Archdiocese of New Orleans

Summary of Benefits POS

January 1, 2019

A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible		
Per Person	$0	$1,000
Family	$0	$3,000
Maximum Out-of-Pocket Expense Per Calendar Year		
Per Person	$3,000	$5,000
Family	$6,000	$10,000
Primary Care Physician Office Visits	$20 co-pay $5 co-pay for Premium Designation providers and Teladoc visits	Covered at 70% after deductible
Specialist Office Visits	100% after $35 co-pay	Covered at 70% after deductible
Urgent Care Visit	$35 co-pay	Covered at 70% after deductible
Emergency Room	$350 co-pay after deductible	
Ambulance	$50 co-pay after deductible	
Durable Medical Equipment	Covered at 100%	Covered at 70% after deductible
Outpatient Diagnostic X-ray and Lab	Covered at 100%	Covered at 70% after deductible
Outpatient Hospital Services	Covered at 100%	Covered at 70% after deductible
Inpatient Hospital Services	$200 co-pay per day up to 3 days	Covered at 70% after deductible
Physical Therapy	$20 co-pay	Covered at 70% after deductible
Speech, Hearing Occupational Therapy	$20 co-pay	Covered at 70% after deductible
Preventive/Routine Exams	Covered at 100%; deductible waived	Covered at 70% after deductible
Immunizations	Covered at 100%; deductible waived	Covered at 70% after deductible
Preventive/Routine Diagnostic Lab and X-Rays	Covered at 100%; deductible waived	Covered at 70% after deductible
Mammograms	Covered at 100%- age 35-39-one baseline exam; age 40 and over-1 exam every 12 months; deductible waived	Covered at 70% after deductible
Preventive/Routine Pap Test	Covered at 100%; deductible waived	Covered at 70% after deductible
Preventive/Routine PSA and Prostate	Covered at 100%- age 40 and over; deductible waived	Covered at 70% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	Covered at 100%-age 50-75; deductible waived	Covered at 70% after deductible
Women's Preventive Health Care	Covered at 100%; deductible waived	Covered at 70% after deductible

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	$100
Family	$200
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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