

**** IMPORTANT:** In order to locate an In-Network Provider or Hospital in your area, please call 1-888-771-7427 or go to www.phcs.com and click on "Find A Provider". Select the PPO network option.

	POINT OF SERVICE PLAN ALTERNATE	
	QualChoice In-Network Provider	Non-QualChoice Provider (e)
This is not a legal document. Complete benefits descriptions and exclusions are contained in the Summary Plan Description.		
INDIVIDUAL DEDUCTIBLE (a)	\$750	\$1,000
FAMILY DEDUCTIBLE (a)	\$1,500	\$2,000
COINSURANCE (b)	20%	40%
Out of Pocket Max (individual) (c)	\$2,000	\$5,000
Out of Pocket Max (family) (c)	\$4,000	\$10,000
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE CARE SERVICES (d)		
Well Baby/Child Visit (f)	Paid in Full	Deductible + Coinsurance
Immunizations	Paid in Full	Deductible + Coinsurance
Screening Mammograms	Paid in Full	Not Covered
Colorectal Cancer Screening (l)	Paid in Full	Deductible + Coinsurance
Physical Exams		
PCP or OB/GYN	Paid in Full	Not Covered
Specialist	\$40 Co-pay	Not Covered
PHYSICIAN SERVICES IN OFFICE (d)		
PCP or OB/GYN Office Visit	\$25 Co-pay	Deductible + Coinsurance
Specialist & Other Provider Office Visit	\$40 Co-pay	Deductible + Coinsurance
Diagnostic Testing	Paid in Full	Deductible + Coinsurance
Surgical Services	Paid in Full	Deductible + Coinsurance
Advanced Imaging Services (CT, PET, MRI, & Nuclear Medicine) Prior Authorization Required	Deductible + Coinsurance	Deductible + Coinsurance
PHYSICIAN SERVICES NOT IN OFFICE		
Inpatient Medical Care	Deductible + Coinsurance	Deductible + Coinsurance
Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance
Surgical Services	Deductible + Coinsurance	Deductible + Coinsurance
PHYSICIAN MATERNITY SERVICES (g)		
Maternity/Obstetrical Care OB/GYN	\$25 Co-pay for initial visit only, no deductible or coinsurance for pre-natal & delivery services	Deductible + Coinsurance
OUTPATIENT FACILITY SERVICES		
Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance
Surgical Services	Deductible + Coinsurance	Deductible + Coinsurance
ER (Co-payment waived if admitted)	\$150 Co-pay	\$150 Co-pay
Urgent Care Center	\$50 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)
OTHER SERVICES		
Ambulance (Co-pay waived if admitted)	\$100 Co-pay	\$100 Co-pay
Home Health (40 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance
Speech Therapy (10 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance
PT, OT Therapy and Chiropractic (30 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance
Durable Medical Equipment (\$2,000 max)	Deductible + Coinsurance	Deductible + Coinsurance
Hospice (6 month max)	Deductible + Coinsurance	Deductible + Coinsurance
TMJ (\$10,000 Lifetime Max) (i)	\$200 copay + \$1,000 Deduct + Coinsurance	\$200 copay + \$2,000 Deduct + Coinsurance
MENTAL HEALTH/SUBSTANCE ABUSE		
Inpatient Services (h)	Pre-authorization required \$250 Co-pay + Ded + Coins	Pre-authorization required \$250 Co-pay + Ded + Coins
Outpatient Services	\$40 Co-pay	Ded + Coins
ROUTINE VISION EXAMS (j)		
One exam covered every 12 month period	\$20 Co-pay	Not Covered
PRESCRIPTION DRUGS (k)		
	\$10 Generic; \$35 Preferred; \$70 Non-Preferred (k)	\$12 Generic; \$37 Preferred; \$72 Non-Preferred (k)

**University of Arkansas participants who reside outside the Service Area (the state of Arkansas; Memphis, TN; Texarkana, TX; and Green County, MO) should access the QualChoice/QCA National Network by calling 1-888-771-7427 or going to www.PHCS.com and using the PPO Provider Search. When in the Service Area, find a participating provider by calling 1-800-235-7111 or going to www.qcark.com.

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.
- (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 does not apply to the deductible or the out-of-pocket maximum. Services rendered in the Network Primacy 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). Only routine screenings are considered preventive care. Procedures and testing performed one a diagnosis is made or problem detected then become diagnostic in nature and deductible and coinsurance will apply.
- (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 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) The plan will cover well baby/child visits in full from birth until the date the child attains age 2 if provided in network; after that there will be a **\$25** Co-payment per well baby/child visit. Out-of-network well baby/child visits will have both deductible and coinsurance applied.
- (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 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 Network or Out-of-Network deductibles. The TMJ deductible is in addition to any In-Network or Out-of-Network deductibles 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.
- (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 is an abbreviated list of 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 the Breast

For a complete list of services that require preauthorization go to www.qcark.com and click on members.

Note: Certain other services have special Pre-authorization requirements: Surgical treatment of Temporomandibular Joint Dysfunction (TMJ), Accidental Injury to Teeth.

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 provides the opportunity for zero copayments on diabetes medication. For more information on both programs call QCARE at 1-888-795-6810