## Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?**                                      | SLUCare + SSM/UHC Network: $1,500 *Individual / $3,000 Family  
Non-Network: $3,000 *Individual / $6,000 Family  
Per calendar year. Services listed below as "No Charge" do not apply to the deductible.  
*Doesn’t apply if policy covers 2+ people.                                                                 | 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 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 annual deductible amount.                                                                                                          |
| Are there other deductibles for specific services?                      | No.                                                                                                                                                                                                     | You don’t have to meet deductibles for specific services.                                                                                                                                                 |
| **Is there an out-of-pocket limit on my expenses?**                      | SLUCare + SSM Network: $1,500 *Individual / $3,000 Family  
UHC Network: $3,000 *Individual / $6,000 Family  
Non-Network: $6,000 *Individual / $12,000 Family  
*Doesn’t apply if policy covers 2+ people.                                                                 | The **out-of-pocket limit** is the most you could pay in a year for covered services.                                                                                                                   |
| **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.                                                                 | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.                                                                                                                       |
| Does this plan use a network of providers?                               | Yes. See [myuhc.com](http://myuhc.com) or call 1-800-382-4259 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 I need a referral to see a specialist?                                | No.                                                                                                                                                                                                     | You can see the **specialist** you choose without permission from this plan.                                                                                                                             |

**Questions:** Call 1-800-382-4259 or visit us at [welcometouhc.com](http://welcometouhc.com). If you aren’t clear about any of the underlined 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.
## Summary of Benefits and Coverage: What This Plan Covers & What it Costs

### Copayments
- Copayments are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.

### Coinsurance
- Coinsurance 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 **coinsurance** 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, copayments, and coinsurance amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>Routine Preventive care</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Includes preventive services specified under the Affordable Care Act</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 – Your Lowest-Cost Option</td>
<td>Not Covered</td>
<td>Deductible and Co-insurance requirements are waived for certain Preventive medications.</td>
</tr>
</tbody>
</table>

**Common Medical Event Services You May Need**

- **Primary care visit to treat an injury or illness**
- **Specialist visit**
- **Routine Preventive care**
- **Diagnostic test (x-ray, blood work)**
- **Imaging (CT / PET scans, MRIs)**
- **Tier 1 – Your Lowest-Cost Option**
## Summary of Benefits and Coverage: What This Plan Covers & What it Costs

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| More information about prescription drug coverage is available at www.Express-Scripts.com | Tier 2 – Your Midrange-Cost Option

  - Deductible, then
  - Retail: 10% coins
  - Mail-Order: 10% co-ins

Not Covered

Retail: Up to a 34 day supply
Mail-Order: Up to a 90 day supply

Provider means Express Scripts pharmacy for purposes of this section. Your plan uses a preferred drug list which identifies the status of covered drugs.

Some drugs may require prior authorization or step therapy. If not obtained, the drug may not be covered.

See the website listed for information on drugs covered by your plan.

| Tier 3 – Your Highest-Cost Option

  - Deductible, then
  - Retail: 10% coins
  - Mail-Order: 10% co-ins | Not Covered

| Tier 4 – Additional High-Cost Options

  - Deductible, then
  - Retail: 10% coins
  - Mail-Order: 10% co-ins | Not Applicable |

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center)

  - SLUCare + SSM:
    - 0% co-ins after ded.
    - UHC Provider:
    - 10% co-ins after ded. | 40% co-ins after ded. |

Prior authorization may be required at certain non-network providers for certain services

| Physician / surgeon fees

  - SLUCare + SSM:
    - 0% co-ins after ded.
    - UHC Provider:
    - 10% co-ins after ded. | 40% co-ins after ded. |

Prior authorization may be required at certain non-network providers for certain services

| If you need immediate medical attention | Emergency room services

  - SLUCare + SSM:
    - 0% co-ins after ded.
    - UHC Provider:
    - 10% co-ins after ded. | 10% co-ins after ded. |

Network deductible applies

| Emergency medical transportation | 10% co-ins after ded. | 10% co-ins after ded. |

Network deductible applies

| Urgent care | 10% co-ins after ded. | 40% co-ins after ded. |

| If you have a hospital stay | Facility fee (e.g., hospital room)

