

**UNIVERSITY OF ARKANSAS
Medical Plans Comparison**

Effective: 1/1/2009

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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 (d) Well Baby/Child Visit (f) Immunizations Mammograms Colorectal Cancer Screening (l) Physical Exams PCP or OB/GYN Specialist	Paid in Full Paid in Full Paid in Full Paid in Full Paid in Full \$40 Co-pay	Paid in Full Paid in Full Paid in Full Paid in Full Paid in Full \$40 Co-pay	Deductible + Coinsurance Deductible + Coinsurance Not Covered Deductible + Coinsurance Not Covered Not Covered
PHYSICIAN SERVICES IN OFFICE (d) PCP or OB/GYN Office Visit Specialist & Other Provider Office Visit Diagnostic Testing Surgical Services Advanced Imaging Services (CT, PET, MRI, & Nuclear Medicine) Prior Authorization Required	\$25 Co-pay \$40 Co-pay Paid in Full Paid in Full Deductible + Coinsurance	\$25 Co-pay \$40 Co-pay Paid in Full Paid in Full 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	\$20 Co-pay for initial visit only, no deductible or coinsurance for pre-natal & delivery services	\$20 Co-pay for initial visit only, no deductible or coinsurance for pre-natal & delivery services	Deductible + Coinsurance
OUTPATIENT FACILITY SERVICES Diagnostic Testing (including diagnostic mammograms & breast ultrasounds) Surgical Services ER (Co-payment waived if admitted) Urgent Care Center	Deductible + Coinsurance Deductible + Coinsurance \$150 Co-pay \$50 Co-pay	Deductible + Coinsurance Deductible + Coinsurance \$150 Co-pay \$50 Co-pay	Deductible + Coinsurance Deductible + Coinsurance \$150 Co-pay \$100 Co-pay
INPATIENT SERVICES (h) Semi-Private Room & Board, Intensive Care Room & Board, Ancillary Charges, & Maternity Inpatient Charges	\$250 Co-pay + Deductible + Coinsurance (h)	\$250 Co-pay + Deductible + Coinsurance (h)	\$250 Co-pay + Deductible + Coinsurance (h)
OTHER SERVICES Ambulance (Co-pay waived if admitted) Home Health (40 visits per year max) Speech Therapy (10 visits per year max) PT, OT Therapy and Chiropractic (30 visits per year max) Durable Medical Equipment (\$2,000 max) Hospice (6 month max) TMJ (\$10,000 Lifetime Max) (i)	\$100 Co-pay Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance Not Covered	\$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 Services	Pre-authorization required \$250 Co-pay + Ded + Coins Max 10 Days/yr; 90 Days life \$40 Co-pay; max 10 Visits/yr	Pre-authorization required \$250 Co-pay + Ded + Coins Max 30 Days/yr; 90 Days life \$40 Co-pay; max 30 Visits/yr	Pre-authorization required \$250 Co-pay + Ded + Coins Max 30 Days/yr; 90 Days life Ded + Coins; max 30 Visits/yr
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.
- (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.pharmacare.com, registering and clicking on 'print temporary ID card'. A complete summary of prescription drug benefits is also on the above web-address.
- (l) Any colorectal cancer screening done outside of the American Cancer Society's guidelines will be covered but subject to deductible and coinsurance. 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.
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.qcark.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.

Only routine screenings are considered preventive care. Procedures and testing performed once a diagnosis is made or problem detected, services then become diagnostic in nature and deductible and coinsurance will apply.