

Active and Retiree
Medical Booklet
Benefit Plan(s) 001, 003, 009, 015, 016, 017, 018

Revised 01-01-2026

BENEFITS ADMINISTERED BY



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UNIVERSITY OF ARKANSAS MEDICAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under the UNIVERSITY OF ARKANSAS MEDICAL BENEFIT Plan (The "Plan") as well as information on a Covered Person's rights and obligations under the Plan. As a valued Employee of UNIVERSITY OF ARKANSAS SYSTEM, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

The President of the UNIVERSITY OF ARKANSAS SYSTEM is named the Plan Administrator for this Plan. The Plan Administrator has designated staff of the UNIVERSITY OF ARKANSAS SYSTEM to act on the President's behalf in plan administration and has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and MedImpact Healthcare Systems, Inc. for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Plan is self-funded by participating campuses of the UNIVERSITY OF ARKANSAS SYSTEM through monies set aside for the purpose of paying Your and Your dependent's medical care; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision where the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document provides information on the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan Document.

This document becomes effective on January 1, 2013.

PLAN INFORMATION

Plan Name	UNIVERSITY OF ARKANSAS MEDICAL BENEFIT PLAN
Name And Address Of Employer	UNIVERSITY OF ARKANSAS SYSTEM 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 ATTN: ASSOCIATE VICE PRESIDENT FOR EMPLOYEE BENEFITS AND RISK MANAGEMENT SERVICES
Name, Address And Phone Number Of Plan Administrator	BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 501-686-2500 ATTN: PRESIDENT
Named Fiduciary	BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS
Employer Identification Number Assigned By The IRS	71-6003252
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 ATTN: PRESIDENT'S OFFICE
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	January 1 through December 31
Compliance	It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law. Nothing herein shall waive the sovereign immunity of the State of Arkansas or of the Plan Administrator.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan 001 – Classic Plan, Non-SmartCare
Class R01

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	In-Network (Tier 2)	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year, Excluding the Prescription Benefit Deductible		
• Per Person	$1,400	
• Per Family	$2,800	
Plan Participation Rate, Unless Otherwise Stated Below		
• Paid by Plan After Satisfaction of Deductible	75%	
Annual Out-of-Pocket Maximum, Excluding the Prescription Benefit Out-of-Pocket Maximum		
• Per Person	$5,300	
• Per Family	$10,600	

Ambulance Transportation	In-Network	Out-of-Network
Ground Ambulance:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $150 copay per trip	
• Does the deductible apply?	No	
• Paid by plan:	100%, after copay	
Air Ambulance:		
• Is there a maximum limit?	No Limit, Effective 1/1/2022	
• Does a copay apply?	Yes, $150 copay per trip	
• Does the deductible apply?	No	
• Paid by plan:	100%, after copay	
Note: Out-of-Network Ambulance paid at the In-Network benefit level. Out-of-Network Ambulance charges may result in provider balance billing.		

Breast Prosthesis	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: Limit of one pump purchase per pregnancy.		

Breast Pumps	In-Network	Out-of-Network
• Is there a maximum limit?	No	$500 per device
• Does a copay apply?	No	No
• Does the deductible apply?	No	No
• Paid by plan:	100%	100%

Contraceptive Methods and Counseling Approved by the FDA	In-Network	Out-of-Network
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.		

Diabetic Services	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Diabetes Treatment Performed In Office:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	Yes	
Primary Care Physician (PCP)	$40 copay	
Specialist	$60 copay	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Diabetes Lab Services:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	No	
• Paid by plan:	75%	
Diabetes Nutritional Counseling:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.		

Durable Medical Equipment (DME)	In-Network	Out-of-Network
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: First $800 of Disposable Items are Covered at 100%; Thereafter, Disposable Items will be Subject to Deductible and Coinsurance.		

Emergency Services / Treatment	In-Network	Out-of-Network
Emergency Room Facility Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $350 copay per visit (Copay Waived if Admitted as Inpatient within 24 Hours)	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Emergency Physicians Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Emergency Room Services:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Hearing Services	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Hearing Exams, Tests Performed In Office:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes	
Primary Care Physician (PCP)	$40 copay	No Benefit
Specialist	$60 copay	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Hearing Aids:		
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years	Yes, $1,400 Limit per Ear Every Three Years
• Does a copay apply?	No	No
• Does the deductible apply?	No	No
• Paid by plan:	100%	100%
Implantable Hearing Aids:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Home Health Care Benefits	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.		

Hospice Care Benefits	In-Network	Out-of-Network
Hospice Services:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Bereavement Counseling:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Hospital Services	In-Network	Out-of-Network
Pre-Admission Testing:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Inpatient Facility Charges:		
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible & Coinsurance Apply after copay.	
• Does a copay apply?	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Inpatient Physician/Surgeon Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Outpatient Facility Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $160 copay per admission	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Outpatient Physician/Surgeon Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Outpatient Lab and X-Ray Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	75%	
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Physician Clinic Visits In An Outpatient Hospital Setting	In-Network	Out-of-Network
Facility Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Physician Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes	
Primary Care Physician (PCP)	$40 copay	No Benefit
Specialist	$60 copay	
• Does the deductible apply?	No	
• Paid by plan:	100%	

Infertility Treatment	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Injections	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Manipulations (Chiropractic Therapy)	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year	
• Does a copay apply?	Yes, $55 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.		

Maternity	In-Network	Out-of-Network
Physician Charges (Global Maternity):		
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	No	No Benefit
• Paid by plan:	100%	
Note: The First Ultrasound of Pregnancy is to be Paid by the Plan at 100%, regardless of diagnosis, unless administered in an emergency room, in which case it will be covered under the emergency room benefit.		
Diagnostic Maternity Services: (Outside of Global Maternity)		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.		
Inpatient Facility Charges:		
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible & Coinsurance Apply after copay.	
• Does a copay apply?	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	In-Network	Out-of-Network
Office Visit:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	$40 copay	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Inpatient Facility Charges:		
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible & Coinsurance Apply after copay.	
• Does a copay apply?	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Inpatient Physician Charges:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Residential Treatment - Facility and Physician Charges:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:		
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	Yes, $160 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Morbid Obesity	In-Network	Out-of-Network
Morbid Obesity Treatment:		
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Bariatric Surgery:		
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information. Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.	
• Does a copay apply?	Yes, $300 copay per admission.	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Metabolic Weight Loss and Nutritional Counseling:		
• Is there a maximum limit?	Yes, $1,000 limit per lifetime	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	100%	
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.		

Nursery and Newborns Expenses	In-Network	Out-of-Network
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
Note: Deductible And / Or Copay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).		

Orthotics	In-Network	Out-of-Network
Orthotic Appliances:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Shoes - Custom Molded:		
• Is there a maximum limit?	Yes	
Ages 0 - 18 years	2 pairs per calendar year	
Ages 18 years and over	1 pair per calendar year	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Shoe Inserts - Custom Molded:		
• Is there a maximum limit?	Yes, 2 pairs per calendar year	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Physician Office Visit	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $40 copay per visit	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
Specialist Office Visit:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $60 copay per visit	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
Physician Services Performed In Office:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
Physician Office Diagnostic Laboratory and X-Ray Charges:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	75%	
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	In-Network	Out-of-Network
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Benefits Include: • Preventive Physical Exams at Appropriate Ages. • Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines). Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason.		
• Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed.		
• Preventive Tests, Lab and X Rays at Appropriate Ages.		
• Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share. Breast Ultrasounds Covered 100% Deductible Waived In-Network.		

Preventive Care Benefits for Children, Ages 0 - 3 years	In-Network	Out-of-Network
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	No	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Benefits Include: • Preventive Physical Exams • Immunizations • Preventive Screenings at Appropriate Ages • Preventive Diagnostic Tests, Lab and X Rays • Preventive Hearing Exam. ***Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.***		

Skilled Nursing	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility: • Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.	No Benefit
• Does a copay apply?	Yes, $350 copay per admission. (Waived if Transferred from an Acute Care Facility)	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Sterilizations	In-Network	Out-of-Network
Female Sterilizations:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.		

Telehealth	In-Network	Out-of-Network
Office Visits:		
• Is there a maximum limit?	No	
• Does a copay apply?	Yes	
Primary Care Physician (PCP)	$40 copay	No Benefit
Specialist	$60 copay	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.		
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.		

Telemedicine	In-Network	Out-of-Network
UAMS HealthNow:		
• Is there a maximum limit?	No	
• Does a copay apply?	$20 copay per visit	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
***Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor only. The vendor for this plan is UAMS HealthNow.**		

Temporomandibular Joint Disorder Benefits (TMJ)	In-Network	Out-of-Network
• Is there a maximum limit?	No	
• Does a copay apply?	Yes, $200 copay per visit	No Benefit
• Does the deductible apply?	Yes, a $1,000 Separate Deductible Applies	
• Paid by plan:	75%	

Therapy Services	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies: (PT, OT and ST)		
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.	
• Does a copay apply?	Yes, $60 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.		

Tobacco Use	In-Network	Out-of-Network
Counseling for Tobacco Use:		
• Is there a maximum limit?	2 Visits per calendar year	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	No	
• Paid by plan:	100%	
After Maximum Is Satisfied:		
• Is there a maximum limit?	No	
• Does a copay apply?	No	No Benefit
• Does the deductible apply?	Yes	
• Paid by plan:	75%	

Urgent Care	In-Network	Out-of-Network
• Is there a maximum limit?	No	No Benefit
• Does a copay apply?	Yes, $55 copay per visit	
• Does the deductible apply?	No	
• Paid by plan:	100%	

Vision Care Benefits	In-Network	Out-of-Network
Eye Exam:		No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year	
• Does a copay apply?	Yes, $40 copay per visit	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Eye Refractions:		No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year	
• Does a copay apply?	Yes, $40 copay per visit	
• Does the deductible apply?	No	
• Paid by plan:	100%	
Additional Vision Care Services Performed in Office:		No Benefit
• Is there a maximum limit?	No	
• Does a copay apply?	No	
• Does the deductible apply?	Yes	
• Paid by plan:	75%	
Note: Only One (1) Copay Applies Per Visit for Preventive and Medical as well as Primary Care Physician or Specialist (Combined for Eye Exams, Glaucoma Testing and Eye Refractions).		

All Other Covered Expenses	In-Network	Out-of-Network
• Does the deductible apply?	Yes	No Benefit
• Paid by plan:	75%	

MEDICAL SCHEDULE OF BENEFITS

Benefit Plans 003 – Classic Plan, with SmartCare
Classes A03; R03; E03; C03

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare (Tier 1)	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year, Excluding the Prescription Benefit Deductible			
• Per Person • Per Family	$850 $1,700	$1,400 $2,800	No Benefit
Plan Participation Rate, Unless Otherwise Stated Below			
• Paid by Plan After Satisfaction of Deductible	80%	75%	No Benefit
Annual Out-of-Pocket Maximum, Excluding the Prescription Benefit Out-of-Pocket Maximum			
• Per Person • Per Family	$4,800 $9,600	$5,300 $10,600	No Benefit

Ambulance Transportation	UAMS SmartCare	In-Network	Out-of-Network
Ground Ambulance:			
• Is there a maximum limit?		No	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Air Ambulance:			
• Is there a maximum limit?		No Limit, Effective 1/1/2022	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Note: Out-of-Network Ambulance paid at the In-Network benefit level. Out-of-Network Ambulance charges may result in provider balance billing.			

Breast Prosthesis	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Breast Pumps	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	$500 per device
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Note: Limit of one pump purchase per pregnancy.			

Contraceptive Methods and Counseling Approved by the FDA	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	No Benefit
• Paid by plan:	100%	100%	
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.			

Diabetic Services	UAMS SmartCare	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Diabetes Treatment Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$40 copay	$35 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Diabetes Lab Services:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Diabetes Nutritional Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.			

Durable Medical Equipment (DME)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	80%	75%	
Note: First $800 of Disposable Items are Covered at 100%; Thereafter, Disposable Items will be Subject to Deductible and Coinsurance.			

Emergency Services / Treatment	UAMS SmartCare	In-Network	Out-of-Network
Emergency Room Facility Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	Yes, $350 copay per visit (Copay Waived if Admitted as Inpatient within 24 Hours)		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		
Emergency Physicians Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		
Emergency Room Services:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		

Hearing Services	UAMS SmartCare	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Hearing Exams, Tests Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$40 copay	$35 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Hearing Aids:			
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years		Yes, $1,400 Limit per Ear Every Three Years
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Implantable Hearing Aids:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Home Health Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year		
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	80%	75%	
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.			

Hospice Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Hospice Services:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Bereavement Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Hospital Services	UAMS SmartCare	In-Network	Out-of-Network
Pre-Admission Testing:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year Is $1,200 Per Person. No More Than One Copay Per 30 Days. Coinsurance and deductible apply after copay		
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	Yes, $160 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Lab and X-Ray Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $75 copay per visit	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Physician Clinic Visits In An Outpatient Hospital Setting	UAMS SmartCare	In-Network	Out-of-Network
Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	

Infertility Treatment	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Injections	UAMS SmartCare	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Manipulations (Chiropractic Therapy)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $45 copay for initial evaluation only	Yes, $60 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.			

Maternity	UAMS SmartCare	In-Network	Out-of-Network
Physician Charges (Global Maternity):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	No Benefit
• Paid by plan:	100%	100%	
Note: The First Ultrasound of Pregnancy is to be Paid by the Plan at 100%, regardless of diagnosis, unless administered in an emergency room, in which case it will be covered under the emergency room benefit.			
Diagnostic Maternity Services: (Outside of Global Maternity)			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after deductible.		
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	UAMS SmartCare	In-Network	Out-of-Network
Office Visit:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	$25 copay	$40 copay	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Residential Treatment - Facility and Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Morbid Obesity	UAMS SmartCare	In-Network	Out-of-Network
Morbid Obesity Treatment:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Bariatric Surgery:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information. Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after deductible.		
• Does a copay apply?	Yes, $150 copay per admission.	Yes, $300 copay per admission.	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Metabolic Weight Loss and Nutritional Counseling:			
• Is there a maximum limit?	Yes, $1,000 limit per lifetime		
• Does a copay apply?	No		
• Does the deductible apply?	Yes		
• Paid by plan:	100%		
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.			

Nursery and Newborns Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: Deductible And / Or Copay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).			

Orthotics	UAMS SmartCare	In-Network	Out-of-Network
Orthotic Appliances:			
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Shoes - Custom Molded:			
• Is there a maximum limit?	Yes		
Ages 0 - 18 years	2 pairs per calendar year		
Ages 18 years and over	1 pair per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Shoe Inserts - Custom Molded:			
• Is there a maximum limit?	Yes, 2 pairs per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Physician Office Visit	UAMS SmartCare	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Specialist Office Visit:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $45 copay per visit	Yes, $60 copay per visit	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Physician Services Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Physician Office Diagnostic Laboratory and X-Ray Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $75 copay per visit	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Benefits Include: • Preventive Physical Exams at Appropriate Ages. • Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines). Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason. • Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed. • Preventive Tests, Lab and X Rays at Appropriate Ages. • Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share. Breast Ultrasounds Covered 100% Deductible Waived In-Network.			

