2021 Medical Plan Summary

Please refer to ASU Summary Plan Description (SPD) for plan coverage, limitations and restrictions.

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 balance billed for charges by the provider if they bill more than what is allowed for in-network services, which may then exceed the out-of-network deductible, 60% coinsurance and out-of-pocket maximum.

WHAT YOU WILL PAY:	Health Savings Plan	Classic Plan	Premier Plan
Premiums	**Pease view rates for per pay period.**	**Pease view rates for per pay period.**	**Pease view rates for per pay period.**
Deductible			
In-network	$2,800 Individual / $5,600 Family	$1,500 Individual / $3,000 Family	$1,000 Individual / $2,000 Family
Out-of-network	$5,600 Individual / $11,200 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	$45 per visit (not subject to deductible)	$20 copay	$20 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	$12/$50/$80/$100 copay
***Certain preventive medications are covered at 100% by the plan. Refer to the Arkansas State University Preferred Drug List (PDL) for a list of medications covered.**			
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.

Prepared by ASU System Office 10/10/2020

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

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 a prior authorization.

ii Out-of-network preventive services are covered at $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. In-network pre-certification is coordinated by your physician. Individual is responsible for out-of-network pre-certification or subject to $200 penalty. Advanced imaging in an outpatient setting, requires a prior authorization. ASU utilizes AIM for advanced imaging prior authorization. ASU utilizes New Directions for both inpatient and outpatient management of behavioral health.