# UMR: UNIVERSITY OF ARKANSAS SYSTEM: Classic SmartCare BP 003



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-888-438-6105. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-888-438-6105 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$750** person / **$1,500** family SmartCare<br>**$1,250** person / **$2,500** family In Network | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | Yes. TMJ has a separate deductible. | 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. |
| **What is the out–of–pocket limit for this plan?** | **$4,750** person / **$9,500** family SmartCare<br>**$5,250** person / **$10,500** family In Network<br>***$1,600*** *person Rx/****$3,200*** *family Rx* | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out–of–pocket limit?** | Copayments for certain services, penalties, deductible for out-of-network charges, premiums, balance billing 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.umr.com or call 1-888-438-6105 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | SmartCare (You will pay the least) | In Network | Out of Network (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 Copay per visit; Deductible Waived | $35 Copay per visit; Deductible Waived | Not covered | None |
| | Specialist visit | $40 Copay per visit; Deductible Waived | $55 Copay per visit; Deductible Waived | Not covered | None |
| | Preventive care/ screening/immunization | No charge; Deductible Waived | No charge; Deductible Waived | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance; Deductible Waived | 25% Coinsurance; Deductible Waived | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $50 Copay per visit; 20% Coinsurance | $100 Copay per visit; 25% Coinsurance | Not covered | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | SmartCare (You will pay the least) | In Network | Out of Network (You will pay the most) | |
| **If you need drugs to treat your illness or condition.**<br><br>**More information about prescription drug coverage is available at www.medimpact.com** | Tier 1 | $15 Retail/Mail; one Copayment for each 30 day | $15 Retail/Mail; one Copayment for each 30 day | $20.00 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". Mail order up to 90 day supply on maintenance medicines. Specialty drugs applicable Copayment applies.<br><br>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. |
| | Tier 2 | $55 Retail/Mail; one Copayment for each 30 day | $55 Retail/Mail; one Copayment for each 30 day | $60.00 Retail/Mail; one Copayment for each 30 day | |
| | Tier 3 | $90 Retail/Mail; one Copayment for each 30 day | $90 Retail/Mail; one Copayment for each 30 day | $95.00 Retail/Mail; one Copayment for each 30 day | |
| | Specialty drugs | $15 Tier 1<br>$50 Tier 2<br>$90 Tier 3 | $15 Tier 1<br>$50 Tier 2<br>$90 Tier 3 | $20.00 Tier 1<br>$60.00 Tier 2<br>$95.00 Tier 3 | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | $150 Copay per visit; 25% Coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 20% Coinsurance | 25% Coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $150 Copay for 1st visit; $200 Copay for 2nd visit; $250 Copay for 3rd & up visit of the calendar year; Deductible Waived | $150 Copay for 1st visit; $200 Copay for 2nd visit; $250 Copay for 3rd & up visit of the calendar year; Deductible Waived | $150 Copay for 1st visit; $200 Copay for 2nd visit; $250 Copay for 3rd & up visit of the calendar year; Deductible Waived | Copay may be waived if admitted |
| | Emergency medical transportation | $100 Copay per occurrence; Deductible Waived | $100 Copay per occurrence; Deductible Waived | $100 Copay per occurrence; Deductible Waived | Copay may be waived if admitted |
| | Urgent care | $55 Copay per visit; Deductible Waived | $55 Copay per visit; Deductible Waived | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | SmartCare (You will pay the least) | In Network | Out of Network (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 Copay per admission; 20% Coinsurance | $300 Copay per admission; 25% Coinsurance | Not covered | Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required. |
| | Physician/surgeon fee | 20% Coinsurance | 25% Coinsurance | Not covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $20 Copay per visit; Deductible Waived office visits; $150 Copay per day for first 2 days; 20% Coinsurance Intensive Day Treatment; 20% Coinsurance other outpatient services | $35 Copay per visit; Deductible Waived office visits; $150 Copay per day for first 2 days; 25% Coinsurance Intensive Day Treatment; 25% Coinsurance other outpatient services | Not covered | Preauthorization is required for Partial hospitalization. |
| | Inpatient services | $150 Copay per admission; 20% Coinsurance | $300 Copay per admission; 25% Coinsurance | Not covered | Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days; Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | Not covered | 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. Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% Coinsurance | 25% Coinsurance | Not covered | |
| | Childbirth/delivery facility services | No charge; Deductible Waived Delivery; $300 Copay per admission; 20% Coinsurance other inpatient services | No charge; Deductible Waived Delivery; $300 Copay per admission; 25% Coinsurance other inpatient services | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | SmartCare (You will pay the least) | In Network | Out of Network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 25% Coinsurance | Not covered | 40 Maximum visits per calendar year;<br>Preauthorization is required. |
| | Rehabilitation services | 20% Coinsurance | 25% Coinsurance | Not covered | 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;<br>20% Coinsurance | $300 Copay per admission;<br>25% Coinsurance | Not covered | Maximum combined Inpatient Copay per calendar year is $1,200 per person, no more than one Copay per 30 calendar days;<br>Copay waived if transferred from an Acute Care Facility;<br>Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 25% Coinsurance | Not covered | Preauthorization is required. |
| | Hospice service | 20% Coinsurance | 25% Coinsurance | Not covered | None |
| **If you need dental or eye care** | Eye exam | $20 Copay per visit;<br>Deductible Waived | $35 Copay per visit;<br>Deductible Waived | $35 Copay per visit;<br>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 (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Infertility treatment | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Private-duty nursing | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery (Tiers 1 & 2 only) | • Hearing aids (Tiers 1 & 2 only) | • Routine eye care (Adult) |
| • Chiropractic care (Tiers 1 & 2 only) | • Non-emergency care when traveling outside the U.S. | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. 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 plan Provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan Meet the Minimum Value Standard? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $300 |
| Other coinsurance | 25% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,250 |
| Copayments | $3,850 |
| Coinsurance | $3,792 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,342** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $300 |
| Other coinsurance | 25% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,250 |
| Copayments | $1,570 |
| Coinsurance | $465 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$3,341** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $300 |
| Other coinsurance | 25% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,138 |
| Copayments | $305 |
| Coinsurance | $354 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,797** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-888-438-6105.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.