 and above. Diagnostic mammograms are subject to deductible & 30% copayment.	Copayment will be waived up to a \$115 benefit per year for one baseline routine mammogram between the ages of 35 - 39 and one routine mammogram per year at age 40 and above. Diagnostic mammograms are subject to 20% copayment.

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16 <u>Maternity</u>	You pay one \$30 office visit copayment for initial visit only, then no office visit copay 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.	30% copayment. Maternity hospital services same as other hospital services.	20% copayment. Maternity hospital services same as other hospital services.
17 <u>Inpatient Care</u>	Annual Deductible and Coinsurance apply. Additional inpatient per occurrence deductible of \$250, \$500, \$750, or \$1,250 (50% of the plan's annual deductible).	30% copayment.	20% copayment.
18 <u>Outpatient Care/Hospital Services</u>	Annual Deductible and Coinsurance apply. Additional per occurrence deductible of \$200 for facility outpatient surgical procedures.	30% copayment.	20% copayment.
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, or must meet guidelines noted in member handbook. \$125 copayment in or out of the service area. \$75 copayment for participating Minor Emergency Care Centers.	Must be authorized by your Primary Care Physician within 48 hours, or must meet guidelines noted in member handbook. \$125 copayment in or out of the service area. \$75 copayment 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%, max of 20 visits per calendar year. Inpatient: 50% up to 7 days per calendar year. Alcoholism and Drug Abuse not covered except for detoxification. Emergency room \$125 per visit. *Inpatient hospital copayment : 30% of allowable charge.	Mental Health Outpatient: 50%, max of 20 visits per calendar year. Inpatient: 50% up to 7 days per calendar year. Alcoholism and Drug Abuse not covered except for detoxification. Emergency room \$125 per visit. *Inpatient hospital copayment : 20% of allowable charge.
21 <u>Lifetime Maximum</u>	\$2,000,000	None.	None.
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.	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.