



Oklahoma City Chamber 2010

**BlueOptions®**

**BLUEOptimize™\***  
A BLUE OPTIONS PRODUCT

Annual Deductible	\$500 \$750 \$1,000 \$1,500 \$2,500	\$500 \$1,000 \$2,500
<b>Lifetime Max</b>	\$2,000,000	\$2,000,000
<b>Coinsurance</b>	80% BluePreferred network 70% BlueChoice network 60% BlueTraditional network 50% Out-of-network (to Blue Choice allowed amount)	70% BluePreferred network 60% BlueChoice network 50% BlueTraditional network 50% Out-of-network (to BlueChoice allowed amount)
<b>Stop-loss</b>	\$10,000 Does not include deductible or copay amounts.	\$20,000 Does not include deductible or copay amounts.
<b>Office Visit Copay (OVC) Benefits</b>	\$30 OVC includes office visit, lab and radiology. Limit six per adult; unlimited for children. Deductible/Coinsurance will apply after sixth visit	\$30 OVC includes office visit and lab only. <b>Radiology excluded.</b> Limit six per adult; unlimited for children. Deductible/Coinsurance will apply after sixth visit
<b>Outpatient Surgery Deductible</b>	\$200 (in addition to deductible and coinsurance)	\$200 (in addition to deductible and coinsurance)
<b>Inpatient Per Occurrence Deductible</b>	\$250 for \$500 deductible \$500 for \$1,000 deductible \$750 for \$1,500 deductible \$1,250 for \$2,500 deductible (in addition to deductible and coinsurance)	\$250 for \$500 deductible \$500 for \$1,000 deductible \$750 for \$2,500 deductible (in addition to deductible and coinsurance)
<b>Emergency Room (ER) Per-occurrence deductible</b>	\$100 (in addition to deductible and coinsurance)	\$100 (in addition to deductible and coinsurance)
<b>Prescription drugs</b>	50/50 Drug Card	50/50 Drug Card
<b>Ambulance</b>	100%	Deductible/Coinsurance
<b>Added Preventive Care</b>	Office Visit Copay / \$150 max	Office Visit Copay / \$150 max
<b>Durable Medical Equipment</b>	Deductible/Coinsurance \$5,000 annual max	Deductible/Coinsurance \$2,500 max
<b>Prosthetic devices</b>	Deductible/Coinsurance \$10,000 annual max	Deductible/Coinsurance \$3,000 annual max
<b>Physical Therapy/Chiropractic Visits</b>	Deductible/Coinsurance 25 visit annual max	Deductible/Coinsurance 15 visit annual max
<b>4th Qtr Carryover</b>	No 4th Qtr carryover	No 4th Qtr carryover

The information noted above is current as of the date of publication; however, BCBSOK reserves the right to amend this information at any time without notice. This is only a brief description of some of the plan benefits. For more complete details, including benefits, limitations and exclusions, please refer to your certificate of coverage. This information is not intended nor does it modify the terms of any agreement in any way. The coverage provided under any group contract may only be changed in accordance with the terms of the agreement and in accordance with the law.

## Oklahoma City Chamber BlueLincs® HMO Value Option

<b>Selection of physicians</b>	Choose a Primary Care Physician (PCP) as your personal health care coordinator. Referrals to specialists, testing and hospitalizations must be authorized by your PCP.
<b>Deductible</b>	Your employer will choose from no annual deductible or \$500 annual deductible per individual, \$1,500 per family, per calendar year.
<b>Coinsurance</b>	No coinsurance, but a 20% copayment of the allowable charge applies for some services.
<b>Out-of-pocket limits</b>	\$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 some copayments. See schedule of benefits for specific out-of-pocket maximum provisions.
<b>Office visits</b>	\$20 copayment. No extra charge after \$20 copayment up to age 19 for routine services in PCP's office.
<b>Immunizations</b>	\$20 copayment, includes well baby care and required immunizations, up to age 19.
<b>Mammography</b>	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% copayment.
<b>Prescription drugs</b>	Deductible: \$300 per subscriber per calendar year; Generic Drug: \$12 copayment; Preferred Drug: \$25 copayment; Other Drug: 30% of the allowable charge with a minimum copayment of \$25. (See BCBSOK Preferred Drug List.)
<b>Adult preventive care</b>	\$20 copayment; 20% copayment for diagnostic, radiology, and laboratory.
<b>Other physician and medical services</b>	No extra charge after \$20 co-payment for most visits. 20% copayment for physical, speech or occupational therapy. (Maximum of 60 consecutive calendar days per condition.) 20% copayment for durable medical equipment. (\$1,000 maximum benefit per year for DME). 50% copayment for allergy and infertility treatment.
<b>Routine DRE (Digital Rectal Exam) and PSA test</b>	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.
<b>Routine gynecological examination</b>	\$20 copayment. Annual self-referral benefit included, contact Members Services to arrange. 20% coinsurance for lab fees.
<b>Pap smear</b>	20% copayment for lab fees.
<b>Maternity</b>	20% copayments for prenatal, postnatal, and diagnostic lab services. Maternity hospital services are the same as other hospital services.
<b>Inpatient Care</b>	20% copayments for surgeon, anesthesiologist, and hospital services.
<b>Outpatient Care/ Hospital Services</b>	20% copayments for diagnostic, radiology, laboratory, surgeon, and anesthesiologist services.
<b>Emergency care</b>	Must be authorized by your PCP 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.
<b>Psychiatric care/Alcoholism/Drug Abuse (groups or 2-50 eligible employees)</b>	Mental Health Outpatient: 50% copayment, 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 copayment for groups of 51 or more eligible employees: 20% copayments, inpatient and outpatient.
<b>Lifetime maximum</b>	Unlimited.

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