Archdiocese of New Orleans

Summary of Benefits HMO 80

January 1, 2019

A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible		
Per Person	$750	No coverage
Family	$2,250	No coverage
Maximum Out-of-Pocket Expense Per Calendar Year		
Per Person	$4,000	No coverage
Family	$8,000	No coverage
Primary Care Physician Office Visits	$30 co-pay $15 co-pay for Premium Designation providers and Teladoc visits	No coverage
Specialist Office Visits	$45 co-pay	No coverage
Urgent Care Visit	$45 co-pay	No coverage
Emergency Room	$350 co-pay after deductible	
Ambulance	$50 co-pay after deductible	
Durable Medical Equipment	Covered at 80% after deductible	No coverage
Outpatient Diagnostic X-ray and Lab	Covered at 80% after deductible	No coverage
Outpatient Hospital Services	Covered at 80% after deductible	No coverage
Inpatient Hospital Services	Covered at 80% after deductible	No coverage
Physical Therapy	$30 co-pay	No coverage
Speech, Hearing Occupational Therapy	$30 co-pay	No coverage
Preventive/Routine Exams	Covered at 100%; deductible waived	No coverage
Immunizations	Covered at 100%; deductible waived	No coverage
Preventive/Routine Diagnostic Lab and X-Rays	Covered at 100%; deductible waived	No coverage
Mammograms	Covered at 100%- age 35-39-one baseline exam; age 40 and over-1 exam every 12 months; deductible waived	No coverage
Preventive/Routine Pap Test	Covered at 100%; deductible waived	No coverage
Preventive/Routine PSA and Prostate	Covered at 100%- age 40 and over; deductible waived	No coverage
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	Covered at 100%-age 50-75; deductible waived	No coverage
Women's Preventive Health Care	Covered at 100%; deductible waived	No coverage

UMR Customer Service: 1-800-826-9781 www.umr.com
Submit Claims to: UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

Prescription Drug Benefits

Maximum Out-of-Pocket Expense	
Per Calendar Year (non-generics)	
Per Person	$250
Family	$250
Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (30-day supply)	
For Generic Drugs	$7
For Preferred Brand Drugs	$30
For Non-Preferred Brand Drug	$70
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	$21
For Preferred Brand Drugs	$90
For Non-Preferred Brand Drugs	$210
Mail Order Option – Optum RX	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	$21
For Preferred Brand Drugs	$90
For Non-Preferred Drugs	$210
Specialty Option – Optum RX	
Co-Pay Per Prescription (30-day supply)	
For Generic Drugs	10% up to $150
For Preferred Brand Drugs	10%up to $150
For Non-Preferred Drugs	10% up to $150

Optum RX Member Services: 1-877-559-2955

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