Preventive Care Benefits for Children, Ages 0 - 3 years	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Benefits Include: • Preventive Physical Exams • Immunizations • Preventive Screenings at Appropriate Ages • Preventive Diagnostic Tests, Lab and X Rays • Preventive Hearing Exam. ***Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.***			

Skilled Nursing	UAMS SmartCare	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility: • Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No Benefit
• Does a copay apply?	Yes, $150 copay per admission. (Waived if Transferred from an Acute Care Facility)	Yes, $300 copay per admission. (Waived if Transferred from an Acute Care Facility)	
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Sterilizations	UAMS SmartCare	In-Network	Out-of-Network
Female Sterilizations:			No Benefit
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.			

Telehealth	UAMS SmartCare	In-Network	Out-of-Network
Office Visits:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.			
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.			

Telemedicine	UAMS SmartCare	In-Network	Out-of-Network
UAMS HealthNow:			
• Is there a maximum limit?	No		
• Does a copay apply?	$25 copay per visit	No Benefit	No Benefit
• Does the deductible apply?	No		
• Paid by plan:	100%		
***Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor. The vendor for this plan is UAMS HealthNow.**			

Temporomandibular Joint Disorder Benefits (TMJ)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $200 copay per visit	Yes, $200 copay per visit	
• Does the deductible apply?	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies	No Benefit
• Paid by plan:	80%	75%	

Therapy Services	UAMS SmartCare	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies: (PT, OT and ST)			
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $45 copay for initial evaluation only	Yes, $60 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.			

Tobacco Use	UAMS SmartCare	In-Network	Out-of-Network
Counseling for Tobacco Use:			
• Is there a maximum limit?	2 Visits per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
After Maximum Is Satisfied:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Urgent Care	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	Yes, $55 copay per visit	Yes, $55 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	

Vision Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Eye Exam:			No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Eye Refractions:			No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Additional Vision Care Services Performed in Office:			No Benefit
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Only One (1) Copay Applies Per Visit for Preventive and Medical as well as Primary Care Physician or Specialist (Combined for Eye Exams, Glaucoma Testing and Eye Refractions).			

All Other Covered Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	80%	75%	

MEDICAL SCHEDULE OF BENEFITS

Benefit Plans 009 – Classic Plan with SmartCare and Wellness Incentive
Classes A05, C05, R05

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare (Tier 1)	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year, Excluding the Prescription Benefit Deductible			
• Per Person • Per Family	$850 $1,700	$1,400 $2,800	No Benefit
Plan Participation Rate, Unless Otherwise Stated Below			
• Paid by Plan After Satisfaction of Deductible	80%	75%	No Benefit
Annual Out-of-Pocket Maximum, Excluding the Prescription Benefit Out-of-Pocket Maximum			
• Per Person • Per Family	$3,500 $7,000	$4,050 $8,100	No Benefit

Ambulance Transportation	UAMS SmartCare	In-Network	Out-of-Network
Ground Ambulance:			
• Is there a maximum limit?		No	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Air Ambulance:			
• Is there a maximum limit?		No Limit, Effective 1/1/2022	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Note: Out-of-Network Ambulance paid at the In-Network benefit level. Out-of-Network Ambulance charges may result in provider balance billing.			

Breast Prosthesis	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Breast Pumps	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	$500 per device
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Note: Limit of one pump purchase per pregnancy.			

Contraceptive Methods and Counseling Approved by the FDA	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	No Benefit
• Paid by plan:	100%	100%	
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.			

Diabetic Services	UAMS SmartCare	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Diabetes Treatment Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$40 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Diabetes Lab Services:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Diabetes Nutritional Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.			

Durable Medical Equipment (DME)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	80%	75%	
Note: First $800 of Disposable Items are Covered at 100%; Thereafter, Disposable Items will be Subject to Deductible and Coinsurance.			

Emergency Services / Treatment	UAMS SmartCare	In-Network	Out-of-Network
Emergency Room Facility Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	Yes, $350 copay per visit (Copay Waived if Admitted as Inpatient within 24 Hours)		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		
Emergency Physicians Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		
Emergency Room Services:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	75%		

Hearing Services	UAMS SmartCare	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Hearing Exams, Tests Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Hearing Aids:			
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years		Yes, $1,400 Limit per Ear Every Three Years
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Implantable Hearing Aids:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Home Health Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year		
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	80%	75%	
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.			

Hospice Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Hospice Services:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Bereavement Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Hospital Services	UAMS SmartCare	In-Network	Out-of-Network
Pre-Admission Testing:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Facility Charges:	Yes, Maximum Combined Inpatient Copay Per Calendar Year Is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and Coinsurance apply after copay.		
• Is there a maximum limit?			
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	Yes, $160 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient Lab and X-Ray Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $75 copay per visit	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Physician Clinic Visits In An Outpatient Hospital Setting	UAMS SmartCare	In-Network	Out-of-Network
Facility Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	

Infertility Treatment	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Injections	UAMS SmartCare	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Manipulations (Chiropractic Therapy)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $45 copay for initial evaluation only	Yes, $60 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.			

Maternity	UAMS SmartCare	In-Network	Out-of-Network
Physician Charges (Global Maternity):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	No Benefit
• Paid by plan:	100%	100%	
Note: The First Ultrasound of Pregnancy is to be Paid by the Plan at 100%, regardless of diagnosis, unless administered in an emergency room, in which case it will be covered under the emergency room benefit.			
Diagnostic Maternity Services: (Outside of Global Maternity)			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	UAMS SmartCare	In-Network	Out-of-Network
Office Visit:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	$25 copay	$40 copay	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Inpatient Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Residential Treatment - Facility and Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Morbid Obesity	UAMS SmartCare	In-Network	Out-of-Network
Morbid Obesity Treatment:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Bariatric Surgery:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information. Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		
• Does a copay apply?	Yes, $150 copay per admission.	Yes, $300 copay per admission.	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Metabolic Weight Loss and Nutritional Counseling:			
• Is there a maximum limit?	Yes, $1,000 limit per lifetime		
• Does a copay apply?	No		
• Does the deductible apply?	Yes		
• Paid by plan:	100%		
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.			

Nursery and Newborn Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: Deductible And / Or Copay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).			

Orthotics	UAMS SmartCare	In-Network	Out-of-Network
Orthotic Appliances:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Shoes - Custom Molded:			
• Is there a maximum limit?	Yes		
Ages 0 - 18 years	2 pairs per calendar year		
Ages 18 years and over	1 pair per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Shoe Inserts - Custom Molded:			
• Is there a maximum limit?	Yes, 2 pairs per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Physician Office Visit	UAMS SmartCare	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Specialist Office Visit:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $45 copay per visit	Yes, $60 copay per visit	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Physician Services Performed In Office:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Physician Office Diagnostic Laboratory and X-Ray Charges:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	80%	75%	
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $75 copay per visit	Yes, $150 copay per visit	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Benefits Include: • Preventive Physical Exams at Appropriate Ages. • Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines). Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason. • Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed. • Preventive Tests, Lab and X Rays at Appropriate Ages. • Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share. Breast Ultrasounds Covered 100% Deductible Waived In-Network.			

Preventive Care Benefits for Children, Ages 0 - 3 years	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Benefits Include: • Preventive Physical Exams • Immunizations • Preventive Screenings at Appropriate Ages • Preventive Diagnostic Tests, Lab and X Rays • Preventive Hearing Exam. ***Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.***			

Skilled Nursing	UAMS SmartCare	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility: • Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No Benefit
• Does a copay apply?	Yes, $150 copay per admission. (Waived if Transferred from an Acute Care Facility)	Yes, $300 copay per admission. (Waived if Transferred from an Acute Care Facility)	
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Sterilizations	UAMS SmartCare	In-Network	Out-of-Network
Female Sterilizations:			No Benefit
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.			

Telehealth	UAMS SmartCare	In-Network	Out-of-Network
Office Visits:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes	Yes	
Primary Care Physician (PCP)	$25 copay	$40 copay	No Benefit
Specialist	$45 copay	$60 copay	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.			
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.			

Telemedicine	UAMS SmartCare	In-Network	Out-of-Network
UAMS HealthNow:			
• Is there a maximum limit?	No		
• Does a copay apply?	$25 copay per visit	No Benefit	No Benefit
• Does the deductible apply?	No		
• Paid by plan:	100%		
***Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor only. The vendor for this plan is UAMS HealthNow.**			

Temporomandibular Joint Disorder Benefits (TMJ)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	
• Does a copay apply?	Yes, $200 copay per visit	Yes, $200 copay per visit	
• Does the deductible apply?	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies	No Benefit
• Paid by plan:	80%	75%	

Therapy Services	UAMS SmartCare	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies: (PT, OT and ST)			
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $45 copay for initial evaluation only	Yes, $60 copay for initial evaluation only	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.			

Tobacco Use	UAMS SmartCare	In-Network	Out-of-Network
Counseling for Tobacco Use:			
• Is there a maximum limit?	2 Visits per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
After Maximum Is Satisfied:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	

Urgent Care	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No Benefit
• Does a copay apply?	Yes, $55 copay per visit	Yes, $55 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	

Vision Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Eye Exam:			No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Eye Refractions:			No Benefit
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $25 copay per visit	Yes, $40 copay per visit	
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
Additional Vision Care Services Performed in Office:			No Benefit
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	80%	75%	
Note: Only One (1) Copay Applies Per Visit for Preventive and Medical as well as Primary Care Physician or Specialist (Combined for Eye Exams, Glaucoma Testing and Eye Refractions).			

All Other Covered Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Does the deductible apply?	Yes	Yes	No Benefit

MEDICAL SCHEDULE OF BENEFITS

Benefit Plans 015 – Premier Plan with SmartCare
Classes A20, C20

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare (Tier 1)	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year, Excluding the Prescription Benefit Deductible			
• Per Person	$550	$850	$2,000
• Per Family	$1,100	$1,700	$4,000
Plan Participation Rate, Unless Otherwise Stated Below			
• Paid by Plan After Satisfaction of Deductible	85%	80%	50%
Annual Out-of-Pocket Maximum, Excluding the Prescription Benefit Out-of-Pocket Maximum			
• Per Person	$2,750	$3,250	$9,000
• Per Family	$5,500	$6,500	$18,000

Ambulance Transportation	UAMS SmartCare	In-Network	Out-of-Network
Ground Ambulance:			
• Is there a maximum limit?		No	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Air Ambulance:			
• Is there a maximum limit?		No Limit, Effective 1/1/2022	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	

Note: Out-of-Network Ambulance paid at the In-Network benefit level. Out-of-Network Ambulance charges may result in provider balance billing.

Breast Prosthesis	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Breast Pumps	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	$500 per device
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Note: Limit of one pump purchase per pregnancy.			

Contraceptive Methods and Counseling Approved by the FDA	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.			

Diabetic Services	UAMS SmartCare	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Diabetes Treatment Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Diabetes Lab Services:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Diabetes Nutritional Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	85%	80%	
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.			

Durable Medical Equipment (DME)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: First $800 of Disposable Items are Covered at 100%; Thereafter, Disposable Items will be Subject to Deductible and Coinsurance (Tier 1 and Tier 2 Only).			

Emergency Services / Treatment	UAMS SmartCare	In-Network	Out-of-Network
Emergency Room Facility Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	Yes, $350 copay per visit (Copay Waived if Admitted as Inpatient within 24 Hours)		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		
Emergency Physicians Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		
Emergency Room Services:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		

Hearing Services	UAMS SmartCare	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Hearing Exams, Tests Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Hearing Aids:			
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years		Yes, $1,400 Limit per Ear Every Three Years
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Implantable Hearing Aids:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Home Health Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.			

Hospice Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Hospice Services:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Bereavement Counseling:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Hospital Services	UAMS SmartCare	In-Network	Out-of-Network
Pre-Admission Testing:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year Is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	Yes, $80 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Lab and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $100 copay per visit	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Physician Clinic Visits In An Outpatient Hospital Setting	UAMS SmartCare	In-Network	Out-of-Network
Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Infertility Treatment	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Injections	UAMS SmartCare	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Manipulations (Chiropractic Therapy)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $35 copay for initial evaluation only	Yes, $50 copay for initial evaluation only	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.			

Maternity	UAMS SmartCare	In-Network	Out-of-Network
Physician Charges (Global Maternity):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: The First Ultrasound of Pregnancy is to be Paid by the Plan at 100%, regardless of diagnosis, unless administered in an emergency room, in which case it will be covered under the emergency room benefit (Tier 1 and Tier 2 Only).			
Diagnostic Maternity Services: (Outside of Global Maternity)			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	UAMS SmartCare	In-Network	Out-of-Network
Office Visit:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	$15 copay	$30 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Residential Treatment - Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Morbid Obesity	UAMS SmartCare	In-Network	Out-of-Network
Morbid Obesity Treatment:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Bariatric Surgery:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information. Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		Yes, Please Refer to the Exclusion Section for Additional Benefit Information.
• Does a copay apply?	Yes, $150 copay per admission.	Yes, $300 copay per admission.	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Metabolic Weight Loss and Nutritional Counseling:			
• Is there a maximum limit?	Yes, $1,000 limit per lifetime		
• Does a copay apply?	No		
• Does the deductible apply?	Yes		
• Paid by plan:	100%		
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.			

Nursery and Newborn Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Deductible And / Or Copay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).			

Orthotics	UAMS SmartCare	In-Network	Out-of-Network
Orthotic Appliances:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Shoes - Custom Molded:			
• Is there a maximum limit?	Yes		
Ages 0 - 18 years	2 pairs per calendar year		
Ages 18 years and over	1 pair per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Shoe Inserts - Custom Molded:			
• Is there a maximum limit?	Yes, 2 pairs per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Physician Office Visit	UAMS SmartCare	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Specialist Office Visit:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $35 copay per visit	Yes, $50 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Physician Services Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Physician Office Diagnostic Laboratory and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $100 copay per visit	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams at Appropriate Ages.
• Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines).
Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason.
• Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed.
• Preventive Tests, Lab and X Rays at Appropriate Ages.
• Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share.
Breast Ultrasounds Covered 100% Deductible Waived In-Network.

Preventive Care Benefits for Children, Ages 0 - 3 years	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams
• Immunizations
• Preventive Screenings at Appropriate Ages
• Preventive Diagnostic Tests, Lab and X Rays
• Preventive Hearing Exam.
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.

Skilled Nursing	UAMS SmartCare	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission. (Waived if Transferred from an Acute Care Facility)	Yes, $300 copay per admission. (Waived if Transferred from an Acute Care Facility)	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Sterilizations	UAMS SmartCare	In-Network	Out-of-Network
Female Sterilizations:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.

Telehealth	UAMS SmartCare	In-Network	Out-of-Network
Office Visits:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.			
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.			

Telemedicine	UAMS SmartCare	In-Network	Out-of-Network
UAMS HealthNow:			
• Is there a maximum limit?	No		
• Does a copay apply?	$15 copay per visit	No Benefit	No Benefit
• Does the deductible apply?	No		
• Paid by plan:	100%		
***Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor only. The vendor for this plan is UAMS HealthNow.**			

Temporomandibular Joint Disorder Benefits (TMJ)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $200 copay per visit	Yes, $200 copay per visit	Yes, $200 copay per visit
• Does the deductible apply?	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies
• Paid by plan:	85%	80%	50%

Therapy Services	UAMS SmartCare	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies: (PT, OT and ST) • Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $35 copay for initial evaluation only	Yes, $50 copay for initial evaluation only	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.			

