

ARKANSAS TECH UNIVERSITY MEDICAL BENEFITS OPTIONS FOR 2018

| PLAN BENEFITS | OPTION 1 HSA 618E | OPTION 2 PPO \$3,000 | OPTION 3 PPO \$950 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|---------------|------------|---------|---------|----------------|-----------|-----------|--|--|-------------------|---------------|------------|---------|----------|----------------|----------|----------|---|--|-------------------|---------------|------------|---------|---------|----------------|----------|----------|
| Deductible | In-Network \$2,700 Individual / \$5,400 Family Out-of-Network \$5,400 Indiv./\$10,800 Family | \$3,000 Individual / \$6,000 Family | \$950 Individual / \$1,900 Family | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Annual Limit on Cost Sharing | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td>In-Network</td> <td style="text-align: center;">\$2,700</td> <td style="text-align: center;">\$5,400</td> </tr> <tr> <td>Out-of-Network</td> <td style="text-align: center;">Unlimited</td> <td style="text-align: center;">Unlimited</td> </tr> </table> | | <u>Individual</u> | <u>Family</u> | In-Network | \$2,700 | \$5,400 | Out-of-Network | Unlimited | Unlimited | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td>In-Network</td> <td style="text-align: center;">\$5,500</td> <td style="text-align: center;">\$11,000</td> </tr> <tr> <td>Out-of-Network</td> <td style="text-align: center;">\$10,000</td> <td style="text-align: center;">\$20,000</td> </tr> </table> | | <u>Individual</u> | <u>Family</u> | In-Network | \$5,500 | \$11,000 | Out-of-Network | \$10,000 | \$20,000 | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td>In-Network</td> <td style="text-align: center;">\$3,450</td> <td style="text-align: center;">\$6,900</td> </tr> <tr> <td>Out-of-Network</td> <td style="text-align: center;">No Limit</td> <td style="text-align: center;">No Limit</td> </tr> </table> | | <u>Individual</u> | <u>Family</u> | In-Network | \$3,450 | \$6,900 | Out-of-Network | No Limit | No Limit |
| | <u>Individual</u> | <u>Family</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In-Network | \$2,700 | \$5,400 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Out-of-Network | Unlimited | Unlimited | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <u>Individual</u> | <u>Family</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In-Network | \$5,500 | \$11,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Out-of-Network | \$10,000 | \$20,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <u>Individual</u> | <u>Family</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In-Network | \$3,450 | \$6,900 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Out-of-Network | No Limit | No Limit | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coinsurance (in-network and out-of-network) | 0%/20% | 20%/40% | 20%/40% | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Care Physician Visits | 0% After Deductible/ 20% After Deductible | \$35.00 Co-Pay | \$35.00 Co-Pay | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialty Physician Visit | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>Preventive Health Service</u> Immunizations (by PCP) Routine Well Baby Care (by PCP) Routine Physicals Exams Adults (by PCP) Annual Routine GYN Visit (PCP or GYN) Mammography/Pap Smear/PSA Colonoscopy Screenings (for ages 50-75 years of age and 1 every 10 years) | 0% / 0% 0% / 20% 0% / 20% 0% / 20% 0% / 20% 0% / 20% 0% / 20% | 0% / 20% 0% / 20% 0% / 20% 0% / 20% 0% / 20% 0% / 20% | 0% / 20% 0% / 20% 0% / 20% 0% / 20% 0% / 20% | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Professional Fees for In-Patient and Out-Patient Surgical and Medical Services | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In-Patient Hospital Services | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| PLAN BENEFITS | <u>OPTION 1</u> HSA 618E | <u>OPTION 2</u> PPO \$3,000 | <u>OPTION 3</u> PPO \$950 |
|---|--|---|---|
| Out-Patient Hospital Services (including surgery) | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible |
| Diagnostics, Lab & X-Ray | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible |
| Emergency Room Visit | 0% After Deductible/0% After Deductible | 20% After Deductible/20% After Deductible | 20% After Deductible/20% After Deductible |
| Maternity and Obstetrics | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible |
| <u>Therapeutic Services</u> In-Patient (limited to 60 days) | 0% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible | 20% After Deductible/40% After Deductible |
| Out-Patient (limited to 30 visits total) • Physical, occupational and speech therapy • Chiropractic | 0% After Deductible/20% After Deductible 0% After Deductible/20% After Deductible | \$35.00 Co-Pay/40% After Deductible 20% After Deductible/40% After Deductible | \$35.00 Co-Pay/40% After Deductible 20% After Deductible/40% After Deductible |
| <u>Other Services</u> Durable Medical Equipment Diabetic Supplies Mental Health Ambulance Services – Ground up to \$1,000 per trip – Air up to \$5,000 per trip | 0% After Deductible/20% After Deductible 0% After Deductible/20% After Deductible 0% After Deductible/20% After Deductible 0% After Deductible/0% After Deductible 0% After Deductible/0% After Deductible | 20% After Deductible/40% After Deductible 20% After Deductible/40% After Deductible 20% After Deductible/40% After Deductible 20% After Deductible/20% After Deductible 20% After Deductible/20% After Deductible | 20% After Deductible/40% After Deductible 20% After Deductible/40% After Deductible 20% After Deductible/40% After Deductible 20% After Deductible/20% After Deductible 20% After Deductible/20% After Deductible |
| Drug Coverage | <u>In-Network</u> 0% After Ded. | <u>Out-of-Network</u> Non Covered | Generic Tier 1 - \$15.00 Preferred Brand Tier 2 - \$45.00 Non-Preferred Brand Tier 3 - \$65.00 |

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.