

# Benefit Summary for University of Tulsa



Benefit levels on all four plans are based on a \$2,500 deductible. University of Tulsa will pay some or all of your \$2,500 deductible, if you incur any eligible PPO expenses. The more you contribute toward your annual deductible, the lower your monthly premium will be. If your deductible expenses exceed the employee contribution level that you choose, then the University of Tulsa will pay additional expenses until the \$2,500 deductible is satisfied.

Benefits	BlueChoice PPO \$2,500 Plan	BlueChoice PPO \$1,800 Plan	BlueChoice PPO \$1,200 Plan	BlueChoice PPO \$500 Plan
0 <u>University of Tulsa Contribution to Deductible</u>	\$0	\$700 per individual and \$2,100 per family	\$1,300 per individual and \$3,900 per family	\$2,000 per individual and \$6,000 per family
1 <u>Employee Contribution to Deductible</u>	\$2,500 per individual and \$7,500 per family.	\$1,800 per individual and \$5,400 per family.	\$1,200 per individual and \$3,600 per family.	\$500 per individual and \$1,500 per family
2 <u>Selection of Physician</u>	Over 4,500 doctors statewide; nationwide access through BlueCard PPO program. To find the most current Provider Directories for all of our networks, please visit our website at <a href="http://www.bcbsok.com">www.bcbsok.com</a> .	Over 4,500 doctors statewide; nationwide access through BlueCard PPO program. To find the most current Provider Directories for all of our networks, please visit our website at <a href="http://www.bcbsok.com">www.bcbsok.com</a> .	Over 4,500 doctors statewide; nationwide access through BlueCard PPO program. To find the most current Provider Directories for all of our networks, please visit our website at <a href="http://www.bcbsok.com">www.bcbsok.com</a> .	Over 4,500 doctors statewide; nationwide access through BlueCard PPO program. To find the most current Provider Directories for all of our networks, please visit our website at <a href="http://www.bcbsok.com">www.bcbsok.com</a> .
3 <u>Co-Insurance</u>	Plan pays 80% of allowable amount for in-network services and 60% of allowable amount of out-of-network services.	Plan pays 80% of allowable amount for in-network services and 60% of allowable amount of out-of-network services.	Plan pays 80% of allowable amount for in-network services and 60% of allowable amount of out-of-network services.	Plan pays 80% of allowable amount for in-network services and 60% of allowable amount of out-of-network services.
4 <u>Out-of-Pocket</u>	\$2,000 per family member for most in-network services plus deductible; \$8,000 plus deductible plus charges above in-network allowable maximum per family member for out-of-network services.	\$2,000 per family member for most in-network services plus deductible; \$8,000 plus deductible plus charges above in-network allowable maximum per family member for out-of-network services.	\$2,000 per family member for most in-network services plus deductible; \$8,000 plus deductible plus charges above in-network allowable maximum per family member for out-of-network services.	\$2,000 per family member for most in-network services plus deductible; \$8,000 plus deductible plus charges above in-network allowable maximum per family member for out-of-network services.
5 <u>Office Visits</u>	You pay only a \$20 copayment for most visits to BlueChoice doctors.	You pay only a \$20 copayment for most visits to BlueChoice doctors.	You pay only a \$20 copayment for most visits to BlueChoice doctors.	You pay only a \$20 copayment for most visits to BlueChoice doctors.
6 <u>Office Visits (Children)</u>	You pay only a \$20 copayment for most routine visits to BlueChoice doctors for children up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors for children up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors for children up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors for children up to age 19.

