**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
**What is the overall deductible?** | Network: $1,750 Individual/$3,500 Family  
Out-of-Network: $3,500 Individual/$7,000 Family per calendar year. Individual amounts do not apply if 2 or more people are covered. Deductible includes medical and pharmacy combined. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. 
This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/).

**Are there services covered before you meet your deductible?** | Yes. Preventive care is covered before you meet your deductible. | 

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | Network: $3,750 Individual/$7,500 Family  
Out-of-Network: $7,000 Individual/$14,000 Family Per calendar year. Individual amounts do not apply if 2 or more people are covered. Out of pocket includes medical and pharmacy combined. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain preauthorization for services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Will you pay less if you use a network provider?

Yes. See myuhc.com or call 1-844-634-1237 for a list of network providers.

This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?

No.

You can see the specialist you choose without a referral.

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Virtual care - 15% coinsurance by a Designated Virtual Network Provider.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>35% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri.
## If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at [http://www.express-scripts.com/curators/universityofmissouri](http://www.express-scripts.com/curators/universityofmissouri)

| Tier 1 – Your Lowest Cost Option | Retail and Mail Order: 15% coinsurance | Retail: 35% coinsurance |
| Tier 2 – Your Mid-Range Cost Option | Retail and Mail Order: 15% coinsurance | Retail: 35% coinsurance |
| Tier 3 – Your Mid-Range Cost Option | Retail and Mail Order: 15% coinsurance | Retail: 35% coinsurance |
| Tier 4 – Your Highest Cost Option | Retail and Mail Order: 15% coinsurance | Retail: 35% coinsurance |

### Mail-Order
- Up to 90-day supply with mail order prescription.
- 90-day supply can be filled at retail if a University of Missouri pharmacy is used. Mail Order copay/coinsurance will apply.

**Specialty**
- 31-day limit on all specialty medications.
- First fill can be made at any pharmacy, but all subsequent fills must be made through a Mizzou Specialty Pharmacy or Accredo specialty pharmacy.
- Please see “Important Questions” regarding the plan’s out-of-pocket limit.

Certain drugs may have a preauthorization requirement or may result in a higher cost.

Certain preventive medications (including certain contraceptives) are covered at No Charge.

If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.

### If you have outpatient surgery

| Facility fee (e.g., ambulatory surgery center) | Retail: 15% coinsurance | Retail: 35% coinsurance |
| Physician/surgeon fees | Retail: 15% coinsurance | Retail: 35% coinsurance |

Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.

**None**

### If you need immediate medical attention

| Emergency room care | Retail: 15% coinsurance | *15% coinsurance |
| Emergency medical transportation | Retail: 15% coinsurance | *15% coinsurance |
| Urgent care | Retail: 15% coinsurance | Retail: 35% coinsurance |

Virtual care - 15% coinsurance by a Designated Virtual Network Provider.

*For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universityofmissouri*
<table>
<thead>
<tr>
<th>If you have a hospital stay</th>
<th>Facility fee (e.g., hospital room)</th>
<th>15% coinsurance</th>
<th>35% coinsurance</th>
<th>Preauthorization is required out-of-network or benefit reduces by $500.00.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need mental health, behavioral health, or substance abuse services</th>
<th>Outpatient services</th>
<th>15% coinsurance</th>
<th>35% coinsurance</th>
<th>Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are pregnant</th>
<th>Office visits</th>
<th>15% coinsurance</th>
<th>35% coinsurance</th>
<th>Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces by $500.00.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs</th>
<th>Home health care</th>
<th>15% coinsurance</th>
<th>35% coinsurance</th>
<th>Preauthorization is required out-of-network or benefit reduces by $500.00.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
<td>Limits per calendar year: Physical / Occupational/ Speech: combined limit 60 visits per calendar year; Cardiac: 36 visits per 12-week period; Pulmonary: 36 visits per 12-week period; Post-Cochlear Implant Aural Therapy: 30 visits per calendar year.</td>
</tr>
<tr>
<td>Habilitative services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
<td>Services are provided under and limits are combined with Rehabilitation Services above.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
<td>Limited to 90 days per calendar year (combined with inpatient rehabilitation) for semi-private room. Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
<td>Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces by $500.00.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
<td>Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces by $500.00.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [whyuhc.com/universitymissouri](http://whyuhc.com/universitymissouri)
<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children’s eye exam</th>
<th>Not Covered</th>
<th>Not Covered</th>
<th>No coverage for Children’s eye exam.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>No coverage for Children’s glasses.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>No coverage for Children’s Dental check-up.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |
|---|---|---|
| Acupuncture                      | Glasses                      | Routine foot care – Except as covered for Diabetes |
| Cosmetic surgery                 | Infertility treatment       | Routine eye care |
| Dental care                       | Long-term care              | |

| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.) |
|---|---|---|
| Bariatric surgery                | Hearing aids                | Private duty nursing |
| Chiropractic (Manipulative care) – 26 visits per calendar year | Non-emergency care when travelling outside - the U.S. | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-287-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri
To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**About these Coverage Examples:**

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

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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

**Total Example Cost:** $12,700

**In this example, Peg would pay:**
- Deductibles: $1,750
- Copayments: $0
- Coinsurance: $1,643

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is:** $3,453

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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

**Total Example Cost:** $5,600

**In this example, Joe would pay:**
- Deductibles: $1,750
- Copayments: $0
- Coinsurance: $578

**What isn’t covered**
- Limits or exclusions: $30

**The total Joe would pay is:** $2,358

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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

**Total Example Cost:** $2,800

**In this example, Mia would pay:**
- Deductibles: $1,750
- Copayments: $0
- Coinsurance: $158

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is:** $1,908

---

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC_Civil_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)
**Mail:** Civil Rights Coordinator, UnitedHealthcare Civil Rights Grievance, P.O. Box 30608 Salt Lake City, Utah 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
**Complaint forms are available at** [http://www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).
**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)
**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

---

**ATENCIÓN:** Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC)內所列的免付費電話號碼。

**XIN LUΥ Y:** Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đại thao bảo hiểm (Summary of Benefits and Coverage, SBC) này.
PAUNAWA: Kung nagpasala ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ATANTAN: Sei w paile Kreyòl ayisyen (Haitian Creole), ou kapab beneficiye sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATTENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: In caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all’interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زیانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پروتکل مانس بگیرید. (Summary of Benefits and Coverage, SBC)

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निष्कल्प उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टॉल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev gab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntaw Ntuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ပြင်သစ်ပါသည်။ သင်များသည် Khmer (ကလေးတိုင်း) သို့သောလောကတော်ဆိုင်ရာလေးဝါးသည် တွင်ပါသည်။

မြန်မာပြင်ပါသည်။ Khmer (ကလေးတိုင်း) သို့သောလောကတော်ဆိုင်ရာလေးဝါးသည် တွင်ပါသည်။

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNZIN: Diné (Navajo) bizaad bee yáni'ti'go, saad bee áka'anida'awo'íí, t'áá ji{l'eh, bee ná'ahóó'tí'. Taá shqo'dí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ák'ëasti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá ji{l'ehgo béésh bee hane'i biká'íííi bee hodiínih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac hambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).