



Oklahoma City Chamber Choice 2012

BlueOptions®

BLUEOptimize™ A BLUE OPTIONS PRODUCT

Annual Deductible	\$500 \$750 \$1,000 \$1,500 \$2,500	\$500 \$1,000 \$2,500
Coinsurance	80% BluePreferred® network 70% BlueChoice® network 60% BlueTraditional® network 50% Out-of-network*	70% BluePreferred® network 60% BlueChoice® network 50% BlueTraditional® network 50% Out-of-network*
Out-of-pocket Limits**	\$2,000 per family member, plus deductible, for BluePreferred providers \$3,000 per family member, plus deductible, for BlueChoice providers \$4,000 per family member, plus deductible, for BlueTraditional providers \$5,000 per family member, plus deductible, for out-of-network providers and charges that exceed the allowable amount	\$6,000 per family member, plus deductible, for BluePreferred providers \$8,000 per family member, plus deductible, for BlueChoice providers \$10,000 per family member, plus deductible, for BlueTraditional providers \$10,000 per family member, plus deductible, for out-of-network providers and charges that exceed the allowable amount
Lifetime Maximum	Unlimited	Unlimited
Office Visits	\$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. Radiology excluded. Limit six per adult; unlimited for children. Deductible/Coinsurance will apply after sixth visit.
Prescription Drugs	50/50 Drug Card	50/50 Drug Card
Preventive Care	Services rated "A" or "B" in U.S. Preventive Services Task Force recommendations, including routine physical exams, well-child care and routine diagnostic tests, covered at 100% in-network	Services rated "A" or "B" in U.S. Preventive Services Task Force recommendations, including routine physical exams, well-child care and routine diagnostic tests, covered at 100% in-network
Immunizations	Includes MMR, pneumonia, Hib, DPT, tetanus and polio vaccines. Childhood immunizations (under age 19) are paid at 100% (no copay, no deductible and no coinsurance).	Includes MMR, pneumonia, Hib, DPT, tetanus and polio vaccines. Childhood immunizations (under age 19) are paid at 100% (no copay, no deductible and no coinsurance).
Inpatient Care Per Occurrence Deductible	\$250 for \$500 deductible \$325 for \$750 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)
Outpatient Care Per Occurrence Deductible	\$200 (in addition to deductible and coinsurance)	\$200 (in addition to deductible and coinsurance)

*Allowable charge for non-contracting providers for covered services will be the lesser of the provider's billed charges or the Plan's non-contracting allowable charge. The non-contracting allowable charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate.

**Some items will not be applied to the out-of-pocket expense limit including office visit copayments, deductibles including per-occurrence deductible on inpatient, outpatient, ER or mental health/substance abuse covered charges, reductions in benefits due to non-compliance with utilization management program requirements and mental health and chemical dependency treatment services (groups 50 and fewer).

BlueLincs HMOSM Value Option

Annual Deductible	No annual deductible or \$500 individual/\$1,500 family
Coinsurance	No coinsurance, but a 20% copayment of the allowable charge applies for some services.
Out-of-pocket Limits*	\$2,000 maximum per individual/\$6,000 maximum per family - per year (does not include some copayments)
Lifetime Maximum	Unlimited
Office Visits	\$20 copayment for Primary Care Physician (PCP) visits
Prescription Drugs	\$300 deductible Generic: 30% coinsurance with a minimum \$12 copayment Preferred Brand: \$25 copayment Non Preferred Brand: 30% coinsurance with a minimum \$25 copayment
Preventive Care	Services rated "A" or "B" in U.S. Preventive Services Task Force recommendations, including routine physical exams, well-child care and routine diagnostic tests, covered at 100% in-network
Immunizations	Includes MMR, pneumonia, HIB, DPT, tetanus and polio vaccines Childhood immunizations (under age 19) are paid at 100% (no copay, no deductible and no coinsurance)
Inpatient Care Per Occurrence Deductible	20% copayments for surgeon, anesthesiologist, and hospital services
Outpatient Care Per Occurrence Deductible	20% copayments for diagnostic, radiology, laboratory, surgeon, and anesthesiologist services

The information noted in the benefit charts is current as of the date of publication for non-grandfathered reform plans; 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.