



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-634-1237 or visit <https://exploreuhcplans.com/universityofmissouri>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$800 Individual / \$2,400 Family <u>Out-of-Network</u> : \$1,600 Individual / \$4,800 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Retail Prescription drugs. \$75 per person.	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 <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$3,750 Individual / \$7,500 Family <u>Out-of-Network</u> : \$11,250 Individual/ \$22,500 Family Per calendar year. Pharmacy: \$6,850 Individual/ \$13,700 Family. Per calendar per year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.

Will you pay less if you use a <u>network provider</u>?	Yes. See myuhc.com or call 1-844-634-1237 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Virtual care - \$25 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces by \$500.00.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces by \$500.00.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition \$75 per person annual deductible for retail More information about prescription drug coverage is available at http://www.express-scripts.com/curatorsuniversityofmissouri	Tier 1 – Your Lowest Cost Option – Formulary Generic	Retail: Non-Maintenance: greater of \$10 copay or 20% coinsurance Maintenance: greater of \$15 copay or 25% coinsurance Mail-Order: greater of \$20 copay or 20% coinsurance (no deductible)	50% coinsurance, minimum \$30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge	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 <u>copay/coinsurance</u> will apply. Specialty 31-day limit on all specialty medications. - Specialty prescriptions are managed and processed through ArchimedesRx. - Please see “Important Questions” regarding the plan’s <u>out-of-pocket limit</u>. Certain drugs may have a <u>preauthorization</u> 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 <u>copay</u> and/or <u>coinsurance</u> may be applied.
	Tier 2 – Your Mid-Range Cost Option – Formulary Brand	Retail: Non-Maintenance: greater of \$30 copay or 25% coinsurance Maintenance: greater of \$40 copay or 30% coinsurance Mail-Order: greater of \$60 copay or 25% coinsurance (no deductible)	50% coinsurance, 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 Maintenance: greater of \$60 copay or 55% coinsurance Mail-Order: greater of \$100 copay or 50% coinsurance (no deductible)	50% coinsurance, 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 Formulary Brand at Retail: 25% coinsurance Non-Formulary Brand at Retail: 50% 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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces by \$500.00.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	*\$250 <u>copay</u> per visit	*\$250 <u>copay</u> per visit	Copay is waived if patient is admitted. * <u>Network deductible</u> applies first. Must meet emergency criteria.
	<u>Emergency medical transportation</u>	*20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies first. Must meet emergency criteria.
	<u>Urgent care</u>	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply.	Virtual care - \$20 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces by \$500.00.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces by \$500.00.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces by \$500.00.
If you are pregnant	Office visits	\$40 <u>copay</u> initial visit only, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces by \$500.00.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces by \$500.00.
	<u>Rehabilitation services</u>	Cardiac and Pulmonary: No Charge All other therapies: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	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.

	<u>Habilitative services</u>	Cardiac and Pulmonary: No Charge All other therapies: \$40 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 days per calendar year (combined with inpatient rehabilitation) for semi-private room. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces by \$500.00
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or benefit reduces by \$500.00.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces benefit reduces by \$500.00.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
- Acupuncture - Cosmetic surgery - Dental care	- Glasses - Long-term care	- Routine eye care - Routine foot care – Except as covered for Diabetes
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
- Bariatric Surgery - Chiropractic (Manipulative care) – 26 visits per calendar year	- Hearing aids - Non-emergency care when travelling outside - the U.S.	- Infertility treatment – lifetime limits apply - Private duty nursing

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-828-7715.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-828-7715.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-828-7715.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-828-7715.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$800	■ The plan's overall deductible	\$800	■ The plan's overall deductible	\$800
■ Specialist copay	\$40	■ Specialist copay	\$40	■ Specialist copay	\$40
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$800	<u>Deductibles</u>	\$800	<u>Deductibles</u>	\$800
<u>Copayments</u>	\$40	<u>Copayments</u>	\$120	<u>Copayments</u>	\$480
<u>Coinsurance</u>	\$2,400	<u>Coinsurance</u>	\$1,320	<u>Coinsurance</u>	\$220
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$30	Limits or exclusions	\$0
The total Peg would pay is	\$3,300	The total Joe would pay is	\$2,270	The total Mia would pay is	\$1,500

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