This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.umr.com or by calling 1-800-826-9781.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$500** family Tier 1 SmartCare **$750** person / **$1,500** family Tier 2 University of Arkansas System Provider Network & Tier 3 Out-of-network Does not apply to copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,850** person / **$8,500** family Tier 1 SmartCare **$6,350** person / **$9,500** family Tier 2 University of Arkansas System Provider Network & Tier 3 Out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Out- of- pocket maximum includes medical and pharmacy expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers,** see www.umr.com. If you are unsure which network list to select, please call 1-800-826-9781.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Tier 1 **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Your cost if you use a Tier 3 Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	$35 Copay per visit	Not covered	Deductible Waived
	Specialist visit	$35 Copay per visit	$50 Copay per visit	Not covered	Deductible Waived
	Other practitioner office visit	$20 Copay per office; 20% Coinsurance all other services Chiropractic care; Not covered Acupuncture	$35 Copay per office; 30% Coinsurance all other services Chiropractic care; Not covered Acupuncture	Not covered	Deductible Waived office visit; 30 Maximum visits per calendar year Chiropractic care combined with OT/ST/PT
	Preventive care/screening/ immunization	No charge	No charge	Not covered	Deductible Waived
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 Copay per occurrence; 20% Coinsurance	$100 Copay per occurrence; 30% Coinsurance	Not covered	Deductible Applies; Prior authorization is required

Common Medical Event	Services You May Need	Your cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Your cost if you use a Tier 3 Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. **More information about prescription drug coverage is available at https://mp.medimpact.com/UAS or call MedImpact at 1-800-788-2949**	Generic drugs	$15 Retail/Mail; one Copayment for each 30 day	$15 Retail/Mail; one Copayment for each 30 day	18.50 Retail/Mail; one Copayment for each 30 day	Some drugs require Prior Authorization and others require Step Therapy or have quantity limits. Reference Based Pricing applies to some drugs. Please refer to your "Prescription Drug Program Summary of Benefits". Members may get a 90 day supply on maintenance medicines at mail order or retail after two 30 day fills. Specialty drugs applicable Copayment applies. OOP max does not include costs for excluded or non-covered medications or devices. Non covered medications do not go to the Rx Max OOP expense.
	Preferred brand drugs	$50 Retail/Mail; one Copayment for each 30 day	$50 Retail/Mail; one Copayment for each 30 day	$53.50 Retail/Mail; one Copayment for each 30 day	
	Non-preferred brand drugs	$80 Retail/Mail; one Copayment for each 30 day	$80 Retail/Mail; one Copayment for each 30 day	$83.50 Retail/Mail; one Copayment for each 30 day	
	Specialty drugs	$15 Generic $50 Preferred $80 Non-Preferred	$15 Generic $50 Preferred $80 Non-Preferred	$18.50 Generic $53.50 Preferred $83.50 Non-Preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	$150 Copay per visit; 30% Coinsurance	Not covered	Deductible Applies; Prior authorization is required
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 Copay for 1st ER visit; $200 Copay for 2nd ER visit; $250 Copay for 3rd + ER visit of the calendar year	$150 Copay for 1st ER visit; $200 Copay for 2nd ER visit; $250 Copay for 3rd + ER visit of the calendar year	$150 Copay for 1st ER visit; $200 Copay for 2nd ER visit; $250 Copay for 3rd + ER visit of the calendar year	Deductible Waived; Copay may be waived if admitted
	Emergency medical transportation	$100 Copay per occurrence	$100 Copay per occurrence	$100 Copay per occurrence	Deductible Waived; Copay may be waived if admitted

Common Medical Event	Services You May Need	Your cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Your cost if you use a Tier 3 Provider	Limitations & Exceptions
	Urgent care	$50 Copay per visit	$50 Copay per visit	$50 Copay per visit	Deductible Waived
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 Copay per admission; 20% Coinsurance	$300 Copay per admission; 30% Coinsurance	Not covered	Deductible Applies; Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Prior authorization is required
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Copay per office visit; $150 Copay per day for first 2 days; 20% Coinsurance Intensive Day Treatment; 20% Coinsurance other outpatient services	$35 Copay per office visit; $150 Copay per day for first 2 days; 30% Coinsurance Intensive Day Treatment; 30% Coinsurance other outpatient services	Not covered	Deductible Waived office visit; ; Deductible Applies Intensive Day Treatment & other outpatient services
	Mental/Behavioral health inpatient services	$150 Copay per admission; 20% Coinsurance	$300 Copay per admission; 30% Coinsurance	Not covered	Deductible Applies; Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days Prior authorization is required
	Substance use disorder outpatient services	$20 Copay per office visit; $150 Copay per day for first 2 days; 20% Coinsurance Intensive Day Treatment; 20% Coinsurance other outpatient services	$35 Copay per office visit; $150 Copay per day for first 2 days; 30% Coinsurance Intensive Day Treatment; 30% Coinsurance other outpatient services	Not covered	Deductible Waived office visit; ; Deductible Applies Intensive Day Treatment & other outpatient services
	Substance use disorder inpatient services	$150 Copay per admission; 20% Coinsurance	$300 Copay per admission; 30% Coinsurance	Not covered	Deductible Applies; Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Prior authorization is required

Common Medical Event	Services You May Need	Your cost if you use a Tier 1 Provider	Your cost if you use a Tier 2 Provider	Your cost if you use a Tier 3 Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge Prenatal; 20% Coinsurance Postnatal	No charge Prenatal; 30% Coinsurance Postnatal	Not covered	Deductible Waived Tier 1& 2 Prenatal
	Delivery and all inpatient services	No charge Delivery; $150 Copay per admission; 20% Coinsurance other inpatient services	No charge Delivery; $300 Copay per admission; 30% Coinsurance other inpatient services	Not covered	Deductible Waived Delivery; Deductible Applies other inpatient services; Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Copay waived after completion of Maternity Management Incentive
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	30% Coinsurance	Not covered	40 Maximum visits per calendar year; Prior authorization is required
	Rehabilitation services	$20 Copay per office; 20% Coinsurance all other services	$35 Copay per office; 30% Coinsurance all other services	Not covered	Deductible Waived office visit; 30 Maximum visits per calendar year combined with Chiropractic care
	Habilitation services	Not covered	Not covered	Not covered	——————none——————
	Skilled nursing care	$150 Copay per admission; 20% Coinsurance	$300 Copay per admission; 30% Coinsurance	Not covered	Deductible Applies; Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Copay waived if transferred from an Acute Care Facility; Prior authorization is required
	Durable medical equipment	20% Coinsurance	30% Coinsurance	Not covered	Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases
	Hospice service	20% Coinsurance	30% Coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	$20 Copay per visit	$35 Copay per visit	$35 Copay per visit	Deductible Waived; 1 Maximum exam per calendar year
	Glasses	Not covered	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-826-9781. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: UMR at 1-800-826-9781. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value of standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,740
- **Patient pays** $1,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$1,400
Limits or exclusions	$150
Total	**$1,820**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,030
- **Patient pays** $1,370

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$800
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,370**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.