

Benefit Summary

ARKANSAS TECH UNIVERSITY

PPO 4000_7500Troop

WELCOME

Arkansas Blue Cross and Blue Shield is pleased to be your health insurance provider. For more than 65 years, Arkansas Blue Cross has been a name Arkansans have trusted. This Benefit Summary gives you an overview of your health coverage. *This summary is not your policy.* You will receive a Benefit Certificate that describes your complete health insurance coverage in greater detail.

SAVE MONEY WITH YOUR HEALTH INSURANCE

Most of us are interested in saving money, and when you use the services of in-network providers, you will pay less money out of pocket. Please take a moment to review this important information about your coverage.

Provider: You will see the term health care provider throughout this document. Providers are doctors, hospitals and others who offer medical services, such as labs or radiology clinics.

In-network providers: In-network health care providers are part of a group of participants who have agreed to give you a discount.

- In-network providers bill according to our agreement

- In-network providers participate in discounts for your medical services
- We pass the savings on to you, resulting in lower out-of-pocket expenses.

Please check to see that your health care provider is in your network.

Out-of-network providers: Out-of-network health care providers may not offer discounted services to our members.

- Out-of-network providers follow their own billing rules for services
- Your out-of-pocket expenses will be greater when you use an out-of-network provider
- Your health insurance policy is set up with a higher coinsurance.

Always check the network status of a provider that your doctor may refer you to for additional care. If you're referred to an out-of-network provider by an in-network provider, you still may have to pay higher costs.

Medical emergency: In a medical emergency, go directly to the nearest hospital. Medical services are covered at your plan's in-network deductible and health coinsurance amounts. Please note, if a visit to the hospital emergency room isn't a medical emergency, then in-network coverage may not be allowed. This can result in higher out-of-pocket costs. See your Benefit Certificate for a complete description of medical emergencies.

At Arkansas Blue Cross, your continued good health is our main concern.

HOW TO FIND AN IN-NETWORK PROVIDER

Always use your member number (on your ID card) to ensure the proper network when searching online.

In Arkansas

For a list of in-network providers, visit us online at: [arkansasbluecross.com/find a doctor](http://arkansasbluecross.com/find-a-doctor)
Your Provider Network is: **True Blue** or call Customer Service at:

501-378-2010 or **1-800-238-8379**

Important Note: For your protection, we want you to know that some doctors and hospitals may require up-front payment of your anticipated portion of the deductible and coinsurance fees.

Outside of Arkansas

Find a list of in-network providers at the Blue Cross and Blue Shield Association site at: bcbs.com/healthtravel/finder.html

Call the Blue Cross and Blue Shield Association at:
1-800-810-BLUE

Important Note: For some health policies, out-of-state providers may not be included at in-network rates. Check your Benefit Certificate for your policy details.

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.

Descriptions

Your Portion

Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.

\$4,000

(Combination of both in-network and out-of-network medical expenses)

Family Deductible: Each family member on your plan has an individual deductible. When two family members have met their individual amounts, then the entire family's deductible has been met for that calendar year and your health plan will begin to pay a portion of your medical expenses (also called coinsurance). *See example on page four.*

\$8,000

(Combination of both in-network and out-of-network medical expenses)

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing

	Individual	Family
In-Network	\$7,500	\$15,000
Out-of-Network*	\$18,000	\$36,000

*Annual limit on out-of-network costs does not include copayments.

Service Type**	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services		
Primary care physician visit	0%	50%
Specialty physician visit (Coinsurance may apply to additional services)	30%	50%
Adult preventive services	0%	20%
Children's preventive services	0%	20%
Professional fees for inpatient surgical and medical services	30%	50%
Professional fees for outpatient surgical and medical services	30%	50%
Hospital and Other Medical Facility Services		
Inpatient services	30%	50%
Outpatient services (Includes surgery, diagnostics, lab and X-ray)	30%	50%
Emergency room visit	30%	30%
Maternity and obstetrics	30%	50%
Therapeutic Services		
Inpatient (limited to 60 days)	30%	50%
Outpatient (limited to 30 visits total)	0%	50%
▪ Physical, occupational and speech therapy	30%	50%
▪ Chiropractic	30%	50%
Other Services		
Durable medical equipment***	30%	50%
Diabetic supplies	30%	50%
Mental health	30%	50%
Ambulance services — Ground: up to \$1,000 per trip	30%	30%
— Air: up to \$5,000 per trip	30%	30%

Additional fees may apply. Please check your Benefit Certificate. * Prior approval required for durable medical equipment that exceeds \$5,000.

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.

Your Drug Coverage

Your prescription drug benefit is an important part of your health coverage. There are often lower-cost options available; ask your doctor for alternatives.

All **preventive** prescription drugs are covered in full.

Generic drugs will cost less and have lower copayments. Selecting generic

drugs is a way to save money on your overall healthcare expenses.

Preferred brand-name drugs will cost less and will have lower copayments than **non-preferred brand-name** drugs.

Non-Preferred brand-name drugs are more expensive drugs. **Specialty** drugs typically require defined handling and

home storage demands, crucial patient education and careful monitoring.

Your coverage features a mail order option that may offer savings on drugs that have been prescribed on an ongoing basis. Check your [Benefit Certificate/Certificate of Coverage/Schedule of Benefits] for details.

Copayments by Category

*One copayment per 100-day supply

Preventive	Generic	Preferred Brand	Non-preferred Brand	Specialty
Covered in full	\$20.00	\$50.00	\$70.00	\$250.00
Mail order*	\$20.00	\$50.00	\$70.00	\$250.00

Family Deductible Details

Example: Bob and Sue Thompson have two children. They have individual deductibles of \$4,000. Bob paid \$4,000 in covered medical expenses, which means he met his individual deductible and his health plan will begin to pay coinsurance. Then [one/both] of the children also met the \$4,000 amount. Since two members of the Thompson family individually paid the \$4,000 individual deductible amount, the family has met their deductible for that calendar year and the health plan will begin paying coinsurance for all family members.

Other Member Services

My Blueprint – your personal online self-service center – allows you access to a wealth of information from the home page of our website at arkansasbluecross.com. Access or register for *My Blueprint* through the log in box on the home page.



Questions?

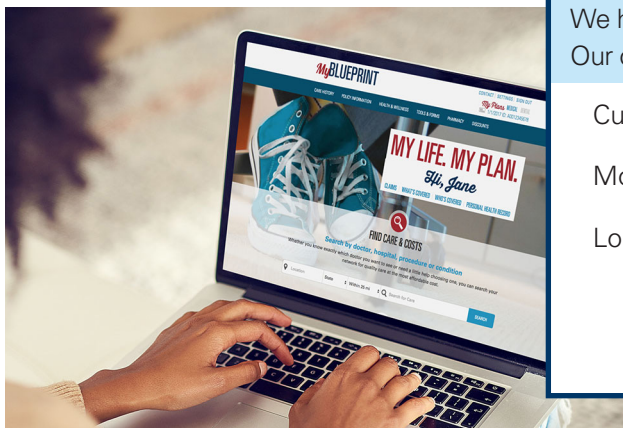
We hope you'll call us with any questions or concerns.

Our office hours are Monday through Friday from 8 a.m. to 4:30 p.m. (CST).

Customer Service Number: **501-378-2010** or **1-800-238-8379**

More information can be found on our website at: arkansasbluecross.com

Local Sales and Service Center: Arkansas Blue Cross and Blue Shield
601 S. Gaines
Little Rock, AR 72201



F PLAN # PPO 4000_7500Troop

MPI #3229 11/15

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.