Tobacco Use	UAMS SmartCare	In-Network	Out-of-Network
Counseling for Tobacco Use:			
• Is there a maximum limit?	2 Visits per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
After Maximum Is Satisfied:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	85%	80%	

Urgent Care	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $50 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Vision Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Eye Exam:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Eye Refractions:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Additional Vision Care Services Performed in Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Tier 1 and Tier 2 Only: Only One (1) Copay Applies Per Visit for Preventive and Medical as well as Primary Care Physician or Specialist (Combined for Eye Exams, Glaucoma Testing and Eye Refractions).			

All Other Covered Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plans 016 – Premier Plan with SmartCare and Wellness Qualified
Classes A22, C22

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Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare (Tier 1)	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year, Excluding the Prescription Benefit Deductible			
• Per Person	$550	$850	$2,000
• Per Family	$1,100	$1,700	$4,000
Plan Participation Rate, Unless Otherwise Stated Below			
• Paid by Plan After Satisfaction of Deductible	85%	80%	50%
Annual Out-of-Pocket Maximum, Excluding the Prescription Benefit Out-of-Pocket Maximum			
• Per Person	$2,400	$2,750	$9,000
• Per Family	$4,800	$5,500	$18,000

Ambulance Transportation	UAMS SmartCare	In-Network	Out-of-Network
Ground Ambulance:			
• Is there a maximum limit?		No	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	
Air Ambulance:			
• Is there a maximum limit?		No Limit, Effective 1/1/2022	
• Does a copay apply?	Not Applicable	Yes, $150 copay per trip	
• Does the deductible apply?		No	
• Paid by plan:		100%, after copay	

Note: Out-of-Network Ambulance paid at the In-Network benefit level.
Out-of-Network Ambulance charges may result in provider balance billing.

Breast Prosthesis	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Breast Pumps	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	$500 per device
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Note: Limit of one pump purchase per pregnancy.			

Contraceptive Methods and Counseling Approved by the FDA	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.			

Diabetic Services	UAMS SmartCare	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Diabetes Treatment Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Diabetes Lab Services:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Diabetes Nutritional Counseling:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	85%	80%	
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.			

Durable Medical Equipment (DME)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: First $800 of Disposable Items are Covered at 100%; Thereafter, Disposable Items will be Subject to Deductible and Coinsurance (Tier 1 and Tier 2 Only).			

Emergency Services / Treatment	UAMS SmartCare	In-Network	Out-of-Network
Emergency Room Facility Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	Yes, $350 copay per visit (Copay Waived if Admitted as Inpatient within 24 Hours)		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		
Emergency Physicians Charges:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		
Emergency Room Services:			
• Is there a maximum limit?	No		
• Does a copay apply?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	80%		

Hearing Services	UAMS SmartCare	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Hearing Exams, Tests Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Hearing Aids:			
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years		Yes, $1,400 Limit per Ear Every Three Years
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	No
• Paid by plan:	100%	100%	100%
Implantable Hearing Aids:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Home Health Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.			

Hospice Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Hospice Services:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Bereavement Counseling:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Hospital Services	UAMS SmartCare	In-Network	Out-of-Network
Pre-Admission Testing:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year Is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	Yes, $80 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient Lab and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $100 copay per visit	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Physician Clinic Visits In An Outpatient Hospital Setting	UAMS SmartCare	In-Network	Out-of-Network
Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Infertility Treatment	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Injections	UAMS SmartCare	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Manipulations (Chiropractic Therapy)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $35 copay for initial evaluation only	Yes, $50 copay for initial evaluation only	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.			

Maternity	UAMS SmartCare	In-Network	Out-of-Network
Physician Charges (Global Maternity):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: The First Ultrasound of Pregnancy is to be Paid by the Plan at 100%, regardless of diagnosis, unless administered in an emergency room, in which case it will be covered under the emergency room benefit (Tier 1 and Tier 2 Only).			
Diagnostic Maternity Services: (Outside of Global Maternity)			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	UAMS SmartCare	In-Network	Out-of-Network
Office Visit:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	$15 copay	$30 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission	Yes, $300 copay per admission	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Inpatient Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Residential Treatment - Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	Yes, $150 Copay. Applies to the First Day Services Only. The Remainder of the Days are Subject to Deductible and Coinsurance.	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Morbid Obesity	UAMS SmartCare	In-Network	Out-of-Network
Morbid Obesity Treatment:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Bariatric Surgery:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information. Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		Yes, Please Refer to the Exclusion Section for Additional Benefit Information.
• Does a copay apply?	Yes, $150 copay per admission.	Yes, $300 copay per admission.	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Metabolic Weight Loss and Nutritional Counseling:			
• Is there a maximum limit?	Yes, $1,000 limit per lifetime		
• Does a copay apply?	No		
• Does the deductible apply?	Yes		
• Paid by plan:	100%		
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.			

Nursery and Newborn Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Deductible And / Or Copay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).			

Orthotics	UAMS SmartCare	In-Network	Out-of-Network
Orthotic Appliances:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Shoes - Custom Molded:			
• Is there a maximum limit?	Yes		
Ages 0 - 18 years	2 pairs per calendar year		
Ages 18 years and over	1 pair per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Shoe Inserts - Custom Molded:			
• Is there a maximum limit?	Yes, 2 pairs per calendar year		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Physician Office Visit	UAMS SmartCare	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Specialist Office Visit:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $35 copay per visit	Yes, $50 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Physician Services Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Physician Office Diagnostic Laboratory and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	85%	80%	50%
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $100 copay per visit	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams at Appropriate Ages.
• Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines).
Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason.
• Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed.
• Preventive Tests, Lab and X Rays at Appropriate Ages.
• Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share.
Breast Ultrasounds Covered 100% Deductible Waived In-Network.

Preventive Care Benefits for Children, Ages 0 - 3 years	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams
• Immunizations
• Preventive Screenings at Appropriate Ages
• Preventive Diagnostic Tests, Lab and X Rays
• Preventive Hearing Exam.
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.

Skilled Nursing	UAMS SmartCare	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility:			
• Is there a maximum limit?	Yes, Maximum Combined Inpatient Copay Per Calendar Year is $1,200 Per Person. No More Than One Copay Per 30 Days. Deductible and coinsurance apply after copay.		No
• Does a copay apply?	Yes, $150 copay per admission. (Waived if Transferred from an Acute Care Facility)	Yes, $300 copay per admission. (Waived if Transferred from an Acute Care Facility)	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

Sterilizations	UAMS SmartCare	In-Network	Out-of-Network
Female Sterilizations:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.

Telehealth	UAMS SmartCare	In-Network	Out-of-Network
Office Visits:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes	Yes	No
Primary Care Physician (PCP)	$15 copay	$30 copay	No
Specialist	$35 copay	$50 copay	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.			
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.			

Telemedicine	UAMS SmartCare	In-Network	Out-of-Network
UAMS HealthNow:			
• Is there a maximum limit?	No		
• Does a copay apply?	$15 copay per visit	No Benefit	No Benefit
• Does the deductible apply?	No		
• Paid by plan:	100%		
***Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor only. The vendor for this plan is UAMS HealthNow.**			

Temporomandibular Joint Disorder Benefits (TMJ)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $200 copay per visit	Yes, $200 copay per visit	Yes, $200 copay per visit
• Does the deductible apply?	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies	Yes, a $1,000 Separate Deductible Applies
• Paid by plan:	85%	80%	50%

Therapy Services	UAMS SmartCare	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies: (PT, OT and ST) • Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does a copay apply?	Yes, $35 copay for initial evaluation only	Yes, $50 copay for initial evaluation only	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.			

Tobacco Use	UAMS SmartCare	In-Network	Out-of-Network
Counseling for Tobacco Use:			
• Is there a maximum limit?	2 Visits per calendar year		
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	No	No	
• Paid by plan:	100%	100%	
After Maximum Is Satisfied:			
• Is there a maximum limit?	No	No	
• Does a copay apply?	No	No	No Benefit
• Does the deductible apply?	Yes	Yes	
• Paid by plan:	85%	80%	

Urgent Care	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does a copay apply?	Yes, $50 copay per visit	Yes, $50 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Vision Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Eye Exam:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Eye Refractions:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does a copay apply?	Yes, $15 copay per visit	Yes, $30 copay per visit	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Additional Vision Care Services Performed in Office:			
• Is there a maximum limit?	No	No	No
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%
Tier 1 and Tier 2 Only: Only One (1) Copay Applies Per Visit for Preventive and Medical as well as Primary Care Physician or Specialist (Combined for Eye Exams, Glaucoma Testing and Eye Refractions).			

All Other Covered Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	85%	80%	50%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plans 017, 018 – Health Savings Plan, with SmartCare
Qualified High Deductible Health Plan (QHDHP)
Classes A50, C50, A51, C51, A52, C52, A53, C53

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare (Tier 1)	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Annual Deductible Per Calendar Year			
Note: Medical and Pharmacy Expenses are Subject to the Same Deductible.			
• Per Person	$3,400	$3,400	$3,400
• Per Family	$6,000	$6,000	$6,000
- Individual Embedded Deductible	$3,400	$3,400	$3,400
Plan Participation Rate, Unless Otherwise Stated Below			
• Paid by Plan After Satisfaction of Deductible	95%	90%	50%
Annual Total Out-of-Pocket Maximum			
Note: Medical and Pharmacy Expenses are Subject to the Same Out-of-Pocket Maximum.			
• Per Person	$6,250	$6,750	$9,800
• Per Family	$12,300	$13,300	$19,800
- Individual Embedded Deductible	$6,250	$6,750	$9,800

Ambulance Transportation	UAMS SmartCare	In-Network	Out-of-Network
Ground Ambulance:			
• Is there a maximum limit?		No	
• Does the deductible apply?	Not Applicable	Yes, In-Network Tier 2 Deductible	
• Paid by plan:		90%	
Air Ambulance:			
• Is there a maximum limit?		No Limit, Effective 1/1/2022	
• Does the deductible apply?	Not Applicable	Yes, In-Network Tier 2 Deductible	
• Paid by plan:		90%	
Note: Out-of-Network Ambulance paid at the In-Network benefit level. Out-of-Network Ambulance charges may result in provider balance billing.			

Breast Prosthesis	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 1 Replacement Every Two Years		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Breast Pumps	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	$500 per device
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Limit of one pump purchase per pregnancy.			

Contraceptive Methods and Counseling Approved by the FDA	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Contraceptives Obtained from a Pharmacy are Covered Under the Prescription Drug Plan.			

Diabetic Services	UAMS SmartCare	In-Network	Out-of-Network
Diabetes Treatment Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Diabetes Treatment Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Diabetes Lab Services:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Diabetes Nutritional Counseling:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Note: Effective 1/1/2023 Continuous Glucose Monitors (CGM's) are excluded on the medical plan, and only available through the pharmacy plan. Diabetic insulin pumps are excluded on pharmacy plan, and only available through the medical plan. Insulin supplies are available through both the medical and pharmacy plans.			

Durable Medical Equipment (DME)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Emergency Services / Treatment	UAMS SmartCare	In-Network	Out-of-Network
Emergency Room Facility Charges:			
• Is there a maximum limit?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	90%		
Emergency Physicians Charges:			
• Is there a maximum limit?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	90%		
Emergency Room Services:			
• Is there a maximum limit?	No		
• Does the deductible apply?	Yes, In-Network Tier 2 Deductible		
• Paid by plan:	90%		

Hearing Services	UAMS SmartCare	In-Network	Out-of-Network
Hearing Exams, Tests Not Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Hearing Exams, Tests Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Hearing Aids:			
• Is there a maximum limit?	Yes, $3,000 Limit per Ear Every Three Years		Yes, $1,400 Limit per Ear Every Three Years
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Implantable Hearing Aids:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Home Health Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, 40 visits per calendar year		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Note: A Home Health Care Visit will be Considered a Periodic Visit by Either a Nurse or Qualified Therapist, as the Case May Be, or up to Four (4) Hours of Home Health Care Services. Care Management Can Extend the Visits In Lieu Of More Expensive Level of Care.			

Hospice Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Hospice Services:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Bereavement Counseling:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Hospital Services	UAMS SmartCare	In-Network	Out-of-Network
Pre-Admission Testing:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Inpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Outpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Outpatient Physician/Surgeon Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Outpatient Lab and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Outpatient Advanced Imaging (CT, PET, MRI & Nuclear Medicine) - Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Physician Clinic Visits In An Outpatient Hospital Setting	UAMS SmartCare	In-Network	Out-of-Network
Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Infertility Treatment	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, $20,000 per Lifetime		
• Does a copay apply?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Injections	UAMS SmartCare	In-Network	Out-of-Network
Non-Preventive Injections (Such as Steroids):			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Manipulations (Chiropractic Therapy)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Note: Combined with Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis (ABA) Therapy. Habilitation services for learning disabilities are not covered.			

Maternity	UAMS SmartCare	In-Network	Out-of-Network
Physician Charges (Global Maternity):			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Diagnostic Maternity Services: (Outside of Global Maternity)			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Preventive Prenatal Services and Postnatal Services as Defined by the Affordable Care Act:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			
Inpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	UAMS SmartCare	In-Network	Out-of-Network
Office Visit:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Inpatient Facility Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Inpatient Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Residential Treatment - Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Outpatient or Partial Hospitalization Services (Day Treatment) Facility and Physician Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Morbid Obesity	UAMS SmartCare	In-Network	Out-of-Network
Morbid Obesity Treatment:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Bariatric Surgery:			
• Is there a maximum limit?	Yes, Please Refer to the Exclusion Section for Additional Benefit Information.		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Metabolic Weight Loss and Nutritional Counseling:			
• Is there a maximum limit?	Yes, $1,000 limit per lifetime		
• Does the deductible apply?	Yes		
• Paid by plan:	100%		
Note: Members Must Pay for the Physician Supervised Weight Loss Program Up Front and Submit a Claim to UMR for Reimbursement. UMR Will Not Reimburse the Provider Directly.			

Nursery and Newborn Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.			

Orthotics	UAMS SmartCare	In-Network	Out-of-Network
Orthotic Appliances:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Shoes - Custom Molded:			
• Is there a maximum limit?	Yes		
Ages 0 - 18 years	2 pairs per calendar year		
Ages 18 years and over	1 pair per calendar year		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Shoe Inserts - Custom Molded:			
• Is there a maximum limit?	2 pairs per calendar year		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Physician Office Visit	UAMS SmartCare	In-Network	Out-of-Network
Primary Care Physician Office Visit (PCP):			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Specialist Office Visit:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Physician Services Performed In Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Physician Office Allergy Services: Allergy Injections, Sublingual Drops, Testing and Serums:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Physician Office Diagnostic Laboratory and X-Ray Charges:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Physician Office Advanced Imaging (CT, PET, MRI & Nuclear Medicine):			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Preventive Care Benefits, Ages 3 and Over (See Glossary of Terms for Definition)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams at Appropriate Ages.
• Immunizations (Including But Not Limited to Flu, COVID, Pneumonia or Shingles Vaccines).
Note: Foreign Travel Vaccinations are Only Covered by the Plan When Traveling for a University Of Arkansas Systems Work-Related Reason.
• Shingles Vaccine, for Ages 50 and older and 19 and older for immunodeficient or immunosuppressed.
• Preventive Tests, Lab and X Rays at Appropriate Ages.
• Preventive Mammograms and Breast Exams - All Mammograms covered as Preventive Benefits Regardless of Diagnosis with no member cost share.
Breast Ultrasounds Covered 100% Deductible Waived In-Network.

