



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 1-800-382-4259 or visit [welcometouhc.com](http://welcometouhc.com). 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/](http://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?	SLU Care & SSM Network: <b>\$500</b> Individual / <b>\$1,000</b> Family Other Participating Provider Network: <b>\$2,000</b> Individual / <b>\$4,000</b> Family. Out-of-Network: <b>\$3,600</b> Individual / <b>\$7,200</b> 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 deductible?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	SLU Care & SSM Network: <b>\$2,700</b> Individual / <b>\$5,400</b> Family. Other Participating Provider Network: <b>\$4,000</b> Individual / <b>\$8,000</b> Family. Out-of-Network: <b>\$9,900</b> Individual / <b>\$19,800</b> Family. Per calendar year. Prescription Drug: <b>\$1,500</b> Individual / <b>\$3,000</b> Family	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 out-of-pocket limit?	<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. Separate out-of-pocket limit for prescription drug benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-800-382-4259 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</u> charge 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 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
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	25% <u>coinsurance</u>	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>Specialist</u> visit	\$40 <u>copay</u> per visit, <u>deductible</u> does not apply	25% <u>coinsurance</u>	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	No Charge	No Charge	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for U.S. <u>out-of-network</u> benefits.

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  <b>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> to learn more.</b>	Rx Out-of-Pocket Limit	\$1,500 Individual / \$3,000 Family			Prescription drug coverage is available through Express Scripts. Preventive Medications are priced according to tier. Maintenance Medications are required to be filled at 90-Day Supply through Express Scripts Mail Order or Walgreens.
	Member Cost Share	Retail (34 Day Supply)	Mail Order (90 Day Supply)		
	Tier 1 – Your Lowest Cost Option	\$10	\$25		
	Tier 2 – Your Mid-Range Cost Option	25% Coinsurance \$30 Min-\$50 Max	25% Coinsurance \$75 Min-\$125 Max		
	Tier 3 – Your Mid-Range Cost Option	50% Coinsurance \$50 Min-\$100 Max	50% Coinsurance \$125 Min-\$250 Max		
	Tier 4 – Your Highest Cost Option	20% Coinsurance \$200 Max	N/A		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services.
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	*25% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$60 <u>copay</u> per visit, <u>deductible</u> does not apply	\$60 <u>copay</u> per visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> .
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services.
	Inpatient services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> .
<b>If you are pregnant</b>	Office visits	No Charge	No Charge	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	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	25% <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).
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> .
	<u>Rehabilitation services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Limits per calendar year: Physical/Occupational/Speech and Pulmonary: combined limit 60 visits; Cardiac: 36 visits
	<u>Habilitative services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required <u>out-of-network</u> .
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000.
	<u>Hospice services</u>	15% <u>coinsurance</u>	25% <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.

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	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> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> <li>• Glasses</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (adult)</li> <li>• Routine foot care – Except as covered for Diabetes</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u> .)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic (Manipulative care) – 26 visits per calendar year</li> </ul>	

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

**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](http://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](http://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](http://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](http://myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://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 1-800-382-4259.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-382-4259.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-382-4259.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-382-4259 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-4259.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-382-4259.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-382-4259.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-800-382-4259

*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 SLU Care/SSM pre-natal care and hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,170</b>

### Managing Joe's type 2 Diabetes

(a year of routine SLU Care/SSM care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,440</b>

### Mia's Simple Fracture

(SLU Care/SSM emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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