**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 on your Human Resources website: http://hr.uark.edu/#, http://ualr.edu/humanresources/#, http://www.uaccb.edu/human-resources.html#, http://www.livethelegacy.org/contact-us , http://www.uapb.edu/index.php?option=com_content&view=article&id=131#, http://www.uamont.edu/FinanceAdministration/PayrollPersonnel.htm#, http://www.pccua.edu/faculty_staff.htm#, http://asmsa.org/human-resources#, http://www.uaex.edu/depts/HR/default.htm#, , by calling your Human Resources Department, or by calling UMR at 1 (888) 438-6105.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: Individual **$750**/Family **$1,500.** Out-of-Network: Individual **$1,000**/Family **$2,000.** Copayments and Out-of-Network amounts over allowable do not count toward deductible. | 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?** | Yes. **$1000** for TMJ In-Network; **$2000** for TMJ Out-of-Network. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. In-Network: Individual **$2,000**/Family **$4,000.** Out-of-Network: Individual **$5,000**/Family **$10,000.** | 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. |
| **What is not included in the out–of–pocket limit?** | Copayments, deductibles, premium, balance-billed charges (unless balanced billing is prohibited), 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. |

**Questions:** Call **1 (888) 438-6150** or visit us at **www.umr.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov,** or call or request a copy from your Human Resources Department website: http://hr.uark.edu/#, http://www.livethelegacy.org/contact-us, http://ualr.edu/humanresources/#, http://www.uaccb.edu/human-resources.html#, http://www.uapb.edu/index.php?option=com_content&view=article&id=131#, http://www.uamont.edu/FinanceAdministration/PayrollPersonnel.htm#, http://www.pccua.edu/faculty_staff.htm#, http://asmsa.org/human-resources#, http://www.uaex.edu/depts/HR/default.htm#, , or call UMR at 1 (888) 438-6105.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. For a list of **In-Network providers**, see www.UMR.com or call 1 (888) 438-6105. | 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 term 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 don't need a referral to see an **In-Network specialist**. | 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 5. 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 in network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a In-Network Provider | Your cost if you use a Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness. | $25 Copayment | 40% Coinsurance | none |
| | Specialist visit. | $40 Copayment | 40% Coinsurance | none |
| | Other practitioner office visit. | 20% Coinsurance | 40% Coinsurance | Maximum of 30 visits combined with chiropractic care, physical, occupational, and speech therapy. |
| | Preventive care/screening/immunization. | No Charge | 40% Coinsurance | In-Network preventive services are covered for age 3 and older. |
| **If you have a test** | Diagnostic test (x-ray, blood work). | 20% Coinsurance | 40% Coinsurance | In-Network services provided in an office covered at no charge. |
| | Imaging (CT/PET scans, MRIs). | 20% Coinsurance | 40% Coinsurance | Prior authorization is required |
| **If you need drugs to treat your illness or condition** | Generic drugs. | $10 Retail/Mail; one Copayment for each 30 day | $12 Retail/Mail; one Copayment for each 30 day | Some drugs require PA and others require Step Therapy. Reference Based Pricing applies to some drugs. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| More information about **prescription drug coverage** is available at www.medimpact.com. | Preferred brand drugs. | $35 Retail/Mail; one Copayment for each 30 day | $37 Retail/Mail ; one Copayment for each 30 day | Please refer to your "Prescription Drug Program Summary of Benefits". Mail order up to 90 day supply on maintenance medicines. Specialty drugs applicable Copayment applies. |
| | Non-preferred brand drugs. | $70 Retail/Mail; one Copayment for 30 day | $72 Retail/Mail ; one Copayment for each 30 day | |
| | Specialty drugs. | $10 generic / $35 preferred / $70 non-preferred | $12 generic / $37 preferred / $72 non-preferred | |
| **If you have outpatient surgery** | Facility fe (e.g., ambulatory surgery center). | $150 Copayment; 20% Coinsurance | $150 Copayment; 40% Coinsurance | ——————none—————— |
| | Physician/surgeon fees. | 20% Coinsurance | 40% Coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services. | $150 Copayment | $150 Co-payment | Deductible waived. Copay also waived if admitted |
| | Emergency medical transportation. | $100 Copayment | $100 Copayment | Deductible waived. Copay also waived if admitted |
| | Urgent care. | $50 Copayment | $100 Copayment | Deductible waived. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room). | $300 Copayment; 20% Coinsurance | $300 Copayment; 40% Coinsurance | Prior Authorization is required. Max Copayment/Calendar Year is $1200/person. No more than one Copayment/30 calendar days. |
| | Physician/surgeon fee. | 20% Coinsurance | 40% Coinsurance | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 Copayment | 40% Coinsurance | ——————none—————— |
| | Mental/Behavioral health inpatient services. | $300 Copayment; 20% Coinsurance | $300 Copayment; 40% Coinsurance | Prior Authorization is required. Max Copayment/Calendar Year is $1200/person. No more than one Copayment/30 calendar days. |
| | Substance use disorder outpatient services. | $25 Copayment | 40% Coinsurance | ——————none—————— |
| | Substance use disorder inpatient services. | $300 Copayment; 20% Coinsurance | $300 Copayment; 40% Coinsurance | Prior Authorization is required. Max Copayment/Calendar Year is $1200/person. No more than one Copayment/30 calendar days. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| **If you are pregnant** | Prenatal and postnatal care. | No Charge | 40% Coinsurance | ——————none—————— |
| | Delivery and all inpatient services. | $300 Copayment; 20% Coinsurance for Inpatient Services; No charge for physician services | $300 Copayment; 40% Coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care. | 20% Coinsurance | 40% Coinsurance | Prior Authorization is required. Maximum 40 visit /calendar year |
| | Rehabilitation services. | 20% Coinsurance | 40% Coinsurance | Maximum of 30 visits combined with chiropractic care, physical, occupational, and speech therapy. However; physical, occupational, and speech therapy will be reviewed for medical necessity at this point and additional visits will be approved based on the medical necessity review. |
| | Habilitation services. | Not Covered | Not Covered | ——————none—————— |
| | Skilled nursing care. | $300 Copayment; 20% Coinsurance | $300 Copayment; 40% Coinsurance | Prior Authorization is required. If transferred from acute care facility, Copayment will be waived. |
| | Durable medical equipment. | 20% Coinsurance | 40% Coinsurance | ——————none—————— |
| | Hospice service. | 20% Coinsurance | 40% Coinsurance | ——————none—————— |
| **If your child needs dental or eye care** | Eye exam. | $25 Copayment | Not Covered | ——————none—————— |
| | Glasses. | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up. | 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 or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care

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

- Chiropractic care
- Hearing aids, $1400/ear every 3 years
- Routine eye care (Adult)
- Non-emergency care outside of the United States, except when traveling for sole purpose of obtaining medical care
- Weight loss programs

## 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 (888) 438-6105. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. You can contact your issuer's member assistance resources at 1 (888) 438-6105. For questions about your rights, this notice, or assistance, you can contact your state insurance department at 1-800-852-5494. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-852-5494.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 866-724-3570.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-724-3570.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-724-3570.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-724-3570.

*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 will also 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** $5,192
- **Patient pays** $2,348

**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 | $750 |
| Copays | $300 |
| Coinsurance | $1,298 |
| Limits or exclusions | $0 |
| **Total** | **$2,348** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,740
- **Patient pays** $1,660

**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 | $750 |
| Copays | $610 |
| Coinsurance | $220 |
| Limits or exclusions | $80 |
| **Total** | **$1,660** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- 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.

## 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.