Preventive Care Benefits For Children, Ages 0 - 3 years	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Preventive Physical Exams
• Immunizations
• Preventive Screenings at Appropriate Ages
• Preventive Diagnostic Tests, Lab and X Rays
• Preventive Hearing Exam.
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.

Preventive Care Benefits, Expanded	UAMS SmartCare	In-Network	Out-of-Network
Expanded Preventive List for Specific Chronic Conditions – Refer to the Covered Medical Benefits Section for Details:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%

Benefits Include:
• Antiresorptive Therapy for the Diagnosis of Osteoporosis and/or Osteopenia.
• Beta-Blockers for the Diagnosis of Congestive Heart Failure.
• Blood Pressure Monitor for the Diagnosis of Hypertension.
• Retinopathy Screening, Glucometer, and Hemoglobin A1C Testing, for the Diagnosis of Diabetes.
• Peak Flow Meter and Inhaled Corticosteroids for the Diagnosis of Asthma.
• International Normalized Ratio (INR) Testing for the Diagnosis of Liver Disease and/or Bleeding Disorders.
• Low-Density Lipoprotein (LDL) Testing for the Diagnosis of Heart Disease.
• Beta-Blockers for the Diagnosis of Coronary Artery Disease.
Note: Not all testing is considered "preventive" or "routine", and therefore not covered at 100%. Please discuss with your provider.

Skilled Nursing	UAMS SmartCare	In-Network	Out-of-Network
Extended Care, Convalescent or Subacute Facility:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Sterilizations	UAMS SmartCare	In-Network	Out-of-Network
Female Sterilizations:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Note: (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider are covered under the Affordable Care Act.			

Telehealth	In-Network	In-Network	Out-of-Network
Office Visits:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Coverage Includes: • Consultations made by a Covered Person's treating Physician to another Physician. • Consultations made by a Covered Person to a Physician. • For Charges Other Than an Office Visit, Deductible and Coinsurance will Apply.			
Telehealth* is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.			

Telemedicine	UAMS SmartCare	In-Network	Out-of-Network
UAMS HealthNow:			
• Is there a maximum limit?	No		
• Does the deductible apply?	Yes	No Benefit	No Benefit
• Paid by plan:	95%		
Telemedicine* refers to the clinical services provided to patients through electronic communications utilizing a vendor only. The vendor for this plan is UAMS HealthNow.			

Temporomandibular Joint Disorder Benefits (TMJ)	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Therapy Services	UAMS SmartCare	In-Network	Out-of-Network
Physical, Occupational and Speech Therapies (PT, OT and ST) • Is there a maximum limit?	Yes, Medical Necessity will be Reviewed After 25 Visits, per calendar year.		
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%
Note: Combined with Manipulations (Chiropractic Therapy). Habilitation services for learning disabilities are not covered.			

Tobacco Use	UAMS SmartCare	In-Network	Out-of-Network
Counseling for Tobacco Use:			
• Is there a maximum limit?	2 Visits per calendar year		
• Does the deductible apply?	No	No	No Benefit
• Paid by plan:	100%	100%	
After Maximum Is Satisfied:			
• Is there a maximum limit?	No	No	
• Does the deductible apply?	Yes	Yes	No Benefit
• Paid by plan:	95%	90%	

Urgent Care	UAMS SmartCare	In-Network	Out-of-Network
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

Vision Care Benefits	UAMS SmartCare	In-Network	Out-of-Network
Eye Exam:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Eye Refractions:			
• Is there a maximum limit?	Yes, 1 Exam per calendar year		
• Does the deductible apply?	No	No	Yes
• Paid by plan:	100%	100%	50%
Additional Vision Care Services Performed in Office:			
• Is there a maximum limit?	No	No	No
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

All Other Covered Expenses	UAMS SmartCare	In-Network	Out-of-Network
• Does the deductible apply?	Yes	Yes	Yes
• Paid by plan:	95%	90%	50%

TRANSPLANT SCHEDULE OF BENEFITS

Classic Plan

Benefit Plan(s) 001, 003, 009

Transplant Services at a Designated Transplant Facility	
Transplant Services:	
• Is there a maximum limit?	No
• Does a copay apply?	Yes, $300 per admission
• Does the deductible apply?	Yes
• Paid by plan:	75%
Travel And Housing:	
• Is there a maximum limit?	Yes, $10,000 per transplant
• Does a copay apply?	No
• Does the deductible apply?	No
• Paid by plan:	100%
Travel And Housing at Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation and Up To One Year From Date Of Transplant.	

***Note: Prior Authorization and an authorized transplant facility is required. Please contact CARE (Care Management) at 866-494-4502.**

TRANSPLANT SCHEDULE OF BENEFITS

Premier Plan

Benefit Plan(s) 015, 016

Transplant Services at a Designated Transplant Facility

Transplant Services:	
• Is there a maximum limit?	No
• Does a copay apply?	Yes, $300 per admission
• Does the deductible apply?	Yes
• Paid by plan:	80%
Travel And Housing:	
• Is there a maximum limit?	Yes, $10,000 per transplant
• Does a copay apply?	No
• Does the deductible apply?	No
• Paid by plan:	100%

Travel And Housing at Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation and Up To One Year From Date Of Transplant.

***Note: Prior Authorization and an authorized transplant facility is required. Please contact CARE (Care Management) at 866-494-4502.**

TRANSPLANT SCHEDULE OF BENEFITS

Health Savings Plan

Benefit Plan(s) 017, 018

Transplant Services at a Designated Transplant Facility	
Transplant Services:	
• Is there a maximum limit?	No
• Does the deductible apply?	Yes
• Paid by plan:	90%
Travel And Housing:	
• Is there a maximum limit?	Yes, $10,000 per transplant
• Does a copay apply?	No
• Does the deductible apply?	No
• Paid by plan:	100%
Travel And Housing at Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation and Up To One Year From Date Of Transplant.	

***Note: Prior Authorization and an authorized transplant facility is required. Please contact CARE (Care Management) at 866-494-4502.**

PRESCRIPTION SCHEDULE OF BENEFITS

Classic Plan

Benefit Plan(s) 001, 003, 009

Covered Person's Co-pay Amount	
Generic Drugs (Tier 1)	$18
Preferred Brand-Name Drugs (Tier 2)	$62
Nonpreferred Brand-Name Drugs (Tier 3)	$97
Annual Out-of-Pocket	
Individual	$1,900
Family	$3,800

***Note: The Pharmacy out-of-pocket amount is not included in the Medical out-of-pocket amount.**

PRESCRIPTION SCHEDULE OF BENEFITS

Premier Plan

Benefit Plan(s) 015, 016

Covered Person's Co-pay Amount	
Generic Drugs (Tier 1)	$14
Preferred Brand-Name Drugs (Tier 2)	$57
Nonpreferred Brand-Name Drugs (Tier 3)	$92
Annual Out-of-Pocket	
Individual	$1,900
Family	$3,800

***Note: The Pharmacy out-of-pocket amount is not included in the Medical out-of-pocket amount.**

PRESCRIPTION SCHEDULE OF BENEFITS

Health Savings Plan

Benefit Plan(s) 017, 018

Covered Person's Co-pay Amount	
Generic Drugs (Tier 1)	90% after Deductible
Preferred Brand-Name Drugs (Tier 2)	90% after Deductible
Nonpreferred Brand-Name Drugs (Tier 3)	90% after Deductible

***Note: Pharmacy spend is included in the Medical out-of-pocket amounts.**

INCENTIVE SOLUTIONS

You may be offered incentive rewards to encourage You to participate in various health and wellness programs or healthy activities. The decision about whether or not to participate is Yours alone, and UNIVERSITY OF ARKANSAS SYSTEM recommends that You discuss participating in such programs with Your Physician. For additional information and answers to questions concerning incentives, please contact Your Human Resources or Personnel office.

ONE PASS SELECT

One Pass Select is a subscription-based fitness and well-being program designed around flexibility and convenience for both the employer and Employees. You can add any individual age 18 or older to Your membership, extending the benefits to family members, friends, or other eligible adults of Your choice. All fees for added members are consolidated under Your account and You are solely responsible for covering these costs. You can select the plan that best fits Your budget and needs and pay a monthly fee for access. Monthly fees and tier structures are subject to change. You can upgrade or downgrade monthly or cancel Your subscription at any time when You provide a 30-day notice prior to the next billing date.

One Pass Select provides customer support that is available 8 am – 9 pm CST, Monday – Friday. You can call 877-515-9364 for additional support on One Pass Select.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) Classic Non-SmartCare

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the in-network and out-of-network total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible**.**

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible**.**

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying copays, coinsurance and deductible up to the annual maximum out of pocket. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). The Pharmacy Benefits Manager is MedImpact. Pharmacy expenses that the Covered Person incurs through the prescription drug benefit plan do not apply toward the out-of-pocket maximum of the medical benefit Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) Classic SmartCare, Premier SmartCare

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at UAMS SmartCare or In-Network benefit levels (whether Incurred at a UAMS SmartCare or In-Network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible**.**

The Deductible amounts that the Covered Person Incurs at an Out-of-Network provider will apply to the Out-of-Network total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible**.**

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible**.**

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). The Pharmacy Benefits Manager is MedImpact. Pharmacy expenses that the Covered Person incurs through the prescription drug benefit plan do not apply toward the out-of-pocket maximum of the medical benefit Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) Health Savings Plan and Qualified High Deductible Health Plan

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be considered Preventive / Routine Care and paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses, including covered Pharmacy expenses, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at UAMS SmartCare or In-Network benefit levels (whether Incurred at a UAMS SmartCare or In-Network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible.

The Deductible amounts that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees, and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person incurs at UAMS SmartCare or In-Network benefit levels (whether Incurred at a UAMS SmartCare or In-Network) will be used to satisfy the total in-network out-of-pocket maximum.

The eligible out-of-pocket expenses that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximums.

ELIGIBILITY AND EFFECTIVE DATE

It is the responsibility of each Covered Individual to review and become familiar with the terms and conditions of eligibility. All changes that materially affect eligibility or Continuation of Benefits must be reported to the UA Campus Human Resource or Personnel representative immediately.

DEFINITIONS

The following definitions contain words and phrases that shall have the meanings as indicated in this section unless a different meaning is plainly required by the context. Any headings used are included for reference only, and do not alter any of the terms of the Plan.

1. **University of Arkansas or UA** means the University of Arkansas System.

2. **Eligible Employee** means You are an eligible Employee if You are a full-time Employee of the University or a designated affiliate. A full-time Employee is any Employee who is employed half-time or greater and holds at least a nine month appointment. However, for purposes of this Plan "Eligible Employees" shall also include Residents, Interns and Housestaff members at the University of Arkansas for Medical Sciences, employees qualifying under the requirements of ACA, and enrolled employees who are placed in temporary paid or unpaid leave status.

3. **Effective Date of Coverage:** The effective date of participation for eligible employees is the first of the following month after completion of enrollment, provided You do so within thirty-one (31) days after the Eligibility Date, and all required documents have been submitted. Under no circumstances can the hire date be the same as the effective date of coverage.

   The only exceptions to first of the following month are divorces, births, adoptions and death, which are effective on the date of the event, when enrollments completed timely. A new spouse's coverage is not effective on the date of the event but is delayed to the first of the following month.

4. **Eligible Retiree** means an Eligible Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of seventy (70) and immediately prior to retirement has completed ten (10) or more consecutive years of continuous coverage under the Plan or an Eligible Employee who retires while covered under the Plan and on the date of retirement is age 65 or older and immediately prior to retirement: has completed five (5) or more consecutive years of service with the UA and has five (5) or more consecutive year of continuous coverage under the Plan or who has retired under an early retirement agreement approved by THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS. Eligible spouse and dependent participants of an eligible retiree are those eligible participants upon the date of retirement. Following separation from employment, new enrollment of an eligible spouse or of eligible dependent participants is available only upon marriage, birth, or adoption. Enrollment due to loss of other coverage or due to other change events is not available. Eligible retirees who become Medicare-eligible while participating in the University of Arkansas Medical Benefit Plan or who are Medicare-eligible upon retirement will be provided enrollment opportunity in the University of Arkansas-sponsored Group Medicare Advantage (PPO) Plan. Medicare-eligible retirees and Medicare-eligible Dependents of eligible retirees are not eligible to continue in the University of Arkansas Medical Benefit Plan. Medicare Primary Retirees must carry both Medicare Parts A & B for full coverage. Please contact Your campus Human Resources Office for information on the Group Medicare Advantage Plan.

5. **Employee or Enrollee** means an Eligible Employee, Eligible Disabled Employee or Eligible Retiree covered under the Plan in accordance with this section.

6. **Eligible Dependent or Covered Dependent** means only the following persons not otherwise eligible for coverage under the Plan as a Covered Person:

    - The lawful spouse of an Eligible Employee;
    - Each Child of the Eligible Employee from birth until the end of the month on which they attain the age of twenty-six (26) years.
    - For retirees, except for HIPAA Family Status Changes as provided herein, only Dependents covered under the Plan as of the date of retirement shall be considered Eligible Dependents.
    - No person may be simultaneously covered as an Employee and as a Dependent under the Plan.

7. **Child** includes (in addition to Your natural Child) the following:

    - An adopted Child for whom a petition for adoption has been filed or the final court order has been issued;
    - A stepchild.
    - A person for whom You are the current Legal Guardian.
    - No person not described above, including a grandchild, shall be considered a Child.

8. **Covered Person** means only Your eligible Dependent who is covered under this Plan in accordance with this section.

    NOTE:

    - Only eligible subscribers and their eligible dependents can participate in the Plan. Falsification of eligibility is a serious offense and may lead to disciplinary action up to and including termination of coverage for benefits and termination of employment. The plan has the right to request reimbursement of premiums and claims paid for ineligible participants.
    - Certain documents such as marriage certificates, birth certificates or divorce decrees to enroll or make changes for dependents are required to enroll in the Plan. Failure to provide the necessary documentation within the designated timeframe will cause a delay, loss of enrollment, or loss of eligibility.
    - Former spouses are not eligible dependents and therefore not eligible to participate in the plan even if there is a court order requiring the employee to obtain coverage for the former spouse. Note: Retirees and their eligible Dependents who cancel coverage cannot re-enroll at a later date.
    - Incarcerated individuals are not eligible to participate in the Plan.

9. **Active Work** means the performance of full or part-time work by You for UA either at Your customary place of employment or at such other place or places as required by UA in the course of work for the full number of hours and full rate of pay in accordance with the established employment practices of UA for full or part-time Employees.

