UNIVERSITY OF ARKANSAS

Human Resources

October 28, 2013

Name
Address
City, State Zip

Effective January 1, 2014, the University of Arkansas is changing the retiree health insurance for retirees and covered spouses who have Medicare Primary from the current UA plan administered by UMR to the University of Arkansas System United Healthcare Group (PPO) Medicare Advantage Plan. Retirees, spouses and covered children who do not have Medicare Primary will remain on the current UA Health Insurance plan (administered by UMR) until they turn 65, become Medicare eligible early due to disability or the in case of children age off the plan. When Medicare becomes primary, retiree health insurance will convert to the UA Medicare Advantage Plan.

Effective January 1, 2014, the University of Arkansas is changing the method by which retirees pay their insurance premiums. Retirees will pay the premiums for the Medicare Advantage plan directly with United Healthcare. Retirees will pay premiums for Major Medical Health insurance (not yet on Medicare Advantage), life insurance and dental insurance through UMR.

Your coverage, as of January 2014, is:

*Retiree with Medicare Advantage ($198.20 a month) & Spouse with Major Medical with UMR ($361.04 a month)
Life Insurance: Enrolled ($10,000 coverage at $8.33 a month)
Dental: Retiree & Spouse ($64.00 a month)

**Health Insurnace enrollment assumes you do not cancel your UA retiree health insurance.*

As of 10/25/2013, your premiums are paid through: 10/31/2013

Changes to UA Major Medical Health Insurance Administered by UMR effective 1/1/2014 and Election Period

This section only applies to health coverage for retirees, covered spouses and children who will not have Medicare Primary as of 1/1/2014 and who will not be on the Medicare Advantage Plan. These indivdiuals will remain on the regular UA Health Insurance plan (administerd by UMR) untl Medicare becomes primary. The changes to the UA health insurance plan, as administered by UMR, effective January 1, 2014, are:

- The copayment for specialists' office visits will increase from $40 to $45 per visit.
- Emergency Room copayment of $150 will increase to $200 for the second visit made by the same participant in the same calendar year and to $250 for each following visit by the same participant in the same calendar year (ER copayment is still waived if admitted to the hospital).
- The calendar year out of pocket maximum ($2,000 per person/$4,000 family) will include copayments & deductibles as well as coinsurance (does not include plan exclusions, limitations & pharmacy copayments).
- Outpatient Intensive Day Treatment (Mental Health & Substance Abuse coverage) will have a $150 copayment, then apply to the $750 deductible and then 20% coinsurance.

You will have until December 6, 2013, to change your health insurance election between the Classic Plan and the Point of Service plan. Contact Human Resources at 479-575-5351 if you wish to make changes . Remember, the UA health plan as administered by UMR has a nation-wide network of providers. You can see any UMR provider anywhere in the US and have in-network benefits. See the attached Medical Plans Comparison for additional coverage information. ***The enclosed comparison is not for the Medicare Advantage Plan.*** The premiums for the Classic and Point of Service Plans are:

Coverage	CLC Monthly Premiums	POS Monthly Premiums
Retiree only or Spouse only or Child(ren) only	$361.04	$399.87
Retiree & Child(ren)	$676.29	$747.01
Spouse & Child(ren)	$676.29	$747.01

You can cancel your coverage at any time. You can delete dependents from your health and dental plans at any time. However, if you cancel coverage or delete dependents from your plans, you will never have an opportunity in the future re-enroll in coverage or add dependents to your retiree insurance plans.

Life and Dental Plans

The life and dental insurance providers, coverage and premiums are not changing January 1, 2014, but the way you pay for those plans is changing.

- UMR will provide the billing services for all retiree life and dental participants.
- If you are currently enrolled in life insurance, you may continue in life insurance. If you and/or your spouse are enrolled in dental insurance you and/or your spouse may continue in dental insurance.
- If you currently send your dental and life premiums to the Human Resources Office, beginning in January you will send those payments to UMR. UMR will provide the billing services for the University for retiree life insurance and dental insurance.
- In early December 2014 you will receive information in the mail from UMR addressing the payment processes for life and dental insurance. That information will include a payment coupon booklet to use in sending in your monthly premium payments. It will also include a form to complete to make your payments through electronic fund transfer from your bank account. You will have the option to pay premiums in advance on a quarterly, semi-annual or annual basis.
- Payments are due on the first of each month. Bank drafts will occur on the 10th of each month. If you choose to use the electronic payment process, it will be best to plan to send a check to pay for January premiums and begin the electronic payment process with February.

Health Insurance if you are Medicare-Eligible

If you are Medicare-eligible now or will be by January 31, 2014, and you do not choose to opt-out of the plan, you will be automatically enrolled in the University of Arkansas System UnitedHealthcare Group Medicare Advantage (PPO) Plan.

- United Healthcare will provide the billing services for the Medicare Advantage plan.
- In December 2013 you will receive information from United Healthcare addressing the payment processes for the Medicare Advantage plan. That information will include a payment coupon booklet to use in sending in your monthly premium payments. It will also include a form to complete to make your payments through electronic fund transfer from your bank account as well as information on the options to make your payments on a quarterly, semi-annual or annual basis.