Benefits	BlueChoice PPO \$2,500 Plan	BlueChoice PPO \$1,800 Plan	BlueChoice PPO \$1,200 Plan	BlueChoice PPO \$500 Plan
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).	Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans, & other excluded services).	Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans, & other excluded services).	Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans, & other excluded services).
8 <u>Adult Preventive Care</u>	\$300 preventive care benefit, includes routine physicals, tests, and tetanus shots.	\$300 preventive care benefit, includes routine physicals, tests, and tetanus shots.	\$300 preventive care benefit, includes routine physicals, tests, and tetanus shots.	\$300 preventive care benefit, includes routine physicals, tests, and tetanus shots.
9 <u>Other Physician &amp; Medical Services</u>	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Co-insurance will apply.
10 <u>Prescription Drugs</u>	Generic \$10 copay Preferred \$25 copay Non Preferred \$50 copay Specialty Drugs \$150 copay (See BCBSOK Drug list)	Generic \$10 copay Preferred \$25 copay Non Preferred \$50 copay Specialty Drugs \$150 copay (See BCBSOK Drug List.)	Generic \$10 copay Preferred \$25 copay Non Preferred \$50 copay Specialty Drugs \$150 copay (See BCBSOK Drug List.)	Generic \$10 copay Preferred \$25 copay Non Preferred \$50 copay Specialty Drugs \$150 copay (See BCBSOK Drug List.)
11 <u>Routine Gynecological Examination</u>	You pay only a \$20 copayment for an annual visit to BlueChoice doctors. Then paid at 100%.	You pay only a \$20 copayment for an annual visit to BlueChoice doctors. Then paid at 100%.	You pay only a \$20 copayment for an annual visit to BlueChoice doctors. Then paid at 100%.	You pay only a \$20 copayment for an annual visit to BlueChoice doctors. Then paid at 100%.
12 <u>Routine Pap Smear</u>	Included in routine gynecological exam.	Included in routine gynecological exam.	Included in routine gynecological exam.	Included in routine gynecological exam.
13 <u>Routine DRE (Digital Rectal Exam) &amp; PSA Test</u>	\$20 copay to in-network doctor. 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.	\$20 copay to in-network doctor. 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.	\$20 copay to in-network doctor. 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.	\$20 copay to in-network doctor. 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.
14 <u>Immunizations</u>	You pay only a \$20 copayment for most routine visits to BlueChoice doctors. Copayment waived for covered childhood immunizations up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors. Copayment waived for covered childhood immunizations up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors. Copayment waived for covered childhood immunizations up to age 19.	You pay only a \$20 copayment for most routine visits to BlueChoice doctors. Copayment waived for covered childhood immunizations up to age 19.
15 <u>Mammography</u>	Covered at 100% of the allowable charge one baseline routine mammogram between the ages of 35-39 then annually for ages 40 and above.			
16 <u>Maternity</u>	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Co-insurance will apply.

Benefits	BlueChoice PPO \$2,500 Plan	BlueChoice PPO \$1,800 Plan	BlueChoice PPO \$1,200 Plan	BlueChoice PPO \$500 Plan
17 <u>Inpatient Care</u>	Plan deductible and co-insurance apply. Additional \$300 deductible per admission for out-of-network hospitalization.	Plan deductible and co-insurance apply. Additional \$300 deductible per admission for out-of-network hospitalization.	Plan deductible and co-insurance apply. Additional \$300 deductible per admission for out-of-network hospitalization.	Co-insurance will apply. Additional \$300 deductible per admission for out-of-network hospitalization.
18 <u>Outpatient Care/Hospital Services</u>	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Plan deductible and co-insurance apply.	Co-insurance will apply.
19 <u>Emergency Care</u>	Plan deductible and co-insurance apply. Additional per occurrence deductible of \$100 for each emergency room visit, waived if admitted.	Plan deductible and co-insurance apply. Additional per occurrence deductible of \$100 for each emergency room visit, waived if admitted.	Plan deductible and co-insurance apply. Additional per occurrence deductible of \$100 for each emergency room visit, waived if admitted.	Co-insurance will apply. Additional per occurrence deductible of \$100 for each emergency room visit, waived if admitted.
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 limit.	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 limit.	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 limit.	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 limit.
21 <u>Lifetime Maximum</u>	\$5,000,000 per person.	\$5,000,000 per person.	\$5,000,000 per person.	\$5,000,000 per person.
22 <u>Age Limit for Dependent Children</u>	To the end of year reaching age 19 or to 25th birthday if full time student.	To the end of year reaching age 19 or to 25th birthday if full time student.	To the end of year reaching age 19 or to 25th birthday if full time student.	To the end of year reaching age 19 or to 25th birthday if full time student.
23 <u>24 hour Nurseline</u>	Nurseline available to call 24 hours a day, 7 days a week.	Nurseline available to call 24 hours a day, 7 days a week.	Nurseline available to call 24 hours a day, 7 days a week.	Nurseline available to call 24 hours a day, 7 days a week.

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.