Effective: January 1, 2017
(2017 comparison grid health plan handout)

UNIVERSITY OF ARKANSAS
Medical Plans Comparison
UMR

This is not a legal document. Complete benefits descriptions and exclusions are contained in the Summary Plan Description which is available through your campus HR Office.	**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 MEDICAL DEDUCTIBLE (a)	**$1,250**	**$1,250**	**$2,000**
FAMILY MEDICAL DEDUCTIBLE (a)	**$2,500**	**$2,500**	**$4,000**
COINSURANCE (b)	30%	30%	50%
MEDICAL OUT OF POCKET MAXIMUM			
Individual (c)	$4,000+Deductible = $5,250	$4,000+Deductible = $5,250	$7,000+Deductible $9000
Family (c)	$8,000+Deductible = $10,500	$8,000+Deductible = $10,500	$14,000+Deductible $18000
PREVENTIVE CARE SERVICES (l)			
Well Baby/Child Visit (f)	Paid in Full	Paid in Full	Deductible + Coinsurance
Immunizations	Paid in Full	Paid in Full	Deductible + Coinsurance
Mammograms(first yearly mammogram)	Paid in Full	Paid in Full	Not Covered
Colorectal Cancer Screening	Paid in Full	Paid in Full	Deductible + Coinsurance
Nutritional Counseling *	Paid in Full	Paid in Full	Not Covered
Physical Exams			
PCP or OB/GYN	Paid in Full	Paid in Full	Not Covered
Specialist	Paid in Full	Paid in Full	Not Covered
PHYSICIAN SERVICES IN OFFICE (d)			
PCP or OB/GYN Office Visit	$35 Co-pay	$35 Co-pay	Deductible + Coinsurance
Specialist Office Visit	$50 Co-pay	$50 Co-pay	Deductible + Coinsurance
Diagnostic Testing	**Deductible + Coinsurance**	**Deductible + Coinsurance**	Deductible + Coinsurance
Surgical Services	**Deductible + Coinsurance**	**Deductible + Coinsurance**	Deductible + Coinsurance
Advanced Imaging Services (CT, PET, MRI, & Nuclear Medicine)Prior Authorization Required	**$100 Copayment** **Deductible + Coinsurance**	**$100 Copayment** **Deductible + Coinsurance**	**$100 Copayment** **Deductible + Coinsurance**
PHYSICIAN SERVICES NOT IN OFFICE			
Inpatient Medical Care	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Surgical Services	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
PHYSICIAN MATERNITY SERVICES (g)			
Maternity/Obstetrical Care OB/GYN	no deductible or coinsurance for pre-natal & physician delivery services	no deductible or coinsurance for pre-natal & physician delivery services	Deductible + Coinsurance
OUTPATIENT FACILTY SERVICES			
Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Surgical Services	$150 Co-pay + Deductible + Coinsurance	$150 Co-pay + Deductible + Coinsurance	$150 Co-pay + Deductible + Coinsurance
ER Copay tiered by visit (Co-payment waived if admitted)	$150 1st visit, $200 2nd visit $250 after 2nd visit	$150 1st visit, $200 2nd visit $250 after 2nd visit	$150 1st visit, $200 2nd visit $250 3rd visit
Urgent Care Center	$50 Co-pay	$50 Co-pay	$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)	$100 Co-pay	$100 Co-pay	$100 Co-pay
Home Health (40 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Speech Therapy , PT, OT, Chiropractic (30 visits Combined / approval required for additional visits)	~~$35 Office Visit Co-pay,~~ Deductible + Coinsurance on All Therapy and Chiropractic	~~$35 Office Visit Co-pay,~~ Deductible + Coinsurance on All therapy and Chiropractic	~~$35 Office Visit Co-pay,~~ Deductible + Coinsurance on All Therapy and Chiropractic
Durable Medical	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Hospice	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
TMJ	$200 copay + $1,000 Deduct + Coinsurance	$200 copay + $1,000 Deduct + Coinsurance	$200 copay + $2,000 Deduct + Coinsurance
MENTAL HEALTH/SUBSTANCE ABUSE			
Inpatient Services (h)	$300 Co-pay + Ded + Coins	$300 Co-pay + Ded + Coins	$300 Co-pay + Ded + Coins
Outpatient Intensive Day Treatment	$150 Copayment + Ded + Coins	$150 Copayment + Ded + Coins	$150 Copayment + Ded + Coins
Outpatient Services in office	$35 Co-pay	$35 Co-pay	Ded + Coins
ROUTINE VISION EXAMS (j)			
One exam per calendar year	$35 Co-pay	$35 Co-pay	$35 Co-pay
PRESCRIPTION DRUGS (k)	Rx OOP Max $1,600	Rx OOP Max $1,600	Rx OOP Max $1,600
$1600 OOP Max individual	$15 Tier 1; $50 Tier 2;	$15 Tier 1; $50 Tier 2;	$18.50 Tier 1; 53.50 Tier 2;
$3200 OOP Max family	$80 Tier 3 (k)	$80 Tier 3 (k)	$83.50 Tier 3 (k)
Separate from Medical OOP Max			