10. **Claims Administrator** means the agent retained by UA to determine the validity of claims and administer benefit payments. The Claims Administrator is UMR, Inc.

11. **HIPAA Family Status Change** means a change in Your coverage level due to marriage, birth or adoption of a Child, death or divorce, or court orders mandating medical coverage for minor Children. HIPAA Family Status Changes apply to active Employees, Retirees and former Employees on COBRA. **NOTE: You have 31 days from any of the above mentioned changes to add UA Medical Benefit Coverage for You and / or Your Dependent.**

12. **HIPAA Special Enrollment** is a 31-day medical Plan enrollment period immediately following Your or Your Eligible Dependent's loss of COBRA coverage, loss of eligibility for other medical coverage (including medical coverage attributable to the spouse's Employment), or loss of the Employer contribution for the other coverage. However, You must have previously declined the UA Medical Benefit Coverage due to having other medical coverage.

13. **Eligible Disabled Employee** is a disabled Employee with over ten years of consecutive service with the UA, and who at the time of the disability, has at least 10 immediately prior consecutive years of medical coverage under the UA Medical Benefit Plan, will be eligible for coverage under the UA Medical Benefit Plan upon full payment of the current premium amount made in the same manner as an Eligible Retiree. Upon completion of the Medicare-eligibility waiting period, the eligible disabled Employee will be provided with enrollment opportunity in the University of Arkansas UnitedHealth Care Group Medicare Advantage (PPO) Plan. Medicare-eligible disabled Employees and Medicare eligible Dependents of disabled Employees are not eligible to continue in the University of Arkansas Medical Benefit Plan. Please contact Your campus Human Resources Office for information on the Group Medicare Advantage Plan.

ELIGIBLE CLASSES OF EMPLOYEES

The Eligible Classes of Employees include the following classes of Employees:

- Eligible Employees;
- COBRA Qualified Beneficiaries;
- Surviving Dependents of deceased Employees, covered under the health plan at the time of death;
- Eligible Retirees; or
- Eligible disabled Employees previously employed and covered by the UA.

Note: J1 Visa Employees are not eligible for the Qualified High Deductible Plan. They are eligible to enroll in the Premier or Classic Benefit Plans.

EMPLOYEE ELIGIBILITY DATE

If You are in an eligible class You are eligible for coverage on the date You enter active work for the Employer. If You are not in an eligible class, You will become eligible for coverage on the date You enter an eligible class.

Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations.

EFFECTIVE DATE OF PARTICIPATION FOR ELIGIBLE EMPLOYEES

Subject to the Effective Date, You shall become effective in this Plan at 12:01 a.m. on the earliest of the following dates:

- Medicare-eligible retirees are subject to a separate Medicare Advantage Group Plan offered throughout United Health Care and are not eligible to continue in this plan. Please consult with Your Human Resources Office for information on enrollment in the University of Arkansas UHC Medicare Advantage PPO plan.
- The first day of the month or next following the date You enroll and authorize any required contributions for coverage, provided You do so within thirty-one (31) days after the Eligibility Date. Medical residents at UAMS are eligible upon benefits date of hire; or
- Please contact Your Human Resources Office to complete the forms adding coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY ADDITION/CHANGE WITHIN 31 DAYS of Your HIPAA Family Status Change or HIPAA Special Enrollment event. Your effective date will be the later of the date of the HIPAA Family Status Change or HIPAA Special Enrollment or the first day of the month following date Your written election is received by the Human Resources Office. In the case of birth of a Child or adoption, the effective date will be the date of birth or placement for adoption. **NOTE: You must enroll and authorize any required contributions for Your coverage, provided You do so within thirty-one (31) days after Your eligibility date;** or

- If You have a benefits-eligible part-time position and are changing to a benefits-eligible full-time position You will be effective on the first day of the month next following the date the You enroll and authorize any required contributions for coverage, provided You enroll within thirty-one (31) days of this non-HIPAA enrollment event; or

- During any Open Enrollment period that may be designated by the University of Arkansas, on the effective date of the Open Enrollment following the date the You enroll and authorize any required contribution for coverage.

- If You do not enroll on Your eligibility date You will not be able to enroll in the plan unless You subsequently have a HIPAA family status change, HIPAA special enrollment event, a non-HIPAA enrollment event as defined above or the University conducts an open enrollment.

- Residents, interns, and house staff members at the University of Arkansas for Medical Sciences will be effective the first officially recognized day of their respective programs.

ELIGIBILITY DATE FOR DEPENDENT COVERAGE

- The eligibility date for Your Dependent's coverage shall be the first date on which You are eligible for coverage under this Plan and have one or more Eligible Dependents, as defined in this section.

EFFECTIVE DATE FOR COVERAGE FOR ELIGIBLE DEPENDENTS

Subject to the Effective Date, coverage for eligible Dependents shall become effective on the applicable date determined below, but in no event prior to the date the Employee becomes a Covered Person in this Plan:

- The eligibility date for Your Dependent's coverage, provided You enroll and authorize any required contributions for Dependent coverage on or before the date;

- If You have a HIPAA family status change or HIPAA special enrollment event, effective the first of the month following Your election to enroll and authorize contributions provided Your election is within 31 days of the qualified status event change. In the case of birth or adoption of a child, coverage will be effective as of the date of birth or placement for adoption. In either case, You must make the written election to enroll within thirty-one (31) days after the HIPAA family status change or HIPAA special enrollment event.

- The first day of the calendar month following the date any Retiree has a HIPAA family status change event and enrolls and authorizes any required contributions for Dependent coverage.

- Please contact Your Human Resources Office to complete the forms adding or dropping Dependent coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY CHANGE WITHIN 31 DAYS OF THE HIPAA family status change or HIPAA special enrollment event. Dependent coverage shall be effective from the date of birth for each Dependent Child born, provided that You notify the Human Resources Office within 31 days of birth. Your effective date of enrollment for any other HIPAA family status change or HIPPA special enrollment event or the first day of the calendar month following the date Your written election is received by the Human Resources Office. **NOTE: An Employee with Employee only coverage or Employee and spouse coverage must enroll and authorize any required contributions for newborn Dependent coverage within 31 days after the date of the eligible dependents birth.**

You must notify Your campus Human Resources Office of a HIPAA enrollment or change event using the online or paper process prescribed for Your campus. You should also select a network Primary Care Physician for any other Dependent who becomes eligible for coverage after Your initial enrollment.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 60 calendar days before the day coverage for the Dependent would normally end.

The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof must be submitted as required; and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

On and after January 1, 2022, new enrollment of any adult dependent child age 26 or older, including a disabled adult dependent child age 26 and older, is not available. A disabled adult dependent child may continue as an eligible dependent beyond age 26 if determined disabled and enrolled in the University health plan before attaining age 26. An adult disabled dependent child who ceases plan participation upon or after age 26 is not eligible to return to participation as an adult disabled dependent child. The Dependent may not be married.

EFFECTIVE DATE OF PARTICIPATON FOR ELIGIBLE RETIREES

A non-Medicare-eligible Retiree shall become a Covered Person in this Plan provided they elect no more than ninety (90) days prior to retirement and no more than thirty-one (31) days after retirement to continue to be covered under the Plan, enrolls for Retiree coverage within thirty-one (31) days of the date of their retirement, and makes the required contributions for coverage. Medicare-eligible retirees are subject to a separate Medicare Advantage Group Plan offered throughout United Health Care and are not eligible to continue in this Plan. Please consult with Your Human Resources Office for information on enrollment in the University of Arkansas UnitedHealth Care Medicare Advantage PPO plan.

TERMINATION OF COVERAGE

When coverage under this Plan stops, You and / or Your Covered Dependents will receive a certificate that will show the period of creditable coverage under this Plan. Please contact Your campus Human Resources Office to determine how to receive a certificate of creditable coverage.

Termination of coverage could occur if You fail to provide information necessary to comply with applicable law, including, but not limited to, Your or Your Covered Dependent's social security number or other government issued identification number.

WHEN YOUR COVERAGE TERMINATES

Your coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, You may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select coverage, see the section entitled Continuation Coverage Rights under COBRA):

- The date the Plan ceases;
- The date the Plan ceases for the Class of Employees to which You belong; or
- The date active employment ceases, except as provided by the Plan; or

- In the event that You terminate Employment before the end of the payroll cycle, Your coverage will end on that date.

- The date You cease to be eligible for coverage under the Plan

- The first day of the following month in which a retiree participant or Dependent of a retiree participant who reaches age 65 or otherwise becomes Medicare-eligible.

- In the event of divorce or when a Dependent ceases to be eligible due to age or any other change resulting in loss of eligibility, the Employee is responsible for notifying the campus Human Resources Office of the status change within 31 days of the event. When a Dependent ceases to be eligible due to age, coverage is terminated at the end of the month in which the Dependent attains age 26. When a Dependent ceases to be eligible due to divorce or any other change resulting in loss of eligibility, coverage ceases on the date eligibility is changed and in all cases coverage will be terminated retroactively to the date eligibility changed. Failure to provide timely notice of change will result in no refund of premiums. In a COBRA-qualifying event the applicable Dependent will be provided COBRA notice to elect continuation of coverage.

BOARD POLICY

SELF-INSURED MAJOR MEDICAL PROGRAM

Effective July 1, 1990, the University of Arkansas established a self-insured major medical program. This program was revised effective November 1, 1994, for eligible Employees and other eligible participants of the University of Arkansas for Medical Sciences and effective January 1, 1995, for all other eligible Employees and other eligible participants of the University of Arkansas.

The extent of coverage for eligible Employees and other eligible participants together with the schedule of benefits shall be governed by the terms and conditions of the University of Arkansas Medical Benefit Plan Documents which shall be approved by the President. All eligible Employees and other eligible participants under the University of Arkansas Medical Benefit Plan shall be provided online access to a summary plan description, and shall be provided a copy of the summary plan description upon request, setting forth the terms and conditions of coverage.

Eligible Employee means You are an eligible Employee if You are a full-time Employee of the University or a designated affiliate. A full-time Employee is any Employee who is employed half-time or greater and holds at least a nine month appointment. However, for purposes of this Plan “Eligible Employees” shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.

The President shall contract with a company qualified to do business in the State of Arkansas to provide for managed care and third-party administrative services and for other services in connection with the University of Arkansas Medical Benefit Plan. The President shall, in consultation with the Chancellors and the Vice President for Agriculture, establish from time to time the coverage and cost of coverage at the separate campuses and the Division of Agriculture for Employee only, Employee and spouse, Employee and child and Employee and family and the percentage of such cost to be paid by the Employee and the University. The cost of coverage paid by the Employee may vary for eligible Employees who work less than full-time. The President shall advise the Board of any changes in the cost of coverage.

The complete Board Policy 430.1 is available on the University System website at https://www.uasys.edu/policies/board-policies/.

COBRA CONTINUATION OF COVERAGE

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than their gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than their gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

Qualifying Event	**Length of Continuation**
• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, Your spouse and Dependent Children may also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code, the bankruptcy may be a Qualifying Event. If the bankruptcy results in the Retired Employee's Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse or surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

Send all notices or other information required by this Summary Plan Description in writing to:

UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when your coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow them 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before their termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

- For Retired Employees and Dependents of Retired Employees only: If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries may elect COBRA continuation coverage for the following maximum periods, subject to all COBRA regulations. The covered Retired Employee may continue COBRA coverage for the rest of their life. The covered spouse or surviving spouse or the Dependent Child of the covered Retired Employee may continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose their special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with their HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.

- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).

- A reduction in work hours of the covered Employee.

- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for their spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

- The covered former Employee becomes enrolled in Medicare.

- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS
2404 N UNIVERSITY AVE
LITTLE ROCK AR 72207

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider’s balance bill.

PROVIDER NETWORK

Applies to all Classic Plans With or Without SmartCare

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see a SmartCare or In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **SmartCare or In-Network** benefit levels that are listed on the Schedule of Benefits:

  Classic with UnitedHealthcare Choice Plus and Smartcare

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. **The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any**.

- **The program for Transplant Services at Designated Transplant Facilities is:**

  OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network provider.

- Covered services provided by a Physician or surgeon during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- If there is no In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50-mile radius of the Covered Person's residence, the Covered Person may be eligible to receive In-Network benefits from an Out-of-Network provider. In this situation, Your In-Network Physician will notify the claims administrator, who will work with You and Your In-Network Physician to coordinate care through an Out-of-Network provider. Contact UMR Customer Service and they will direct You on how to set up an out-of-network provider exception.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior Claims Administrator but which are not considered at the In-Network benefit level by the current Claims Administrator may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous Network but who is not a member of the Plan's current Network in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care or six months for mental health office services. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post-acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

- Undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;
- Pregnant and being treated; or
- Terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.

2. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

3. **Allergy Treatment** including: injections, testing and serum.

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

   Coverage for triage, treatment, and transport to an alternative destination if the ambulance service is coordinating the care through telemedicine.

5. **Anesthetics and Their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below.)

7. **Autism Spectrum Disorders (ASD) Treatment.**

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

   Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

8. **Bariatric Surgical Procedures** are covered with the criteria below:

   - A Body Mass Index (BMI) above 40 kg/m2 without co-morbidity; **or**
   - A BMI of 35 kg/m2 or greater with obesity-related co-morbid medical conditions including:
     - Hypertension
     - Cardiopulmonary condition
     - Sleep apnea
     - Diabetes
     - Any life threatening or serious medical condition that is weight induced
   - Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program, such as Weight Watchers or Jenny Craig; **and** within the 12 month period immediately prior to the request for the surgical treatment have completed one structured physician-supervised diet program of no less than six months duration and including all of the following:
     - Documentation in the medical record of the participation by the physician (a physician's summary letter is not sufficient)
     - No weight gain during the program
     - Behavior modification supervised by a qualified professional
     - Consultation with and participation in a reduced-calorie diet program supervised by a dietician or nutritionist
     - Exercise regimen (unless contraindicated)
   - Completion of a psychological examination of the member's readiness and fitness for surgery and the necessary postoperative lifestyle changes.
   - The covered surgical procedures will be performed only at INN facilities accredited under ACS, ASMBS and MBSAQIP.
   - Procedures identified as experimental and investigations are excluded.
   - Plan coverage is limited to one procedure and one revision per lifetime.
   - Cosmetic procedures are excluded.

   Bariatric Surgery is only allowed at accredited facilities and by accredited surgeons.

   Coverage of surgical treatment of morbid obesity is limited to adults 18 years of age or older.

   Absolute contraindications, which should be considered during prior authorization process, include patients with active substance abuse. A signed physician statement indicating that the patient is substance free is recommended. The following conditions should be considered relative contraindications to bariatric surgery: Major mental disorders, such as schizophrenia, uncontrolled depression, active suicidal ideation or personality disorders can interfere with the ability to comprehend informed consent for bariatric surgery and/or to comply with the recommended post-surgical follow-up. A variety of serious illnesses could be exacerbated by caloric restriction, including anorexia nervosa or bulimia nervosa.

9. **Biofeedback Services.**

10. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

11. **Breast Reductions** if Medically Necessary.

12. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

13. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.

