### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | SLUCare $0 Individual / $0 Family  
Network $500 Individual/$1,000 Family  
Non-Network: $750 Individual / $1,500 Family  
Does not apply to copays, prescription drugs, and services listed below as "No Charge".  
Per calendar year. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there other deductibles for specific services?** | No. There are no other deductibles. | You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | SLUCare $0 Individual / $0 Family  
Network $1,500 Individual/$3,000 Family  
Non-Network: $4,750 Individual / $9,500 Family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premium, balance-billed charges, health care this plan doesn’t cover, and penalties for failure to obtain pre-notification for services, prescription drug copays. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| **Is there an overall annual limit on what the insurer pays?** | No. This policy has no overall limit on the amount it will pay each year. | The Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call 1-800-382-4259 for a list of network providers. | If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn’t cover?** | Yes. | Some of the services this plan doesn’t cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-800-382-4259 or visit us at welcometouhc.com. If you aren’t clear about any of the terms used in this form, see the Glossary.

You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy. **This is only a summary.** It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.
- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, co-payments and co-insurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</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>SLUCare: $10 copay per visit 10% co-ins 40% co-ins</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>SLUCare: $20 copay per visit 10% co-ins 40% co-ins</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>N/A 10% co-ins per Manipulative (Chiropractic) visit 40% co-ins per Manipulative (Chiropractic) visit</td>
<td>Limited to 26 visits of Manipulative (Chiropractic) services per calendar year</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge               No Charge No Charge</td>
<td>Includes preventive health services specified in the health care reform law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>N/A 10% co-ins 40% co-ins</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>N/A 10% co-ins 40% co-ins</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLUCare</td>
<td>Network Provider</td>
</tr>
<tr>
<td></td>
<td>Tier 1 – Your Lowest-Cost Option</td>
<td>N/A</td>
<td>Retail: $8 copay per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mail-Order: $16 copay per prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 2 – Your Midrange-Cost Option</td>
<td>N/A</td>
<td>Retail: $30 copay per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mail-Order: $60 copay per prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 3 – Your Highest-Cost Option</td>
<td>N/A</td>
<td>Retail: $50 copay per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mail-Order: $100 copay per prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 4 – Additional High-Cost Options</td>
<td>N/A</td>
<td>Retail: 20% co-ins to a maximum of $150</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about drug coverage is at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>N/A</td>
<td>10% co-ins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>N/A</td>
<td>10% co-ins</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>N/A</td>
<td>$100 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>10% co-ins</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>N/A</td>
<td>$50 copay per visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>N/A</td>
<td>10% co-ins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>N/A</td>
<td>10% co-ins</td>
</tr>
</tbody>
</table>
# Summary of Benefits and Coverage: What This Plan Covers & What it Costs

**Saint Louis University Plus Plan**

**Coverage Period:** 01/01/2014 – 12/31/2014

**Coverage for:** Employee + Family

**Plan Type:** PS1

## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 copay per visit</td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>$10 copay per visit</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>N/A</td>
<td>10% co-ins Global Maternity copay</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Home health care</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$10 copay per outpatient visit</td>
<td>10% co-ins per outpatient visit</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$10 copay per outpatient visit</td>
<td>10% co-ins per outpatient visit</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
<tr>
<td>Hospice service</td>
<td>N/A</td>
<td>10% co-ins per visit</td>
</tr>
</tbody>
</table>

## If you have mental health, behavioral health, or substance abuse needs

- **Mental/Behavioral health outpatient services:**
  - **SLUCare:** $10 copay per visit
  - **Network Provider:** 10% co-ins per visit
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** None

- **Mental/Behavioral health inpatient services:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Pre-Notification is required non-network.

- **Substance use disorder outpatient services:**
  - **SLUCare:** $10 copay per visit
  - **Network Provider:** 10% co-ins per visit
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** None

- **Substance use disorder inpatient services:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Pre-Notification is required non-network.

## If you become pregnant

- **Prenatal and postnatal care:**
  - **Network Provider:** 10% co-ins Global Maternity copay
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Additional co-pays, deductibles or co-insurance may apply. Routine pre-natal care is covered at No Charge.

- **Delivery and all inpatient services:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Additional copays, deductible, co-insurance or Notification may apply.

## If you have a recovery or other special health need

- **Home health care:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Limited to 60 days per calendar year. Pre-Notification is required non-network.

- **Rehabilitation services:**
  - **Network Provider:** 10% co-ins per outpatient visit
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Depending on the type of therapy, there is a limit of 36-60 visits per calendar year.

- **Habilitation services:**
  - **Network Provider:** 10% co-ins per outpatient visit
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Pre-Notification is required non-network.

- **Skilled nursing care:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Limited to 60 days per calendar year. Limit is combined with IP Rehabilitation Services. Pre-Notification is required non-network.

- **Durable medical equipment:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** $2,500 maximum per calendar year if the benefit/device is determined to be non-essential. Pre-Notification is required for DME over $1,000. Covers 1 per type of DME (including repair/replacement) every 3 years.

- **Hospice service:**
  - **Network Provider:** 10% co-ins
  - **Non-Network Provider:** 40% co-ins
  - **Limitations & Exceptions:** Inpatient Pre-Notification is required for non-network.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SLUCare</td>
<td>Network Provider</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Hearing aids – may be covered with limitations
- Routine eye care (Adult) – may be covered with limitations
- Habilitation Services

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit [http://www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit [http://www.cciio.cms.gov](http://www.cciio.cms.gov).

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).


Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzhí ninizingo, bee neehozin biniyee nantinigii number bikaa'igii bich'i' hodilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong
### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

#### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,200
- **You pay:** $1,340

**Sample care costs:**
- Hospital charges (mother): $2,700
- Routine obstetric care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $200
- Vaccines, other preventive: $40
- **Total:** $7,540

**Patient pays:**
- Deductibles: $500
- Co-pays: $10
- Co-insurance: $680
- Limits or exclusions: $150
- **Total:** $1,340

---

#### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,290
- **You pay:** $1,110

**Sample care costs:**
- Prescriptions: $2,900
- Medical Equipment & Supplies: $1,300
- Office Visits and Procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100
- **Total:** $5,400

**Patient pays:**
- Deductibles: $500
- Co-pays: $310
- Co-insurance: $220
- Limits or exclusions: $80
- **Total:** $1,110
## Questions and answers about Coverage Examples:

<table>
<thead>
<tr>
<th>What are some of the assumptions behind the Coverage Examples?</th>
<th>What does a Coverage Example show?</th>
<th>Can I use Coverage Examples to compare plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs don’t include premiums.</td>
<td>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.</td>
<td>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.</td>
</tr>
</tbody>
</table>
| Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan. | Does the Coverage Example predict my own care needs?  
✓ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors. | |
| The patient’s condition was not an excluded or preexisting condition. | Does the Coverage Example predict my future expenses?  
✓ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows. | |
| All services and treatments started and ended in the same coverage period. | | ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses. |
| There are no other medical expenses for any member covered under this plan. | | |
| Out-of-pocket expenses are based only on treating the condition in the example. | | |
| The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher. | | |

---

**Questions:** Call 1-800-382-4259 or visit us at welcometouhc.com. If you aren’t clear about any of the terms used in this form, see the Glossary.

You can view the Glossary at [cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf](http://cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.