Effective: 7/1/2012

UNIVERSITY OF ARKANSAS
Medical Plans Comparison

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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 QualChoice	QualChoice Network Provider	Non-QualChoice 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 Max (individual) (c)	$2,000	$2,000	$5,000
Out of Pocket Max (family) (c)	$4,000	$4,000	$10,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited
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	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	$40 Co-pay	$40 Co-pay	Not Covered
PHYSICIAN SERVICES IN OFFICE (d)			
PCP or OB/GYN Office Visit	$25 Co-pay	$25 Co-pay	Deductible + Coinsurance
Specialist	$40 Co-pay	$40 Co-pay	Deductible + Coinsurance
Diagnostic Testing	Paid in Full	Paid in Full	Deductible + Coinsurance
Surgical Services	Paid in Full	Paid in Full	Deductible + Coinsurance
Advanced Imaging Services (CT, PET, MRI, & Nuclear Medicine) Prior Authorization Required	**Deductible + Coinsurance**	**Deductible + Coinsurance**	**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)	$25 Co-pay for initial visit only, no deductible or coinsurance for pre-natal & delivery services	$25 Co-pay for initial visit only, no deductible or coinsurance for pre-natal & delivery services	Deductible + Coinsurance
Maternity/Obstetrical Care OB/GYN			
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 (Co-payment waived if admitted)	$150 Co-pay	$150 Co-pay	$150 Co-pay
Urgent Care Center	$50 Co-pay	$50 Co-pay	$100 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 (10 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
PT, OT Therapy and Chiropractic (30 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Durable Medical Equipment ($2,000 max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Hospice (6 month max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
TMJ ($10,000 Lifetime Max) (i)	Not Covered	$200 copay + $1,000 Deduct + Coinsurance	$200 copay + $2,000 Deduct + Coinsurance
MENTAL HEALTH/SUBSTANCE ABUSE			
Inpatient Services (h)	$250 Co-pay + Ded + Coins	$250 Co-pay + Ded + Coins	$250 Co-pay + Ded + Coins
Outpatient Services	$25 Co-pay	$25 Co-pay	Ded + Coins
Treatment Plan may be required after initial visit			
ROUTINE VISION EXAMS (j)			
One exam covered every 12 month period	$25 Co-pay	$25 Co-pay	Not Covered
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)

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 coinsurance you would pay in any calendar year. Excludes co-payments and deductibles.

(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)

(e) When you obtain health care through a Non-QualChoice Provider, your Benefit payments for covered services will be based on the Maximum Allowable Payment for out-of-network services, as determined by QualChoice. 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-QualChoice 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.**

(h) Maximum combined Inpatient Co-payment per calendar year is $1,000 per person (no more than one co-payment per 30 calendar days).

(i) 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) You must see an in-network Ophthalmologist or Optometrist for services to be covered under the plan.

(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, 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, Home Infusion Services, or Hospice (Inpatient or Outpatient)
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.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 Kick the Nic 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 QCARE at 1-888-795-6810 .
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 QCARE at 1-888-795-6810.