  - SLUCare + SSM:
    - 0% co-ins after ded.
    - UHC Provider:
    - 10% co-ins after ded. | 40% co-ins after ded. |

Prior Authorization may be required

If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician / surgeon fees</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td></td>
<td>40% co-ins after ded.</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Outpatient Services</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td></td>
<td>Inpatient Services</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Additional copays, deductibles, or co-ins may apply depending on services rendered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of service coinsurance or deductible may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Limits per calendar year: 60 combined visits of physical, speech, occupational, pulmonary therapies and 36 visits for Cardiac Rehabilitation therapy.</td>
</tr>
</tbody>
</table>
# Saint Louis University QHDHP Plan

**Summary of Benefits and Coverage:** What This Plan Covers & What it Costs

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

## Coverage Period:
01/01/2018 – 12/31/2018

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Limits are combined with Rehabilitation Services limits listed above.</td>
</tr>
<tr>
<td>Habilitative services</td>
<td></td>
<td>UHC Provider: 10% co-ins after ded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Limited to 60 days per calendar year</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>UHC Provider: 10% co-ins after ded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>UHC Provider: 10% co-ins after ded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Prior authorization may be required at certain non-network providers for certain services</td>
</tr>
<tr>
<td>Hospice service</td>
<td></td>
<td>UHC Provider: 10% co-ins after ded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td>Limited to 1 exam every year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UHC Provider: 10% co-ins after ded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td></td>
<td>SLUCare + SSM: 0% co-ins after ded.</td>
<td>40% co-ins after ded.</td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for glasses.</td>
<td></td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for dental check-up.</td>
<td></td>
</tr>
</tbody>
</table>

### 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 (Adult/Child)  
- Long-term care  
- Infertility treatment  
- Non-emergency care when traveling outside the U.S.  
- Private-duty nursing  
- Routine foot care  
- Weight loss programs

#### 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.)

- Chiropractic care  
- ABA Therapy
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 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.

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 the Member Service number listed on the back of your ID card or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.


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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-382-4259.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-382-4259.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-382-4259.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-4259.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage Period: 01/01/2018 – 12/31/2018

Saint Louis University QHDHP Plan

Coverage for: Employee & Family

Plan Type: PS1

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.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,310
- Patient pays $2,230

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 $1,500
- Copays $0
- Coinsurance $580
- Limits or exclusions $150

Total $2,230

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

- Amount owed to providers: $5,400
- Plan pays $3,440
- Patient pays $1,960

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

Total $5,400

Patient pays:
- Deductibles $1,500
- Copays $0
- Coinsurance $380
- Limits or exclusions $80

Total $1,960
### 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 <strong>premiums</strong>.</td>
<td>For each treatment situation, the Coverage Example helps you see how <strong>deductibles</strong>, <strong>copayments</strong>, and <strong>coinsurance</strong> 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>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient’s condition was not an excluded or preexisting condition.</td>
<td>Does the Coverage Example predict my own care needs?</td>
<td>Are there other costs I should consider when comparing plans?</td>
</tr>
<tr>
<td>• All services and treatments started and ended in the same coverage period.</td>
<td>✓ <strong>No.</strong> 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.</td>
<td>✓ Yes. An important cost is the <strong>premium</strong> you pay. Generally, the lower your <strong>premium</strong>, the more you’ll pay in out-of-pocket costs, such as <strong>copayments</strong>, <strong>deductibles</strong>, and <strong>coinsurance</strong>. 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.</td>
</tr>
<tr>
<td>• There are no other medical expenses for any member covered under this plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Out-of-pocket expenses are based only on treating the condition in the example.</td>
<td>Does the Coverage Example predict my future expenses?</td>
<td></td>
</tr>
<tr>
<td>• The patient received all care from in-network <strong>providers</strong>. If the patient had received care from out-of-network <strong>providers</strong>, costs would have been higher.</td>
<td>✓ <strong>No.</strong> Coverage Examples are <strong>not</strong> 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 <strong>providers</strong> charge, and the reimbursement your health plan allows.</td>
<td></td>
</tr>
<tr>
<td>• If other than individual coverage, the Patient Pays amount may be more.</td>
<td></td>
<td></td>
</tr>
</tbody>
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