14. **Cardiac Rehabilitation** programs, if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Covered services include:

    - Phase I, cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II, cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

15. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

16. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

17. **Cleft Palate And Cleft Lip,** including Medically Necessary oral surgery and pre-graft palatal expanders.

18. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

19. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

20. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

21. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

22. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.

23. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

24. **Durable Medical Equipment** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the UMR CARE section of this SPD, if applicable.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits may be payable for subsequent repairs including batteries, except over the counter batteries, if obtained from a Durable Medical Equipment provider or replacement only if required:
        - due to the growth or development of a Dependent Child;
        - when necessary because of a change in the Covered Person’s physical condition; or
        - because of deterioration caused from normal wear and tear.

      The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse, misuse, loss, or theft, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
    - This Plan covers insulin pumps and supplies.
    - This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

25. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

26. **Emergency Services Provided in a Foreign Country,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or physician services in a Provider’s office, as shown in the Schedule of Benefits.

27. **Expanded Preventive List for Specific Chronic Conditions:** The following services will be covered when diagnosed with specific chronic conditions as indicated below and not covered under the Prescription Drug Benefits section of this SPD.

    - Antiresorptive therapy for the diagnosis of osteoporosis and/or osteopenia.
    - Beta-blockers for the diagnosis of congestive heart failure.
    - Blood pressure monitor for the diagnosis of hypertension.
    - Retinopathy screening, glucometer, and hemoglobin A1C testing for the diagnosis of diabetes.
    - Peak flow meter and inhaled corticosteroids for the diagnosis of asthma.
    - International normalized ratio (INR) testing for the diagnosis of liver disease and/or bleeding disorders.
    - Low-density lipoprotein (LDL) testing for the diagnosis of heart disease.
    - Beta-blockers for the diagnosis of coronary artery disease.

28. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the UMR CARE section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

29. **Eye Refractions** if related to a covered medical condition.

30. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

31. **Genetic Counseling** based on Medical Necessity.

32. **Genetic Testing** when Medically Necessary (see below).

    Genetic Testing MUST meet the following requirements:

    The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

    And must meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicate a genetic cause.
    - The patient meets defined criteria that place them at high genetic risk for the condition.

    Generally, genetic testing is not covered for:

    - Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies.
    - Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing).
    - Test is considered Experimental or Investigational.

33. **Growth Hormones** when billed by a medical provider or facility. Prior authorization is required. Growth hormones are covered under the drug plan when obtained through a pharmacy.

34. **Hearing Services** include:

    - Exams, tests, services and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.
    - Implantable hearing devices.

35. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

36. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Bereavement Counseling** benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

37. **Hospital Services (Includes Inpatient Services, Surgical Centers And Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private and private room and board services:
        - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
        - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

    Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

38. **Hospital Services (Outpatient).**

    Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

39. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person. Food and formula, regardless of the method, is covered for PKU.

40. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

    Infertility services related to egg donors will be limited to Medically Necessary labs, diagnostic and retrieval services and will apply to the member's lifetime maximum. Donor services are subject to Coordination of Benefits and this Plan will pay secondary to any donor insurance plan.

    This coverage would include the following benefits:

    - Associated IVF prescription drugs
    - Artificial insemination
    - Gamete intrafallopian tube transfer (GIFT)
    - Intracytoplasmic sperm injections (ICSI)
    - Medical costs for the extraction of donor sperm and eggs but not the costs of purchasing, preserving, and storing sperm, eggs, and embryos.
    - Genetic testing to diagnose infertility.

    Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

41. **IVIG Therapy** for PANS/PANDAS when it is a pediatric diagnosis to comply with State of Arkansas mandate for coverage.

42. **Ketamine IV for Depression.** Patient must show treatment-resistance in: (a) have on their profile at least 2 different antidepressant strategies; (b) 2 different augmentation strategies for 6 weeks each.

43. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

44. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

45. **Massage Therapy.** (See Therapy Services below)

46. **Marriage Counseling** that is part of a behavioral health treatment plan.

47. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care
    - Postnatal care.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.

    Special additions for maternity management allows a nurse to act as advisor and maternal/newborn specialist. This allows one-on-one coaching and information and can:

    - Discuss health history, including diet and exercise routines.
    - Identify and assess potential pregnancy risk factors.
    - Discuss ways to minimize risks for mother and baby.
    - Answer questions and provide information on pregnancy and Childcare issues.
    - Contact Physician to coordinate care.
    - Provide education and support related to labor and delivery.
    - Identify community resources for additional information and support.

48. **Mental Health Treatment** (Refer to Behavioral Health section of this SPD).

49. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

50. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

51. **Nutritional Counseling and Weight Management Program** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

    - Level 1 Preventive – nutritional counseling with a registered dietician. In-Network service only and accessed by contacting the network Hospital and speaking to a dietician.
    - Level 2 nutritional counseling weight loss (prior authorization required) – Individuals who have BMI of 27 or greater.
    - Level 3 metabolic weight loss (prior authorization required) – Individuals who have a BMI of 30 or greater are eligible for reimbursement of the cost of metabolic weight loss programs. The weight management program must be under the direction of a Physician, with documentation through a Physician attestation form.

    The Covered Person must pay for the Physician's supervised weight loss program up front and then submit a claim for reimbursement. The Plan will not reimburse the provider directly.

    This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions of this SPD.

52. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

53. **Occupational Therapy.** (See Therapy Services below)

54. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.

55. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

56. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, custom molded shoe inserts and braces.

57. **Oxygen And Its Administration.**

58. **Pharmacological Medical Case Management** (Medication management and lab charges).

59. **Physical Therapy.** (See Therapy Services below)

60. **Physician Services** for covered benefits.

61. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

62. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

63. **Preventive Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under the applicable law:

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
    - Well-Woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

        - Screening for gestational diabetes;
        - Human papillomavirus (HPV) DNA testing;
        - Counseling for sexually transmitted infections;
        - Counseling and screening for human immune-deficiency virus; and
        - Screening and counseling for interpersonal and domestic violence.
        - Breast cancer genetic test counseling (BRCA) for women at high risk.

    Please visit the following links for additional information:

    https://www.healthcare.gov/preventive-care-benefits/
    https://www.healthcare.gov/preventive-care-benefits/children/
    https://www.healthcare.gov/preventive-care-benefits/women/.

64. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

65. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

    - Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and
    - Cardiovascular disease (cardiac/stroke) that is not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
    - Surgical musculoskeletal disorders of the spine, hip and knees, that are not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
    - Other diseases or disorders that are not life threatening for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below.

    Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

    Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

    Benefits are only reimbursable as directed by the Patient Protection and Affordable Care Act. Experimental or investigational services are not typically reimbursed under this Plan but considered as part of the clinical trial sponsored by the manufacturer or principle.

    Travel expenses will be reimbursed while the member is participating in an approved Qualifying Clinical Trial center of excellence or tertiary facility. All travel expenses must be pre-approved. The reimbursement will follow the same guidelines as the transplant travel reimbursement**.**

    Routine patient care costs for Qualifying Clinical Trials may include:

    - Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
    - Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
    - Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

    Routine costs for clinical trials do not include:

    - The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
    - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
    - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

66. **Radiation Therapy and Chemotherapy.**

67. **Radiology and Interpretation Charges.**

68. **Reconstructive Surgery** includes:

- Following a mastectomy (Women's Health and Cancer Rights Act)
  The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly resulting in a functional defect or impairment of a Child, Accident, or from an infection or other disease of the involved part.

69. **Respiratory Therapy.** (See Therapy Services below)

70. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

71. **Sleep Disorders** if Medically Necessary.

72. **Sleep Studies.**

73. **Speech Therapy.** (See Therapy Services below)

74. **Sterilizations.**

75. **Substance Use Disorder Services** (Refer to Behavioral Health section of this SPD).

76. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

77. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician. Consultations made by a Covered Person to a Physician.

78. **Telemedicine.** (Provided by UAMS HealthNow.)

79. **Temporomandibular Joint Disorder (TMJ) Services** includes:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

80. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT), or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
    - **Aquatic therapy** by a Qualified physical therapist (PT), Qualified Aquatic Therapist (AT), or other Qualified Provider, if applicable.
    - **Massage therapy** by a Qualified chiropractor, a Qualified massage therapist (MT), Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

81. **Treatment for Acquired Head Injury.**

82. **Tobacco Addiction:** Preventive / Routine benefits as required by applicable law and diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.

83. **Transplant Services** (Refer to Transplant section of this SPD).

84. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

85. **Vision Care Services** (Refer to Vision Care section of this SPD).

86. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician, or other Qualified Provider, if applicable.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a Qualified therapist, or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person’s Covered Expenses when the donor’s own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by MedImpact Healthcare Systems, Inc. and EBRx

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

The University of Arkansas System uses MedImpact Healthcare Systems, Inc. and UAMS EBRx as the Prescription Benefit Manager (PBM) to administer the Prescription Drug Program for individuals who are covered under the Plan.

You may obtain the Summary of Benefits for the Prescription Drug Program that details covered drugs, exclusions, pre-authorizations, and other programs by going to Your campus human resources' webpage, contacting Your campus human resources' personnel, or by contacting MedImpact Healthcare Systems, Inc. at 800-788-2949 or EBRx at 833-650-0475.

Delivery of High-Cost Medications

The Plan will evaluate prescription services for certain covered high-cost medications and, when significant savings may be achieved, may redirect delivery of the medications through the University's UAMS facilities and providers. When redirected, Plan coverage for the medication will be available only through UAMS, based upon prescription by a UAMS physician located at the UAMS Little Rock, Arkansas campus. Reasonable Member out-of-pocket expenses for prescription related travel to UAMS will be reimbursed by the Plan, and co-payments and facility charges for UAMS physician services and pharmacy services related to the prescription will be waived by the Plan.

Prescription Medication Benefit

With enrollment in the University's Medical Benefit Plan, You will automatically be enrolled in prescription drug coverage. Your contribution to the cost of Your prescription drug coverage is included in the premium You pay for medical coverage. Your prescription drug benefit provides coverage for retail, specialty and mail order prescriptions and medication-related supplies.

Most prescription medications require a fixed copayment (coinsurance in the Health Savings Plan) and You will be required to meet the annual pharmacy deductible before medications are covered with no out-of-pocket cost to You. However, certain preventive drugs and immunizations will be made available to You at no cost.

The pharmacy provider network and pharmacy benefits are administered by MedImpact (MI), the University's Pharmacy Benefits Manager (PBM). Pharmacy Prior Authorization review, Step Therapy, Quantity Limits, and appeals and exceptions are administered through the UAMS EBRx program.

Prescription Drug Benefit Questions

Contact MedImpact at **800-788-2949 or mp.medimpact.com/uas**

MedImpact can assist You with:

- Coverage information
- Locating a participating pharmacy
- Claims processing and payment questions
- Submitting claims, if necessary
- Checking the status of a claim
- Questions on formulary placement, medications covered, excluded, alternative covered medications and medications provided at no cost to You
- Mail order options

Drug Coverage Information
Contact EBRx at **501-214-2156 or 833-650-0475**

EBRx can assist You with:

- Prior authorization and Step Therapy requirements
- Quantity Limits in place
- Formulary exclusions and alternative medications available
- Appeals and exception request on the pharmacy formulary
- Appeals and exceptions procedures and options

Benefits-at-a-Glance

The following charts provide an overview of the benefits under the prescription drug program effective on and after January 1, 2023:

Classic Plan, Pharmacy Benefits	
Tier 1 Medications	$18 copayment
Tier 2 Medications	$62 copayment
Tier 2 Medications	$97 copayment
Pharmacy Out-Of-Pocket Maximum (separate from medical)	$1,900 Individual $3,800 Family

Premier Plan, Pharmacy Benefits	
Tier 1 Medications	$14 copayment
Tier 2 Medications	$57 copayment
Tier 2 Medications	$92 copayment
Pharmacy Out-Of-Pocket Maximum (separate from medical)	$1,900 Individual $3,800 Family

Health Savings Plan, Pharmacy Benefits

Medical deductible then 10% coinsurance to Medical Out-Of-Pocket Maximum.

The pharmacy plan design including the formulary of covered and excluded medications, network access, specialty distribution and no-cost preventive medications and immunizations is uniform across all three health plan election options. A medication covered in the Classic Plan is also covered in the Premier and Health Savings Plans.

As a convenience, Mail Order and 90-Day Prescription Supplies are available for some medications. Members pay three copayments for 90-day supplies.

Preventive Medicines Under the Affordable Care Act

The Affordable Care Act requires health plans to cover certain items and services, including certain drugs, in-network with no cost sharing. This is true even if You have not met Your deductible (if applicable). Examples of Affordable Care Act preventive items and services include certain vaccines and contraceptives. For a complete list of medications required to be covered under the Affordable Care Act, contact MedImpact customer service. Sometimes, certain preventive items and services that are required to be covered by the Affordable Care Act may be covered by the medical plan instead of the prescription drug plan.

What is Not Covered

The prescription drug plan does not pay benefits for every type of medication, prescription drug, supply, or device and does not provide coverage for medications available without a prescription (OTC). The MedImpact website provides information on medications, supplies, and devices that are covered and excluded from coverage. Visit mp.medimpact.com/uas.

Your Rights to Appeal

You and Your physician have the opportunity to appeal formulary coverage and exclusion decisions as well as Prior Authorization and Step Therapy requirements and decisions. First level requests for appeal or exception should be directed to EBRx. Should Your first level request not be determined in Your favor, You may request a second-level appeal through the University System. In some cases, an opportunity for third level appeal through an independent review organization may be available and the Plan will provide access to that third level review at no cost to You. EBRx will serve as the contact for and will coordinate second and third level appeal or review requests.

VISION CARE BENEFITS

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Participation amount, maximums and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, or the Negotiated Rate.

COVERED BENEFITS

- Eye exam.
- Refraction.
- Contact lenses are not covered, as they are for vision correction, and vision correction is not a covered service. Services for prescribing and fitting contact lenses are not covered.
- When contact lenses are for treatment of a disease other than vision disturbance, or for replacement of the lens of the eye, they may be covered.
- Standard Intraocular lenses (IOC) implants are covered as a basic medical service.
- Hydrophylic (soft) contact lenses are covered as a prosthetic when they are prescribed for an aphakia (loss of natural lens) due to surgical removal (cataract extraction) or congenital absence, unless otherwise stated in the member's contract.
- Hydrophylic (soft) contact lenses that are part of a treatment plan (used as a moist corneal bandage in the treatment of acute or chronic pathology) are covered as a supply incidental to physician services. Examples: corneal ulcers, keratitis, bullous keratopathy, and other diseases.
- Hard plastic contact lenses are covered for a post-cataract patient only if there was no intraocular lens implanted, and are limited to soft contact lenses as noted above.
- Long-term vision correction is covered for a post-cataract patient only if there was no intraocular lens implanted, and is limited to soft contact lenses as noted above. Replacement lenses for the above covered indications will be covered when there is a change in Prescription that in the opinion of a plan Physician necessitates obtaining new contacts. Contacts prescribed as a prosthetic or bandage will also be replaced when the life expectancy of the product has expired. Replacement shall not be covered for lost, damaged, misused, or abused contact lenses.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
  - Lenticular.
- Frames.
- Elective Contacts.
- Safety lenses and frames.
- Eye surgeries used to improve/correct eyesight for refractive disorders including lasik surgery, radial keratotomy, refractive keratoplasty or similar surgery.
- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a Physician or optometrist.
- Vision therapy services (including orthoptics) or supplies.
- Correction of visual acuity or refractive errors.
- Aniseikonia.