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. Two 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) **Medical Out of Pocket Maximum** is the maximum combined deductible, coinsurance and copayments you will pay in any calendar year. It does not include costs for services not covered by the plan such as exclusions, limitations and pharmacy copayments. The maximum OOP for prescriptions drugs is a separate OOP from medical expenses. Family OOP max requires two individual family member meet the individual OOP max.

(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. Certain services rendered in the Network Primary Care Physician or Network Specialist's office are not subject to coinsurance. Services rendered in the Network Primary Care Physician or Network Specialist's office **that are** subject to deductible, coinsurance and additional copayments include advanced imaging such as MRI, CT Scans, PET Scans and Nuclear Medicine (imaging studies using medical radioisotopes), Temporomandibular Joint Disorder (TMJ) treatment and all therapy including chiropractic .

(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) Facility inpatient charges are subject to co-payment and coinsurance. **It is your responsibility to notify Human Resources within 31 days of the birth or adoption of your child in order to obtain coverage for your newborn.**

(h) Maximum combined Inpatient Co-payment per calendar year is $1,200 per person (no more than one co-payment per 30 calendar days).

(i) The TMJ deductible is separate from the 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 $18.50 for Tier 1, $53.50 for Tier 2, and $83.50 for Tier 3. 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 $18.50, $53.50, or $83.50 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, registering and clicking on 'member ID card'. A complete summary of prescription drug benefits is also on the above web-address. Prescription drug OOP max $1600 individuals and $3200 family. OOP max does not include costs for excluded or non-covered medications or devices. Non covered medication do not go to the Rx Max OOP expense.

(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 $500 waiver of out-of-pocket expenses for deliveries at its hospital.**
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 for a complete listing) regardless of place of service.
7. MRI of the Breast

Note: Certain other services have special Pre-authorization including 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 Program: smoking cessation program provides free PCP visits and $0 copay for certain nicotine addiction drugs. The **Diabetes Management Initiative and the Healthy Heart Program** provide the opportunity for $0 copayments on certain medications. 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 three 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 program compliance.

Metabolic weight loss programs are reimbursable up to $1000/ life time for individuals with a BMI of 30 and above who participate in coaching. Prior authorization is required. For more information call UMR 888-438-6105

modified 09-17-16

UACCB
Rates for 2017

CLASSIC PLAN	Under 30,000	Between $30,000 & $59,000	Between $60,000 & $89,999	$90,000 & Above
E ONLY				
EE	91.23	97.86	104.49	115.54
ER	321.23	314.60	307.97	296.92
TOTAL E ONLY	**412.46**	**412.46**	**412.46**	**412.46**
E & S				
EE	205.29	220.33	235.39	260.47
ER	731.25	716.21	701.15	676.07
TOTAL E&S	**936.54**	**936.54**	**936.54**	**936.54**
E & C				
EE	162.29	174.71	187.13	207.82
ER	610.31	597.89	585.47	564.78
TOTAL E&C	**772.60**	**772.60**	**772.60**	**772.60**
FAMILY				
EE	276.63	297.61	318.60	353.58
ER	1,029.31	1,008.33	987.34	952.36
TOTAL FAMILY	**1,305.94**	**1,305.94**	**1,305.94**	**1,305.94**

POS PLAN	Under 30,000	Between $30,000 & $59,000	Between $60,000 & $89,999	$90,000 & Above
E ONLY				
EE	125.84	133.17	140.52	152.74
ER	330.98	323.65	316.30	304.08
TOTAL E ONLY	**456.82**	**456.82**	**456.82**	**456.82**
E & S				
EE	283.05	299.72	316.39	344.18
ER	754.23	737.56	720.89	693.10
TOTAL E&S	**1,037.28**	**1,037.28**	**1,037.28**	**1,037.28**
E & C				
EE	223.49	237.21	250.92	273.78
ER	629.89	616.17	602.46	579.60
TOTAL E&C	**853.38**	**853.38**	**853.38**	**853.38**
FAMILY				
EE	381.13	404.38	427.62	466.36
ER	1,065.35	1,042.10	1,018.86	980.12
TOTAL FAMILY	**1,446.48**	**1,446.48**	**1,446.48**	**1,446.48**