UnitedHealthcare

PPO Retiree Health Plan

Coverage for: Employee & Family | **Plan Type:** PS1

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 deductible?	Network: **$1,700** Individual / **$5,100** Family Out-of-Network:**$4,400** Individual/ **$13,200** Family Per calendar year.	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.	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/.
Are there other deductibles for specific services?	Yes. Retail Prescription Drugs. **$75** per person.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$5,100** Individual / **$10,200** Family Out-of-Network: **$8,800** Individual / **$17,600** Family Per calendar year. Pharmacy: **$3,800** Individual / **$7,600** Family Per calendar year.	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	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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	40% coinsurance	Virtual care - 30% coinsurance by a Designated Virtual Network Provider.
	Specialist visit	30% coinsurance	40% coinsurance	None
	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network or benefit reduces by $500.00.

* For more information about limitations and exceptions, see the plan or policy document at umurl.us/SPD.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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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 $10 copay or 25% coinsurance Mail-Order: greater of $20 copay or 20% coinsurance (no deductible.)	50% co-insurance, 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 copay/coinsurance 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 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.
	Tier 2 – Your Mid-Range Cost Option – Formulary Brand	Retail: Non-Maintenance: greater of $30 copay or 25% coinsurance Maintenance: greater of $20 copay or 30% coinsurance Mail-Order: greater of $60 copay or 25% coinsurance (no deductible.)	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 Maintenance: greater of $40 copay or 55% coinsurance Mail-Order: greater of $100 copay or 50% coinsurance (no deductible)	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 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)	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	*30% coinsurance	*Network deductible applies. Must meet emergency criteria.
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies. Must meet emergency criteria.
	Urgent care	30% coinsurance	40% coinsurance	Virtual care - 30% coinsurance by a Designated Virtual Network Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$325 copay per admission, then 30% coinsurance	40% coinsurance	Preauthorization is required out-of-network or benefit reduces by $500.00. Limited to one copay per 60-day period for the same diagnosis.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces by $500.00.
	Inpatient services	$325 copay per admission, then 30% coinsurance	40% coinsurance	Preauthorization is required out-of-network or benefit reduces by $500.00.
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	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	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$325 copay per admission, then 30% coinsurance	40% coinsurance	Inpatient preauthorization applies out-of-network 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	Home health care	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network or benefit reduces by $500.00.
	Rehabilitation services	30% coinsurance	40% coinsurance	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.
	Habilitative services	30% coinsurance	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	$325 copay per admission, then 30% coinsurance	40% coinsurance	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.
	Durable medical equipment	30% coinsurance	40% coinsurance	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
	Hospice services	30% coinsurance	40% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care	• Glasses • Infertility treatment • 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 plan document.)		
• Bariatric surgery • Chiropractic (Manipulative care) – 26 visits per calendar year	• Hearing aids • Non-emergency care when travelling outside - the U.S.	• 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, 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 umurl.us/SPD.

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	$1,700
Specialist coinsurance	30%
Hospital (facility) copay	$325
Other coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$325
Coinsurance	$3,232.50
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,317.50**

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

The plan's overall deductible	$1,700
Specialist coinsurance	30%
Hospital (facility) copay	$325
Other coinsurance	30%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$1,710
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$3,440**

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

The plan's overall deductible	$1,700
Specialist coinsurance	30%
Hospital (facility) copay	$325
Other coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,760**

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