2024 Medical Plan Summary

This is not a legal document.
Complete plan coverage, limitations, and restrictions are contained in the Summary Plan Description (SPD).

WHAT YOU WILL PAY:	Health Savings Plan	Classic Plan	Premier Plan
Premiums	**Please view rates per pay period.**	**Please view rates per pay period.**	**Please view rates per pay period.**
Deductible			
In-network	$3,200 Individual / $6,400 Family	$1,500 Individual / $3,000 Family	$1,000 Individual / $2,000 Family
Out-of-network	$6,400 Individual / $12,800 Family	$3,000 Individual / $6,000 Family	$2,000 Individual / $4,000 Family
Coinsurance			
	20% in-network /40% out-of-network	20% in-network / 40% out-of-network	20% in-network / 40% out-of-network
Out-of-Pocket Maximum			
In-network	$6,650 Individual / $13,300 Family	$4,000 Individual / $8,000 Family	$3,000 Individual / $6,000 Family
Out-of-network	$13,300 Individual / $26,600 Family	$8,000 Individual / $16,000 Family	$6,000 Individual / $12,000 Family
Medical Services			
PCP Office Visit[i] Additional services may be subject to coinsurance	20% after deductible (in-network) 40% after deductible (out-of-network)	$35 copay[i] (in-network) 40% after deductible (out-of-network)	$35 copay[i] (in-network) 40% after deductible (out-of-network)
Specialist Office Visit Additional services may be subject to coinsurance	20% after deductible (in-network) 40% after deductible(out-of-network)	$50 copay[i] (in-network) 40% after deductible (out-of-network)	$50 copay[i] (in-network) 40% after deductible (out-of-network)
Mental Health Office Visit	20% after deductible (in-network) 40% after deductible (out-of-network)	$35 copay (in-network) 40% after deductible (out-of-network)	$35 copay (in-network) 40% after deductible (out-of-network)

Preventive Care[ii]	$0 (available in-network only)	$0 (available in-network only)	$0 (available in-network only)
Diagnostic Services	20% coinsurance after deductible 40% coinsurance (out-of-network)	20% coinsurance 40% coinsurance (out-of-network)	20% coinsurance 40% coinsurance (out-of-network)
Advanced Imaging (CT/PET scans, MRIs) [iii]	20% after deductible (in-network) 40% after deductible (out-of-network)	20% after deductible (in-network) 40% after deductible (out-of-network)	20% after deductible (in-network) 40% after deductible (out-of-network)
Telemedicine (MDLive)	$60 per visit (not subject to deductible)	$30 copay	$30 copay
Hospital and Outpatient Services	20% after deductible (in-network) 40% after deductible (out-of-network)	20% after deductible (in-network) 40% after deductible (out-of-network)	20% after deductible (in-network) 40% after deductible (out-of-network)
Chiropractic Services (Limit of 20 visits per year)	20% after deductible (Available in-network only)	50% deductible waived (Available in-network only)	50% deductible waived (Available in-network only)
Urgent Care[i] Additional services may be subject to coinsurance	20% after deductible	$35 copay[i]	$35 copay[i]
Emergency Room	20% after deductible	20% after deductible, plus $200 copay	20% after deductible, plus $200 copay
Emergency medical transportation	20% after deductible	20% coinsurance after deductible Ground and water transport is limited to $2,000 per trip. Air transport is limited to $10,000 per trip.	
Pharmacy Coverage*			
Prescription Drugs	20% after deductible	$12/$50/$80/$100 copay per 30-day supply	$12/$50/$80/$100 copay per 30-day supply
Pharmacy Out-of- Pocket Maximum**			
Individual	Combined with medical out-of-pocket maximum.	$2,000	$2,000
Family		$4,000	$4,000

Networks			
	• Arkansas True-Blue PPO and the National Blue Card network. • National Blue Card network is nationwide and includes both Baptist and Methodist in the Memphis area.	• Arkansas True-Blue PPO Network Only including the Baptist System in the Memphis Area. • Out-of-network includes claims outside of the True-Blue PPO network including out-of-state claims other than Baptist in the Memphis area.	• Arkansas True-Blue PPO and the National Blue Card network. • National Blue Card network is nationwide and includes both Baptist and Methodist in the Memphis area.

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i Copays cover basic office visit but does not cover other services including labs, x-rays, injections, testing, and other procedures. Additional services are subject to co-insurance. Some outpatient services are also subject to a deductible even if performed in your physician's office as part of an office visit. Advanced imaging in an outpatient setting, requires prior authorization.

ii Out-of-network preventive services are covered at a $0 copay for children under age 19 only.

iii Pre-certification is required for in-patient and outpatient services such as surgery and medical procedures. Your physician coordinates in-network pre-certification. The individual is responsible for out-of-network pre-certification or is subject to a $200 penalty. Advanced imaging in an outpatient setting, requires prior authorization. ASU utilizes AIM for advanced imaging prior to authorization. ASU utilizes New Directions for both inpatient and outpatient management of behavioral health.

Out-of-network services are covered under out-of-network benefits except in case of emergency. Out-of-network providers are reimbursed at the in-network fee schedule. You may be billed for charges by the provider if they bill more than what is allowed for in-network services, which may exceed the out-of-network deductible, 60% coinsurance, and out-of-pocket maximum.

**Out-of-pocket costs associated with excluded drugs will not apply to the out-of-pocket maximum.