- Medicare Advantage plans bill each participant individually, they do not bill for retiree plus spouse or for retiree plus family. If you and your spouse are Medicare eligible and you both choose to remain in the Medicare Advantage plan, each of you will receive a coupon booklet and payment processes must be set up for each of you. That means you will need to write two checks, one for your premium and one for your spouse's premium or you will need to complete a separate electronic fund transfer form for each of you.
- Payments are due on the first of each month. Bank drafts will occur on the 5th of each month. If you choose to use the electronic payment process, it will be best to plan to send a check to pay for January premiums and begin the electronic payment process with February.

Health Insurance if you are NOT Medicare-Eligible

If you are NOT Medicare-eligible and will NOT be by January 31, 2014, you will continue in the current retiree health plan (administered by UMR) unless you choose to drop that plan.

- As with retiree life and dental, UMR will provide the billing services for the Non-Medicare-eligible health plan.
- In early December 2013 you will receive information from UMR addressing the payment processes for the plan. That information will include payment coupons to use in sending in your monthly premium payments. It will also include a form to complete to make your payments through electronic fund transfer from your bank account. You will have the option of paying your premiums on a quarterly, semi-annual or annual basis.
- Payments are due on the first of each month. Bank drafts will occur on the 10th of each month. If you choose to use the electronic payment process, it will be best to plan to send a check to pay for January premiums and begin the electronic payment process with February.

Health if You and Your Spouse or Dependent have Different Medicare Eligibility Status

If you are Medicare-eligible but your spouse or dependent is not OR if you are not Medicare-eligible but your spouse or dependent is, the billing for health will be provided by both UMR and United.

- UMR will bill for any health participant who is NOT Medicare-eligible using the steps outlined above.
- United Healthcare will bill for any health participant who is Medicare-eligible using the steps outlined above.

Life and Dental if You and Your Spouse or Dependent have Different Medicare Eligibility Status

If you are Medicare-eligible but your spouse or dependent is not OR if you are Not Medicare-eligible but your spouse or dependent is, there is no difference, the billing for retiree life and dental participants will be provided by UMR.

When You Become Medicare Eligible

- Your health insurance (and your covered spouse's health insurance coverage) will stay with UMR until you turn 65 or become eligible for Medicare early due to disability.
- When you become Medicare eligible, you will need to enroll in Medicare Part's A & B. Contact Social Security Administration no later than the month before your 65th birthday to enroll
- Your UA retiree health insurance coverage will automatically switch to the University of Arkansas System United Healthcare Group (PPO) Medicare Advantage Plan unless you elect to opt out of the Medicare Advantage Plan.
- When you covert to the Medicare Advantage Plan, you will pay your health insurance premiums directly to United Healthcare. Payment for life insurance and dental insurance will continue with UMR.

Helpful Reminders and Tips

- For United Healthcare Medicare Advantage Information ---If you have not received your Welcome Kit and new ID card by December 31, 2013, please contact United Customer Service at 1-800-457-8506. Please be patient with the mailing process and allow until December 31, 2013, for your kit and ID to arrive. And please remember, if you receive a request from United Healthcare for confirmation of your address, Medicare ID number or other information, the Welcome Kit and new ID Card will be delayed until you provide that needed information.
- For UMR Information ---If you have not received the payment information mailing from UMR by December 10, 2013, please contact UMR retiree/direct billing at 1-800-207-1824. They will confirm your participation information and request a replacement packet be mailed out for you. But please be patient and wait until December 10, 2013, to ensure the mailing has had time to reach you.
- If you wish to set up electronic funds transfers to pay your insurance premiums, it will be best to send checks covering those payments for the month of January 2014 and begin the electronic fund transfers with February 2014. Remember, payments for January are due on January 1st.
- If you are currently on an Early Retirement Agreement covering any of your insurance premiums, payment for those premiums will continue under the existing terms of that agreement and you will not be responsible for your premium payments until the agreement has expired. See paid through date above.
- If you have paid premiums in advance and are pre-paid past December 2013, you will not switch to paying through UHC and UMR until your pre-paid period is past. *Note the UA cannot accept premium payments for retiree insurance past December 2013.*

We know this is a big change and our office will continue to be available to you to assist with questions and clarifications. Please do begin to work directly with the UMR billing representatives but don't hesitate to contact us if you have difficulty in finding needed information or have other questions.

Sincerely,

Richard Ray
Benefits Director

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)	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	$25 Co-pay	$25 Co-pay	Deductible + Coinsurance
Specialist	$45 Co-pay	$45 Co-pay	Deductible + Coinsurance
Diagnostic Testing	Paid in Full	Paid in Full	Deductible + Coinsurance
Surgical Services	Office Copay if applicable	Office Copay if applicable	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)	no deductible or coinsurance	no deductible or coinsurance for	Deductible + Coinsurance
Maternity/Obstetrical Care OB/GYN	for pre-natal & delivery services	pre-natal & delivery services	
OUTPATIENT FACILTY SERVICES			
Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Surgical Services	$150 Co-pay + Ded + Coins	$150 Co-pay + Ded + Coins	$150 Co-pay + Ded + Coins
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 (Reviewed after 30 visits for medical necessity)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Chiropractic (30 visits per year max)	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Durable Medical	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Hospice	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
TMJ ($10,000 Lifetime Max) (i)	No Coverage	$200 copay + $1,000 Ded + Coins	$200 copay + $2,000 Ded + Coins
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 Copay + Ded + Coins	$150 Copay + Ded + Coins	$150 Copay + Ded + Coins
Outpatient Services in office	$25 Co-pay	$25 Co-pay	$25.00 Cp-pay
ROUTINE VISION EXAMS (j)			
One exam per calendar year	$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 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.**

(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 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, 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 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