NOTE: THE UNIVERSITY SYSTEM OFFERS A SEPARATE VISION BENEFIT. PLEASE SEE YOUR CAMPUS HUMAN RESOURCE PERSONNEL FOR INFORMATION ON THE VISION BENEFITS.

BEHAVIORAL HEALTH BENEFITS

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment (Prior Authorization required) means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).]

Day Treatment (Partial Hospitalization) (Prior Authorization required) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

NOTE: Refer to Services Requiring Prior Authorization for additional information.

SUBSTANCE USE DISORDER BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Substance Use Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).]

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment and must be affiliated with a facility outpatient day program.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment, and all counseling or therapy notes, and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis.

NOTE: Refer to Services Requiring Prior Authorization for additional information.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and at the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. In general, when the Covered Person receives services from a Managed Care UnitedHealthcare Network Provider or facility, the provider or facility is responsible for obtaining the Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Managed Care UnitedHealthcare Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Managed Care UnitedHealthcare Network Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service clinical approval is on file). If it is not a Managed Care UnitedHealthcare Network Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Notes: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible through the umr.com portal, by phone, or by fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

When certain medical or prescription expenses exceed or are projected to exceed $75,000 members may be contacted by UMR for referral.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Managed Care UnitedHealthcare Network Providers are providers participating in any UnitedHealthcare Network product with the exception of Options PPO.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization at the number on the back of Your ID card or complete a Prior Authorization search at www.umr.com **before** a Covered Person receives services for the following:

- Inpatient stay in a Hospital, Extended Care Facility or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics over $1,500 or any Durable Medical Equipment rentals over $500.
- Prosthetics over $1,000.
- Qualifying Clinical Trials.
- Dialysis.
- Medical Specialty Drug / Specialty Injectables Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit Specialty Injectable | UMR for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug / Specialty Injectables list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions. (Also see General Exclusions for additional information.)
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Bariatric Surgery.
- Inpatient admissions – urgent or emergent admissions including those directly from the Physician's office require Prior Authorization within 72 hours of admission.
- Physician supervised Level III non-surgical weight loss. Must have BMI of 30 or greater.
- Proton Therapy.
- Genetic testing.
- Outpatient spinal procedures / back procedures including but not limited to:
  - Vertebroplasty.
  - Kyphoplasty.
  - Total Disk Arthroplasty – cervical or lumbar.
  - Intervertebral disk prosthesis.
  - Radio Frequency Ablation Codes

- Non-emergent outpatient diagnostic imaging services:
  - MRI
  - MRA
  - PET
  - CT
  - CTA
  - EBCT
  - Nuclear imaging
- The following injectables and/or drugs require Prior Authorization; however, this is not an all-inclusive list:
  - Synargis.
  - Growth hormone.
  - Imfinzi.
- Specific Outpatient surgeries:
  - Abortions.
- All infertility services require prior authorization excluding diagnostics and labs.

  UMR to approve MRI Bone Marrow Testing, when performed at UAMS, with the following criteria:

  - Must have a diagnosis for which BMT is being considered;
  - Must be done in relation to a BMT/stem cell transplant workup. Refer to Case Management.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount a Covered Person may be required to pay if an authorization has not been completed prior to receiving certain services or prior to admissions as defined in this section. A penalty of $250 may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case management. Opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

The goal of Case Management is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review may be conducted upon request or at the Plan's discretion, and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

CARE PROVISIONS

CARE Cues

CARE Cues features a digital solution for clinical gaps in care, including care for behavioral health and Substance Use Disorders. The CARE Cues program is integrated into a Covered Person's umr.com portal with notifications sent to the Covered Person's email that include next best action education and prompts to close the gap(s) in care.

There are over 150 digital gaps in care, including missed wellness / preventative opportunities, duplicative treatment, treatment disparities, condition management, immunizations, chronic condition drug interactions, and more. The email notifications will be offered to those Covered Persons with viable email addresses on file.

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers review available clinical information from utilization activity and other available resources to identify anticipated member needs. Collaboration with the member, caregiver, and provider is initiated to coordinate care in order to address gaps and barriers with the goal of reducing readmissions and/or complications. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and Substance Use Disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

Ongoing Condition CARE

Ongoing Condition CARE identifies those individuals who have certain ongoing conditions and would benefit from this program. Specially trained CARE nurses work telephonically with Covered Persons to help close gaps in care and improve self-management of their condition(s). Program participants are identified through predictive modeling. Our unique approach to Ongoing Condition CARE identifies individuals with one of the following 23 targeted conditions:

- Neuromuscular / Autoimmune Disorders: Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Rheumatoid Arthritis
- Cardiovascular Disorders: Hypertension, Heart Failure (HF), Coronary Artery Disease (CAD)
- Respiratory Disorders: Asthma (Adult and Pediatric), Chronic Obstructive Pulmonary Disease (COPD)
- Behavioral Health Disorders: Depression and General Anxiety Disorder (GAD is a comorbidity)
- Blood Disorders: HIV, Hepatitis C, Sickle Cell Anemia
- Gastrointestinal Disorders: Ulcerative Colitis, Crohn's Disease
- Oncology: Breast, Prostate, Colorectal, Lung
- Endocrine Disorders: Diabetes: Type 1 and Type 2 (Adult and Pediatric)
- Genitourinary Disorders: Chronic Kidney Disease (CKD)

Maternity CARE

Maternity CARE provides pre-pregnancy/pregnancy education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term Hospital stays for both mothers and babies. Program members are contacted by CARE nurses at least once each trimester and once postpartum. This program also offers an educational call and materials specifically to assist the participant's support person.

UMR's pre-pregnancy support program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, face risks not only to their babies, but also to themselves while they are pregnant.

Members can self-enroll in the Maternity CARE program by calling our toll-free number or enrolling online at www.umr.com. They are then contacted by CARE nurses who have extensive clinical backgrounds in obstetrics/gynecology.

Beyond the standard incentive for enrolling in Maternity CARE, you are also eligible to receive an incentive reward for your engagement and completion of the program. To become eligible, you must:

- Enroll during your first or second trimester;
- Remain engaged in the program during the entire pregnancy; and
- Complete the post-partum call and survey.

After completion of these requirements the eligible participant will receive a $300 gift card mailed to their home address.

Wellness CARE

Components of Wellness CARE are as follows:

Tobacco and Nicotine Coaching Program: The UMR Tobacco and Nicotine Coaching Program connects the participant with an experienced and certified personal CARE coach who assists in the development of a quit plan and establishment of specific reduction or cessation goals and strategies. In addition, the participant will receive printed educational materials.

UMR's Health Center

UMR's online Health Center is designed to help keep Covered Persons healthy by addressing lifestyle health issues and assisting in preventing chronic conditions such as diabetes and heart disease. It provides information and tools to help Covered Persons reach and maintain good health.

Health Center may include the following components:

- **Wellness Activity Center**, where participants go online to view specific employer wellness program information and access applications such as the health risk assessment, action plans, and reminder messages.

- **Message Center:** A secure message center that allows the participant to ask questions and receive answers via secure online messaging with a health expert.

- **Clinical Health Risk Assessment (CHRA):** A Covered Person may complete a CHRA and receive immediate results and personalized feedback on how to reduce specific health risks. Upon completion, the participant receives access to a printable CHRA Summary Report to share with his or her Physician.

- **Action Plans:** Action plans are interactive tools that educate and motivate participants to make gradual lifestyle changes that lead to sustainable improvements in health behavior. Action plans may be delivered as self-learning modules or may be assigned by CARE coaches to enhance programs.

- **Personal Health Record (PHR):** In the Personal Health Record participants can create, store, and manage health information all in one central location. The health records grow as participants' needs grow. Participants can also access the PHR online at any time or print a report for medical office visits and Emergency events.

Additional CARE Provisions

Real Appeal Program: This Plan provides the Real Appeal Program, which represents a practical solution for weight-related conditions, with the goal of helping individuals at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support Covered Persons over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live, virtual coach. The experience will be personalized for each participant though an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Co-pays, Plan Participation, or Deductibles that need to be met when services are received as part of the Real Appeal Program. If Covered Persons would like to participate, or would like any additional information regarding the program, they can visit the Real Appeal website at Coach.WeRally.com.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

(Applies to Classic Non-SmartCare, Classic SmartCare, Premier SmartCare) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

(Applies to Health Savings Plan and Qualified High Deductible Health Plan) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

Eligible disabled participants, eligible retirees and eligible Dependents of retirees Medicare-eligible will be provided enrollment opportunity in the University of Arkansas UnitedHealth Care Group Medicare Advantage (PPO) Plan and are not eligible to continue in the University of Arkansas Medical Benefit Plan. In accordance with Medicare regulations, participants who are Medicare-eligible but who are also End-Stage Renal Disease patients are eligible to continue in the University of Arkansas Medical Benefit Plan. The following section addresses the order of benefits for those participants.

(Applies to Classic Non-SmartCare, Classic SmartCare, Premier SmartCare) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

(Applies to Health Savings Plan and Qualified High Deductible Health Plan) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

Physicians and other health care providers and facilities not participating in Medicare are not required to follow the Medicare fee schedules and may balance bill the Covered Person for services. In these cases, the Plan will still pay only that part it would have paid if the provider had been a Medicare provider. The Covered Person will be responsible for all remaining amounts.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstance:

    - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstance:

    - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are allegedly related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You are made whole by receiving a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity against whom You may have any claim arising out of any alleged wrongful or bad faith conduct by such person or entity.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.

- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, no matter how those proceeds are allocated, captioned, characterized, or classified, and regardless of the theory of recovery. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, bad faith, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery by You or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to a Dependent Child who allegedly incurs an Illness or Injury caused by a third party and to the parents, guardian, or other representative of that Dependent Child. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect from third party recoveries held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence. However, The Plan will not cover any treatment or supplies for work related injury, condition or disease.

1. **Abdominoplasty.**

2. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

3. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

4. **Acupuncture Treatment.**

5. **Alcohol:** Services, supplies, care or treatment to a Covered Person for an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol for which the person has been arrested. The arresting officer's determination of intoxication will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in this Plan.

6. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

7. **Appointments Missed:** An appointment the Covered Person did not attend.

8. **Assistance With Activities of Daily Living.**

9. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

10. **Augmentation Communication Devices** and related instruction or therapy.

11. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.

12. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

13. **Blood:** Blood donor expenses.

14. **Breast Pumps** unless covered elsewhere in this SPD.

15. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

16. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

17. **Claims** received later than twelve months from the date of service.

18. **Conditions Listed** in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases – Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:

    - Personality disorders; or
    - Behavior and impulse control disorders; or
    - "V" codes refer to Marriage Counseling within the Covered Medical Benefits section of this SPD.

19. **Contraceptive Products and Counseling** unless covered elsewhere in this SPD.

20. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

21. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan.

22. **Custodial Care** as defined in the Glossary of Terms of this SPD.

23. **Dental Services,** unless covered elsewhere in this SPD.

24. **Developmental Delays:** Medical charges and occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy.

25. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

26. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.

27. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

28. **Examinations:** Examinations for employment, insurance, licensing, litigation purposes or adoption.

29. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, or the Negotiated Rate. This exclusion does not apply to payments that may be required under the No Surprises Act.

30. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

31. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

32. **Financial Counseling**.

33. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

34. **Foot Care (Podiatry):** Routine foot care, unless covered elsewhere in this SPD.

35. **Foreign Coverage for Medical Care Expenses Which Includes Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency**,** except for Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.

36. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery.

37. **Genetic Counseling** other than based on medical Necessity unless covered elsewhere in this SPD.

38. **Genetic Testing** unless covered elsewhere in this SPD.

39. **Growth Hormones,** unless covered elsewhere in this SPD.

40. **Home Births** and associated costs.

41. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

42. **Illegal Drugs or Medications:** Services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan.

43. **Immigration Physicals** and all ancillary charges.

44. **Infant Formula** not administered through tube as the sole source of nutrition for the Covered Person other than for the diagnosis of PKU.

45. **Infertility Treatment:**

    - Services related to the reversal of any sterilization procedure regardless of the reason for the sterilization are not covered.
    - Costs for services rendered to a surrogate.
    - Costs of purchasing, preserving, and storing sperm, eggs, and embryos.
    - Costs for an egg or sperm donor which are not medically necessary.
    - Experimental treatments.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

46. **Lamaze Classes** or other childbirth classes.

47. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for the primary diagnosis of a Learning Disability, including Developmental Delays on Speech Therapy, Physical Therapy and Occupational Therapy. If another medical or behavioral/mental health condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

48. **Liposuction** regardless of purpose.

49. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

50. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

51. **Marriage Counseling,** unless covered elsewhere in this SPD.

52. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

53. **Medical Specialty Medications / Specialty Injectables excluded from the plan:**

Excluded, Effective 1/1/2022:
- Zolgensma (onasemnogene abeparvovec-xioi)
- Makena (Hydroxyprogesterone caproate)
- Scenesse (afamelanotide)
- Sarclisa (isatuximab)
- Jemperli (Dostarlimab-gxly)
- Rybrevant (amivantamab-vmjw)
- Zynlonta (loncastuximab tesirine-lpyl)

Excluded, Effective 4/1/2022:
- Fyarro (sirolimus protein-bound particles [albumin-bound])
- Nexviazyme (avalglucosidase alfa-ngpt)
- Susvimo (ranibizumab)

Excluded, Effective 7/1/2022:
- Stelara *(*Ustekinumab)
- Stelara IV *(*Ustekinumab)

Excluded, Effective 9/1/2022:
- Ketamine (ketamine hydrochloride):
  - Unless for treatment resistant depression

Excluded, Effective 4/1//2023
- Abecma (Idecabtagene vicleucel)
- Breyanzi (lisocabtagene maraleucel)
- Nulibry (Fosdenopterin)
- Oxlumo (Lumasiran)
- Reblozl (luspatercept-aamt)
- Margenza (margetuximab-cmkb)
- Tivdak (tisotumab-tftv)
- Tepezza (teprotumumab-trbw)

Excluded, Effective 3/14//2024
- Relyvrio

Excluded, Effective 4/01//2025
- Alhemo
- Aucatzyl
- Hympavzi Pen
- Kebilidi
- Vyalev
- Ziihera

54. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

55. **Morbid Obesity Treatment**, unless covered elsewhere in this SPD. Refer to the Glossary of Terms for a definition of Morbid Obesity.

56. **Nocturnal Enuresis Alarm.**

57. **Non-Custom-Molded Shoe Inserts.**

58. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

59. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

60. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

61. **Nutritional Counseling,** unless covered elsewhere in this SPD.

62. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

63. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

64. **Palliative Foot Care.**

65. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

66. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

67. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like, unless otherwise required by applicable Arkansas law or other applicable law or regulation.

