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| **Effective: 1/1/2014** | **UNIVERSITY OF ARKANSAS**  **Medical Plans Comparison**  **UMR** | | **Effective: 1/1/2014** |
| This is not a legal document. Complete benefits descriptions and exclusions are contained in the Summary Plan Description. | CLASSIC | POINT OF SERVICE PLAN | |
| No benefits for out-of-network service without prior authorization from UMR | **UMR Network Provider** | **Non-UMR Provider (e)** |
| **INDIVIDUAL DEDUCTIBLE (a)** | **$750** | **$750** | **$1,000** |
| **FAMILY DEDUCTIBLE (a)** | **$1,500** | **$1,500** | **$2,000** |
| **COINSURANCE (b)** | 20% | 20% | 40% |
| **OUT OF POCKET MAXIMUM**  Individual (c) | $2,000 | $2,000 | $5,000 |
| Family (c) | $4,000 | $4,000 | $10,000 |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited | Unlimited |
| **PREVENTIVE CARE SERVICES** (l)  Well Baby/Child Visit (f)  Immunizations  Mammograms(first yearly mammogram)  Colorectal Cancer Screening  Nutritional Counseling \*  **Physical Exams**  PCP or OB/GYN  Specialist | Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full | Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full  Paid in Full | Deductible + Coinsurance  Deductible + Coinsurance  Not Covered  Deductible + Coinsurance  Not Covered  Not Covered  Not Covered |
| **PHYSICIAN SERVICES IN OFFICE (d)**  PCP or OB/GYN Office Visit  Specialist  Diagnostic Testing  Surgical Services  **Advanced Imaging Services (CT, PET, MRI, & Nuclear Medicine) Prior**  **Authorization Required** | $25 Co-pay  $45 Co-pay  Paid in Full  Office Copay if applicable  **Deductible + Coinsurance** | $25 Co-pay  $45 Co-pay  Paid in Full  Office Copay if applicable  **Deductible + Coinsurance** | Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  **Deductible + Coinsurance** |
| **PHYSICIAN SERVICES NOT IN OFFICE**  Inpatient Medical Care  Diagnostic Testing  Surgical Services | Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance | Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance | Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance |
| **PHYSICIAN MATERNITY SERVICES (g)**  Maternity/Obstetrical Care OB/GYN | no deductible or coinsurance for pre-natal & delivery services | no deductible or coinsurance for  pre-natal & delivery services | Deductible + Coinsurance |
| **OUTPATIENT FACILTY SERVICES**  Diagnostic Testing  Surgical Services  ER Copay tiered by visit ( Co-payment waived if admitted)  Urgent Care Center | Deductible + Coinsurance  $150 Co-pay + Deductible + Coinsurance  $150 1st visit, $200 2nd visit  $250 after 2nd visit  $50 Co-pay | Deductible + Coinsurance  $150 Co-pay + Deductible + Coinsurance  $150 1st visit, $200 2nd visit  $250 after 2nd visit  $50 Co-pay | Deductible + Coinsurance  $150 Co-pay + Deductible + Coinsurance  $150 1st visit, $200 2nd visit  $250 3rd visit  $50 Co-pay |
| **INPATIENT SERVICES (h)**  Semi-Private Room & Board, Intensive Care Room & Board, Ancillary Charges, & Maternity Inpatient Charges | $300 Co-pay + Deductible  + Coinsurance (h) | $300 Co-pay + Deductible  + Coinsurance (h) | $300 Co-pay + Deductible  + Coinsurance (h) |
| **OTHER SERVICES**  Ambulance (Co-pay waived if admitted)  Home Health (40 visits per year max)  Speech Therapy , PT, OT (Reviewed  after 30 visits for medical necessity )  Chiropractic (30 visits per year max)  Durable Medical  Hospice  TMJ ($10,000 Lifetime Max) (i) | $100 Co-pay  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  No Coverage | $100 Co-pay  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  $200 copay + $1,000 Deduct + Coinsurance | $100 Co-pay  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance  $200 copay + $2,000 Deduct + Coinsurance |
| **MENTAL HEALTH/SUBSTANCE ABUSE**  Inpatient Services (h)  Outpatient Intensive Day Treatment    Outpatient Services in office | $300 Co-pay + Ded + Coins  $150 Copayment +  Ded + Coins  $25 Co-pay | $300 Co-pay + Ded + Coins  $150 Copayment +  Ded + Coins  $25 Co-pay | $300 Co-pay + Ded + Coins  $150 Copayment +  Ded + Coins  $25 Co-pay |
| **ROUTINE VISION EXAMS (j)**  One exam per calendar year | $25 Co-pay | $25 Co-pay | $25 Co-pay |
| **PRESCRIPTION DRUGS (k)** | $10 Generic; $35 Preferred;  $70 Non-Preferred (k) | $10 Generic; $35 Preferred;  $70 Non-Preferred (k) | $12 Generic; $37 Preferred;  $72 Non-Preferred (k) |

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| **FOOTNOTES:**  (a) **Deductible** means a fixed *dollar* amount that you must incur each calendar year before the health plan begins to pay for covered medical services. The calendar year deductible applies to all Covered Services except for those that a Co-payment applies, unless otherwise noted. In-network deductibles do not apply to out-of-network deductibles and visa versa. 2 individual deductible = family deductible.  (b) **Coinsurance** means a fixed *percentage* of charges you must pay toward the cost of covered medical services. Coinsurance applies to all Covered Services except those for which a Co-payment applies unless otherwise noted.  (c) **Out of Pocket Maximum** is the maximum deductible, coinsurance and copayments you would pay in any calendar year. Does not include plan exclusions, limitations and pharmacy copayments.  (d) **Co-Payment** means a fixed dollar amount that you must pay each time you receive a particular medical service. You pay a Co-payment when you obtain health care directly from your Network Primary Care Physician or an In-Network Specialist. Referrals are NOT required for Network Specialists office visits. Certain services rendered in the Network Primary Care Physician or Network Specialist’s office are not subject to coinsurance and do not apply to the deductible or the out-of-pocket maximum. Services rendered in the Network Primary Care Physician or Network Specialist’s office **that are** subject to deductible and coinsurance include advanced imaging such as MRI, CT Scans, PET Scans and Nuclear Medicine (imaging studies using medical radioisotopes). Office surgery will apply the physician specific (specialist vs PCP) copayment.  (e) When you obtain health care through a Non-UMR Provider, your Benefit payments for covered services will be based on the Maximum Allowable Payment for out-of-network services, as determined by UMR. Charges in excess of the Maximum Allowable Payments do not count toward meeting the deductible or meeting the limitation on your Out of Pocket maximum. Non-UMR Providers may bill the patient for amounts in excess of the Maximum Allowable Payment.  (f) Well baby/child visits from an In-Network provider are covered in full from birth until the day the child attains age 19.  (g) Inpatient and other services are subject to Co-payment and coinsurance. **It is your responsibility to notify the Benefits Section of Human Resources within 31 days of the birth or adoption of your child in order to obtain coverage for your newborn.**   1. Maximum combined Inpatient Co-payment per calendar year is $1,200 per person (no more than one co-payment per 30 calendar days). 2. The TMJ deductible is separate from the any other In-Network or Out-of-Network deductibles. The TMJ deductible is in addition to any In-Network or Out-of-Network deductible and **requires pre-authorization.**   (j) Vision Exams: Ophthalmologist or Optometrist in-network and out-of-network benefits are the same.  (k) Under the Point of Service Plan and the Classic Plan, Co-payments at non-participating pharmacies will be $12 for generic, $37 for preferred name brand, and $72 for non-preferred name brand. If a new enrollee has to get a prescription prior to receiving his/her pharmacy card, he/she will have to pay for the prescription in full, apply for reimbursement, and will be reimbursed less the $12, $37, or $72 Co-payments. Alternatively, if the enrollment process has been completed and benefits are in effect, a temporary prescription drug ID card can be printed by going to [www.medimpact.com](http://www.medimpact.com), registering and clicking on ‘member ID card’. A complete summary of prescription drug benefits is also on the above web-address. Reference Based Pricing applies a set price per dose in a specific class of drugs. Example: In the Proton Pump Inhibitor (PPI) class, the plan pays $0.64/dose and the member pays the remainder of the cost.  (l) Preventive care services and cancer screenings will follow the U.S. Preventive Task Force Recommendations. See the health plan Summary Plan Description for details on coverage.  The following procedures for both the Point of Service Plan and the Classic Plan will require pre-authorization **before** the services are rendered:  1. Any admission to Inpatient Facilities or Partial Hospitalization Units  2. Any referral by your PCP to an Out-of-Network Provider  3. Pre-Natal/Maternity Care. Authorization includes physician care and one ultra sound. Additional ultrasounds require pre-authorization**. UAMS offers a $1000 waiver of out-of-pocket expenses for deliveries at its hospital. (This includes deductible and inpatient copayment/coinsurance.)**  4. Home Health Care and Home Infusion Services  5. Transplant Services (including the evaluation to determine if you are a candidate for transplant by a transplant program)  6. All Advanced Imaging (CT, MRI, Thallium Stress Test, PET. Go to [www.UMR.com](http://www.qualchoice.com) for a complete listing) regardless of place of service.  7. MRI of the Breast  Note: Certain other services have special Pre-authorization requirements: Surgical treatment of Temporomandibular Joint Dysfunction (TMJ), Accidental Injury to Teeth.  Procedures for testing and treatment of a diagnosed condition will be subject to deductible and coinsurance.  **The Smoking Cessation Progrmam:** smoking cessation program provides free PCP visits and zero copay for Chantix, a medication for nicotine addiction. The **Diabetes Management Initiative and the Healthy Heart Program** provide the opportunity for zero copayments on many generic medication. For more information on all programs call UMR 888-438-6105  **\*Nutritional Counseling and** **Weight Management Services:**  One annual visit with a dietitian and up to 3 additional visits in conjunction with health coaching for those who have a BMI of 27 and above. Prior authorization is required and continued approval contingent upon compliance with health coaching engagement. **Metabolic weight loss programs** are reimbursable up to $1000/ life time for individuals with a BMI of 30 and above who participate in health coaching. Prior authorization is required. More information is available by calling UMR 888-438-6105  modified 12-13-13 |