ARKANSAS TECH UNIVERSITY
MEDICAL BENEFITS OPTIONS FOR 2019

PLAN BENEFITS	OPTION 1 HSA 618E	OPTION 2 PPO $3,500
Deductible	In-Network $2,700 Individual / $5,400 Family Out-of-Network $5,400 Indiv./$10,800 Family	$3,500 Individual / $7,000 Family
Annual Limit on Cost Sharing	Individual / Family In-Network $2,700 / $5,400 Out-of-Network Unlimited / Unlimited	Individual / Family In-Network $6,000 / $12,000 Out-of-Network $10,000 / $20,000
Coinsurance (**in-network** and **out-of-network**)	0%/20%	20%/40%
Primary Care Physician Visits	0% After Deductible/ 20% After Deductible	$40.00 Co-Pay
Specialty Physician Visit	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible
Preventive Health Service 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%
Professional Fees for In-Patient and Out-Patient Surgical and Medical Services	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible
In-Patient Hospital Services	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible

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Out-Patient Hospital Services (including surgery)	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible
Diagnostics, Lab & X-Ray	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible
Emergency Room Visit	0% After Deductible/0% After Deductible	20% After Deductible/20% After Deductible
Maternity and Obstetrics	0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible
Therapeutic Services In-Patient (limited to 60 days) 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 0% After Deductible/20% After Deductible	20% After Deductible/40% After Deductible $40.00 Co-Pay/40% After Deductible 20% After Deductible/40% After Deductible
Other Services 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
Drug Coverage	In-Network: 0% After Ded. Out-of-Network: Non Covered	Generic Tier 1 - $20.00 Preferred Brand Tier 2 - $50.00 Non-Preferred Brand Tier 3 - $70.00

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.