### Important Questions and Answers

| **What is the overall deductible?** | **Network:** $500 Individual / $1,500 Family  
**Out-of-Network:** $1,000 Individual / $3,000 Family Per calendar year.  
**Why This Matters:** Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
|---|---|
| **Are there services covered before you meet your deductible?** | **Yes. Preventive care** is covered before you meet your deductible.  
**Why This Matters:** 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 other deductibles for specific services?** | **Yes. Retail Prescription drugs:** $75 per person.  
**Why This Matters:** You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **Network:** $3,750 Individual / $7,500 Family  
**Out-of-Network:** $11,250 Individual / $22,500 Family Per calendar year.  
**Pharmacy:** $5,200 Individual / $10,400 Family. Per calendar per year.  
**Why This Matters:** The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | **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 pharmacy out-of-pocket limits.**  
**Why This Matters:** Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</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></td>
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</tbody>
</table>
| Primary care visit to treat an injury or illness  | Designated Network: $15 copay per visit, deductible does not apply.  
Network: $30 copay per visit, deductible does not apply. | 40% coinsurance  | Designated Network consists of Tier 1 providers who have been designated as meeting quality and cost measures and all oncologists. Virtual care - $30 copay per visit by a Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| Specialist visit                                  | Designated Network: $35 copay per visit, deductible does not apply.  
Network: $45 copay per visit, deductible does not apply. | 40% coinsurance  | Designated Network consists of Tier 1 providers who have been designated as meeting quality and cost measures and all oncologists. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. |
| Preventive care/screening/immunization            | No Charge                                      | 40% coinsurance  | 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. |

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri
<table>
<thead>
<tr>
<th>If you have a test</th>
<th>Designated Network: 10% coinsurance</th>
<th>40% coinsurance</th>
<th>Designated Network consists of non-hospital affiliated free standing facility, office, or outpatient center. Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network: 20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Designated Network: 10% coinsurance</td>
<td>40% coinsurance</td>
<td>Designated Network consists of free standing facility, office or outpatient center. Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
</tr>
<tr>
<td></td>
<td>Network: 20% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you need drugs to treat your illness or condition

| Tier 1 – Your Lowest Cost Option – Formulary Generic | Retail: Non-Maintenance: greater of $10 copay or 20% coinsurance | 50% co-insurance, minimum $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge. |
| Tier 2 – Your Mid-Range Cost Option – Formulary Brand | Retail: Non-Maintenance: greater of $30 copay or 25% coinsurance | 50% co-insurance, minimum $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge. |
| Tier 3 – Your Mid-Range Cost Option – Non-Formulary Brand | Retail: Non-Maintenance: greater of $50 copay or 50% coinsurance | 50% co-insurance, minimum $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge. |
| Tier 4 – Your Highest Cost Option – Specialty Drugs | Formulary Generic at retail: 20% coinsurance | 50% coinsurance, minimum. $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge. |

If you have outpatient surgery

| Facility fee (e.g., ambulatory surgery center) | Designated Network: 10% coinsurance Network: 20% coinsurance | 40% coinsurance |
| Physician/surgeon fees | Designated Network: 10% coinsurance Network: 20% coinsurance | 40% 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 Accredo specialty pharmacy or a Mizzou 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.

Facility fee (e.g., ambulatory surgery center)

Designated Network consists of non-hospital affiliated free standing facility, office or outpatient center. Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.

Physician/surgeon fees

Designated Network consists of Tier 1 providers who have been designated as meeting quality and cost measures and all oncologists.

More information about prescription drug coverage is available at [http://www.express-scripts.com/curatorsuniversityofMissouri](http://www.express-scripts.com/curatorsuniversityofMissouri)
| If you need immediate medical attention | Emergency room care | **$250 copay per visit** | **$250 copay per visit** | Copay is waived if patient is admitted. *Network deductible applies first. Must meet emergency criteria.*
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical transportation</td>
<td><strong>$200 copay per transport</strong></td>
<td><strong>$200 copay per transport</strong></td>
<td><em>Network deductible applies first. Must meet emergency criteria.</em></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td><strong>$50 copay per visit, deductible does not apply.</strong></td>
<td>40% coinsurance</td>
<td>Virtual care - $25 copay per visit by a Virtual Network Provider, deductible does not apply. If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a hospital stay</th>
<th>Facility fee (e.g., hospital room)</th>
<th>10% coinsurance</th>
<th>40% coinsurance</th>
<th>Preauthorization is required out-of-network or benefit reduces by $500.00.</th>
</tr>
</thead>
</table>
| Physician/surgeon fees | Designated Network: 10% coinsurance  
Network: 20% coinsurance | 40% coinsurance | Designated Network consists of Tier 1 providers who have been designated as meeting quality and cost measures and all oncologists. |

<table>
<thead>
<tr>
<th>If you need mental health, behavioral health, or substance abuse services</th>
<th>Outpatient services</th>
<th><strong>$45 copay per visit, deductible does not apply.</strong></th>
<th>40% coinsurance</th>
<th>Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces by $500.00.</td>
<td></td>
</tr>
</tbody>
</table>

| If you are pregnant | Office visits | Designated Network:  
$35 copay initial visit only, deductible does not apply.  
Network:  
$45 copay per visit, deductible does not apply. | 40% coinsurance | Designated Network consists of Tier 1 providers who have been designated as meeting quality and cost measures and all oncologists.  
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.) |
| --- | --- | --- | --- | --- |
| Childbirth/delivery professional services | Designated Network:  
10% coinsurance  
Network:  
20% coinsurance | 40% coinsurance | Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces by $500.00. |
| Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | --- | --- |

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Cardiac and Pulmonary:</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>All other therapies:</td>
<td>$45 copay per visit, deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Habilitative services</td>
<td>Cardiac and Pulmonary:</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>All other therapies:</td>
<td>$45 copay per visit, deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri
Excluded Services & Other Covered Services:

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

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

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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:
Navajo (Dine): Dinek'ehgo shika at'ohwl ninisingo, kwiijigo holne’  1-855-828-7715.

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

* For more information about limitations and exceptions, see the plan or policy document at whyuhc.com/universitymissouri
### 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**: $500
- **Specialist copay**: $45
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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

- **Deductibles**: $500
- **Copayments**: $45
- **Coinsurance**: $1,220
- **What isn’t covered**: $60
- **The total Peg would pay is**: $1,825

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

- **The plan’s overall deductible**: $500
- **Specialist copay**: $45
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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

- **Deductibles**: $500
- **Copayments**: $135
- **Coinsurance**: $510
- **What isn’t covered**: $30
- **The total Joe would pay is**: $1,175

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

- **The plan’s overall deductible**: $500
- **Specialist copay**: $45
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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

- **Deductibles**: $500
- **Copayments**: $540
- **Coinsurance**: $230
- **What isn’t covered**: $0
- **The total Mia would pay is**: $1,270

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
**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.

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**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).

**越南語:** 如果您說越南文(Vietnamese)，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。

**Chinese:** 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。
알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagpasalita 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).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чьё родной язык является русскому (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis 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).

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (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).

ATENÇÃO: 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 Benefiti 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.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリー・ダイヤルにてお電話ください。
توجه: اگر زبان شما فارسی است، خدمات امداد زیانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره‌شماره رایگان ذکر شده در این خلاصه مذاکه و پرداخت.

Summary of Benefits and Coverage (SBC)