68. **Preventive Care Services** unless covered elsewhere in this SPD and recommended by the United States Preventative Task Force.

69. **Private Duty Nursing Services.**

70. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

71. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

74. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion. This includes care and prescription medications provided for self or for immediate family members.

75. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

76. **Services** that should legally be provided by a school.

77. **Services Provided by a Close Relative,** unless covered elsewhere in this SPD. See Glossary of Terms of this SPD for definition of Close Relative.

78. **Sex Therapy.**

79. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, leading to or maintaining, sex transformation surgery.

80. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence unless as a result of disease, condition or complication of surgical procedure.

81. **Standby Surgeon Charges.**

82. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

83. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

84. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.

85. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

86. **Travel:** Travel costs, unless covered elsewhere in this SPD.

87. **Vision Care** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

88. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

89. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

90. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

91. **Weight Control**, unless covered elsewhere in this SPD. Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

92. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

93. **Workers' Compensation:** Health care services for which other coverage is required by federal, state, or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than twelve months from the date of service. Where Medicare or Medicaid paid as primary in error, the Plan will follow that federal agencies guidelines. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.

- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Persons who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.

- The Covered Person may submit written comments, documents, records and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative) or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review medical or pharmacy denials of a requested service or procedure (other than a predetermination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fail to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR (MEDICAL)
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

MEDIMPACT HEALTHCARE SERVICES (PHARMACY)
10181 SCRIPPS GATEWAY CT
SAN DIEGO CA 92131
ATTN: APPEALS COORDINATOR
OR
FAX 858-790-6060

EBRX
501-214-2156 OR 833-650-0475
ATTN: EVIDENCE-BASED PRESCRIPTION DRUG PROGRAM (EBRX)
C/O UAMS COLLEGE OF PHARMACY
4301 W. MARKHAM ST., SLOT #522
LITTLE ROCK AR 72205
PHONE: (833) 650-0475
FAX: (877) 540-9036

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four (4) months of the date You receive the Adverse Benefit Determination. You, or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- all other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence You or Your Physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on Your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.
- Notify the Plan when an event such as divorce or dependent reaches age 26 occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact Your campus Human Resource Administrator for information on processing Qualified Medical Child Support.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).
- 1557 Non Discrimination.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how the University of Arkansas Health and Dental Plans may collect, use and disclose Your protected health information, and Your rights concerning Your protected health information.

"Protected health information" (PHI) is information about You, including demographic information collected from You, that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health or condition, the provision of health care to You or the payment for that care.

We are required to maintain the privacy of Your protected health information and to provide You this notice about our legal duties and privacy practices. We must follow the privacy practices described in this notice while it is in effect. A version of this notice was originally provided in 2003 and was effective April 14, 2003. This updated notice is effective September 23, 2013 and reflects changes made by the Final Rule under the Health Insurance Portability and Accountability Act generally referred to as HIPAA.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures for Payment and Health Care Operations. The University of Arkansas Health and Dental Plans do not disclose Protected Health Information unless required by law. However, we do use Protected Health Information for payment and for health care operations.

Payment: We will use Your protected health information to administer Your health benefits policy, which may involve the determination of eligibility; claims payment; utilization review and care management; Medical Necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. We may also use protected health information for purposes of premium billing, and the determination of premium rates and co-payments, deductibles, co-insurance and other cost sharing amounts.

Health Care Operations: We will use Your protected health information to support other business activities, including the following:

- Health claims analysis.
- Premium determination and administration of reinsurance.
- Risk management.
- Transfer of eligibility and plan information to business associates (for example, Pharmacy Benefit
- Management -PBM's- for the management of pharmacy benefits).
- Other general administrative activities, including data and information systems management and customer service.

We will not disclose protected health information to any University of Arkansas Employee unless required by law. We will, however, provide minimal protected information necessary to allow payroll to pay the monthly premium for Your group health enrollment (for example, name, identification number, and family coverage status).

Other Permitted or Required Uses and Disclosures of Protected Health Information.

The University of Arkansas Health and Dental Plans will not disclose Protected Health Information unless required by law. We may disclose Your protected health information in the following additional situations without Your authorization:

Others Involved in Your Healthcare: Unless You request Restriction or Confidential Communication, we may disclose to Your spouse (or Your parent if You are a Dependent child), the Protected Health Information directly related to payment for health care services. Otherwise, we will not disclose Your Protected Health Information regarding health care to Your spouse, Your family (except for parents of Dependents covered under the plan), a relative, a close friend, or any other person without Your signed authorization explicitly directing us to do so. If You are present for such a disclosure (whether in person or on a telephone call), we will either seek Your verbal agreement to the disclosure or provide You an opportunity to object to it. We may also make such disclosures to the persons described above in situations where You are not present or You are unable to agree or object to the disclosure, if we determine that the disclosure is in Your best interest. We may also disclose Your protected health information to an authorized public or private entity to assist in disaster relief efforts.

Unless our administrator (UMR, MedImpact, EBRx or Arkansas Blue Cross) is given an alternative address, Your explanation of benefits forms and other mailings containing protected health information will be sent to the address on record for the subscriber of the health benefits plan. Separate mailings for enrolled Dependents of the subscriber will not be done, unless requested through the administrator by Confidential Communications described in this notice. If available, this also pertains to the claims information contained electronically and available via secured Internet access and corresponding telephonic claims sites.

If You would not like us to share any information in any of the foregoing manners with any particular individuals or organizations, please call the appropriate number listed on page 4 of this document.

REQUIRED BY LAW

We may use or disclose Your protected health information to the extent we are required to do so by law.

Public Health: We may disclose Your protected health information to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as controlling disease, injury or disability. In addition, we may make disclosures to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Abuse or Neglect: We may make disclosures to government authorities concerning abuse, neglect or domestic violence.

Health Oversight: We may disclose Your protected health information to a government agency authorized to oversee the healthcare system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.

Legal Proceedings: We may disclose Your protected health information in the course of any legal proceeding, in response to an order of a court or administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose Your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, Funeral Directors and Organ Donation: We may disclose Your protected health information in certain instances to coroners, funeral directors and in connection with organ donation.

Research: We may disclose Your protected health information to researchers, provided that certain established measures are taken to protect Your privacy.

Threat to Health or Safety: We may disclose Your protected health information to the extent necessary to avert a serious and imminent threat to Your health or safety or to the health or safety of others.

Military Activity and National Security: We may disclose Your protected health information to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

Correctional Institutions: If You are an inmate in a correctional facility, we may disclose Your protected health information to the correctional facility for certain purposes, including the provision of health care to You or the health and safety of You or others.

Workers' Compensation: We may disclose Your protected health information to the extent required by workers' compensation laws.

Uses and Disclosures of Protected Health Information with an Authorization. Other uses and disclosures of protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization being revoked.

Many members ask us to disclose their protected health information to third parties for reasons not described in this notice. For example, elderly members often ask us to make their records available to caregivers. The administrator of the group Health and Dental Plans maintains this information. To authorize us to disclose any of Your protected health information to a person or organization for reasons other than those described in this notice, please call the appropriate number listed on page 4 of this document and You will be provided the appropriate authorization and address to submit the form. You may revoke the authorization at any time by sending a letter to the same address. Please include Your name, address, member identification number and a telephone number where we can reach You. A revocation is not effective until it is actually received by us.

MEMBER RIGHTS

The following is a brief statement of Your additional rights with respect to Your protected health information:

Right to Request Restrictions: You have the right to ask us to place restrictions on the way we use or disclose Your protected health information for treatment, payment or healthcare operations or as described in the section of this notice entitled "Others Involved in Your Healthcare." However, we are not required to agree to these restrictions. If we do agree to a restriction, we may not use or disclose Your protected health information in violation of that restriction, unless it is needed for an emergency. All requests for restrictions should be submitted to the administrator of our group Health and/or Dental Plans.

Confidential Communications: We will accommodate reasonable requests to communicate with You about Your protected health information by alternative means or to alternative locations. For example, if You are covered under a Health and/or Dental Plan as an adult Dependent (e.g., a spouse or a child attending college) and You want us to send correspondence that contains protected health information to a different address from the subscriber we can accommodate that request. We may ask You to make Your confidential communication request in writing. All requests for confidential communications should be submitted to the administrator of our group Health and/or Dental Plans.

Access to Protected Health Information: You have the right to receive a copy of protected health information about You that is contained in a "designated record set", with some specified exceptions. A "designated record set" means a group of records that are used by or for us to make decisions about You, including enrollment, payment, claims adjudication and case or medical management records. Any request to access protected health information should be directed to the administrator of our group Health and/or Dental Plans.

You may be asked to request access to copies of Your records in writing and to provide the specific information needed to fulfill Your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. More information on our fee structure is available by contacting our group Health and Dental Plan administrators at the addresses provided below.

Amendment of Protected Health Information: You have the right to ask us to amend any protected health information about You that is contained in a "designated record set" (see above). All requests for amendment must be in writing to our group Health and/or Dental Plan administrators. In certain cases, we may deny Your request. For example, we may deny a request if we did not create the information, as is often the case for medical information in our records. All denials will be made in writing. You may respond by filing a written statement of disagreement with us, and we would have the right to rebut that statement. If You believe someone has received inaccurate protected health information from us, You should inform us at the time of the request if You want him or her to be informed of the amendment.

Accounting of Certain Disclosures: You have the right to have us provide You an accounting of times when we have disclosed Your protected health information for any purpose other than the following: (a) payment or health care operations; (b) as described in the section of this notice entitled "Others Involved in Your Healthcare"; (c) disclosures that You or Your personal representative has authorized; or (d) certain other disclosures, such as disclosures for national security purposes. All requests for an accounting must be in writing to the administrator of our group Health and Dental Plans. We will require You to provide us the specific information we need to fulfill Your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003. If You request this accounting more than once in a 12-month period, we may charge You a reasonable fee. More information is available on our fee structure by contacting us at the address provided below.

Final HIPAA Rule: Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act generally referred to as the HIPAA Final Rule, are as follows:

- You have the right to be notified of a data breach relating to Your unsecured health information.
- You have the right to ask for a copy of Your electronic medical record in an electronic form provided the information already exists in that form.
- To the extent the Plan performs any underwriting; the Plan cannot disclose or use any genetic information for such purposes.
- The Plan may not use Your PHI for marketing purposes or sell such information without Your written authorization.
- The Plan will not use or disclose psychotherapy notes without an authorization.

Contact Information for Exercising Member Rights: You may exercise any of the rights described above by contacting, in writing, the Privacy Official at the following addresses.

University of Arkansas Group Health & Dental Plans
University of Arkansas System Administration
Benefit and Risk Management Services
Privacy Officer
2404 North University Avenue
Little Rock, AR 72207
Phone: 501-686-2942

Group Health Plan Administrator
UMR, Inc.
Customer Service Department
P.O. Box 30541
Salt Lake City, UT 84130-0541
Phone: 888-438-6105

Pharmacy Benefits Manager
MedImpact Healthcare Systems, Inc.
Customer Service Department
10680 Treena Street, 5th Floor
San Diego, CA 92131-2446
Phone: 800-788-2949

Group Dental Plan Administrator

BlueCross BlueShield

Customer Service Department

P.O. Box 15965
North Little Rock, AR 72231
Phone 844-662-2284

EBRx

501-214-2156 or 833-650-0475

Attn: Evidence-Based Prescription Drug Program (EBRx)

c/o UAMS College of Pharmacy

4301 W. Markham St., Slot #522

Little Rock, AR 72205

Phone: (833) 650-0475

Fax: (877) 540-9036

CHANGES TO PRIVACY PRACTICES

We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain. We redistribute a new Notice of Privacy Practices whenever we make a material change in our privacy practices described in our notice.

QUESTIONS AND COMPLAINTS

If You have any questions about this notice or would like an additional copy of the notice, please contact the University of Arkansas Group Health and Dental Plans Privacy Officer at the above number or Your campus Human Resources/Personnel Office.

If You are concerned that Your privacy rights may have been violated, please contact the University of Arkansas Group Health & Dental Plans Privacy Officer at the above number. You also have the right to complain to the Secretary of Health and Human Services. We will not retaliate against You for filing a complaint. If You have any questions about the complaint process, including the address of the Secretary of Health and Human Services, contact the University of Arkansas Group Health and Dental Plans Privacy Officer at the above number.

PLAN AMENDMENT AND TERMINATION INFORMATION

The University fully intends to maintain this Plan indefinitely; however, the University through action by the President reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits or contributions required under this Plan. Amendments may be applicable to all participants or specific classes. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or

Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; a foster Child for whom the Employee is legally responsible; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes a husband or wife, birth or adoptive parent, Child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee, Retiree or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible means the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Eligible Retiree means an Eligible Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of seventy (70) and immediately prior to retirement has completed ten (10) or more consecutive years of continuous coverage under the Plan or an Eligible Employee who retires while covered under the Plan and on the date of retirement is age 65 or older and immediately prior to retirement: has completed five (5) or more consecutive years of service with the UA and has five (5) or more consecutive years of continuous coverage under the Plan or who has retired under an early retirement agreement approved by THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS. Eligible spouse and dependent participants of an eligible retiree are those eligible participants upon the date of retirement. Following separation from employment, new enrollment of an eligible spouse or of eligible dependent participants is available only upon marriage, birth, or adoption. Enrollment due to loss of other coverage or due to other change events is not available. Eligible retirees who become Medicare-eligible while participating in the University of Arkansas Medical Benefit Plan or who are Medicare-eligible upon retirement will be provided enrollment opportunity in the University of Arkansas-sponsored Group Medicare Advantage (PPO) Plan. Medicare-eligible retirees and Medicare-eligible Dependents of eligible retirees are not eligible to continue in the University of Arkansas Medical Benefit Plan. Medicare Primary Retirees must carry both Medicare Parts A & B for full coverage. Please contact Your campus Human Resources Office for information on the Group Medicare Advantage Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition that is likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications / Specialty Injectables (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications / Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, Substance Use Disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, Substance Use Disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and

- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means any disease or condition that falls under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopment disorders in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body Mass Index (BMI) of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the “Essential Health Benefit” definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a Doctor of Medicine (MD), Doctor of Dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT). Subject to the limitations below, the term 'Physician' shall also include the following practitioner types: a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA) when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the UNIVERSITY OF ARKANSAS Medical Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to Health Savings Plan and Qualified High Deductible Health Plan) For a High Deductible Health Plan, Preventive / Routine Care means care consistent with IRS Code Section 223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a High Deductible Health Plan (HDHP) without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (e.g., those that work out of a family practice clinic), pediatrician, obstetrician/gynecologist, mental health/Substance Use Disorder providers and geriatric. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered and/or in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

SmartCare is available to University Employees and Retiree participants and their eligible Dependents who receive care from a university provider at a university facility. All services covered by the Plan are not available or eligible for SmartCare. SmartCare is located at UAMS facilities which are staffed by UAMS providers, at the UALR Employee Health Clinic and at the Fayetteville Pat Walker Health Center.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder providers.

Substance Use Disorder means any disease or condition that falls under the diagnostic categories as a mental or behavioral disorder due to psychoactive substance use listed in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease – Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - "V" codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You / Your means the Employee.