



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ucare.org or by calling 1-877-903-0070.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$6,350 /Individual; \$12,700 /Family. Non-network: \$12,700 /Individual; \$25,400 /Family. Deductible doesn't apply to in-network preventive care. Copayments don't apply to deductible.	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 <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,350 Individual/ \$12,700 Family for in-network services. No out-of-pocket limit for non-network services.	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 <u>out-of-pocket limit</u> ?	Premiums, all non-network services, non-network balance-billed charges, and health care services this plan doesn't cover.	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 plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network UCare Choices providers, see www.ucare.org or call toll-free 1-877-903-0070.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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 <u>specialist</u> ?	No.	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 on page 5. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$60 copay for first 3 visits, then 100% until deductible and maximum out-of-pocket met.	Not covered	No coverage non-network.
	Specialist visit	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	_____none_____
	Other practitioner office visit	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	Authorization required for physical therapy, speech therapy, and occupational therapy.
	Preventive care/screening/immunization	No charge	Not covered	No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	—————none—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ucare.org	Formulary generic drugs	100% until deductible and maximum out-of-pocket met.	Not covered	Must be on UCare formulary. No coverage non-network. Authorization may be required.
	Formulary brand drugs			
	Non-formulary drugs	Not covered	Not covered	Non-formulary drugs not covered.
	Formulary specialty drugs	100% until deductible and maximum out-of-pocket met.	Not covered	Must be on UCare formulary. No coverage non-network. Authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	—————none—————
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	100% until deductible and maximum out-of-pocket met.	100% until in-network deductible and maximum out-of-pocket met.	Not covered outside U.S.
	Emergency medical transportation	100% until deductible and maximum out-of-pocket met.	100% until in-network deductible and maximum out-of-pocket met.	Not covered outside U.S.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Urgent care	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	Authorization required.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	Authorization required.
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal care	No charge	Not covered	No coverage non-network.
	Postnatal care	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	_____none_____
	Delivery and all inpatient services	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	Authorization required.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% until deductible and maximum out-of-pocket met.	100% until non-network deductible met, then 50% coinsurance.	Authorization required. Limit of 120 home health care visits per calendar year. Skilled nursing facility services limited to 120 days per admission. Limit of 30 days of home hospice services per calendar year, no authorization required.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limit of 1 routine eye exam per calendar year. No coverage non-network.
	Glasses	100% until deductible and maximum out-of-pocket met.	Not covered	Limit of 1 per calendar year. No coverage non-network.
	Dental check-up	100% until deductible and maximum out-of-pocket met.	Not covered	Limit of 2 per calendar year. No coverage non-network.

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Cosmetic Surgery Dental Care (Adult) Hearing aids-unless under age 18 and requirements are met Infertility treatment 	<ul style="list-style-type: none"> Intensive behavioral therapy for treatment of autism spectrum disorders Long-term care Non-emergency care when traveling outside U.S. Non-formulary drugs unless an exception is obtained 	<ul style="list-style-type: none"> Private-duty nursing-except up to 120 hours is covered to train hospital staff for a ventilator-dependent patient Routine eye care (Adult) Routine foot care Weight loss programs

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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

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if: •You commit fraud •The insurer stops offering services in the State •You move outside the coverage area.

For more information on your rights to continue coverage, contact the insurer at 612-676-6600 or toll-free 1-877-903-0070. You may also contact your state insurance department at 651-296-2488 or toll-free 1-800-657-3602.

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: Minnesota Department of Commerce at 651-296-2488 or toll-free 1-800-657-3602.

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 not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-903-0070

Hmong (Hmoob): Yog koj yuav kev pab hais lus hmoob, hu rau 1-877-903-0070

Somali: Caawimaad luuqada af Soomaaliga ah wac: 1-877-903-0070

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-877-903-0070

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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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 \$2,190
- Patient pays \$4,650

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	\$4,500
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$4,650

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

- Amount owed to providers: \$5,400
- Plan pays \$250
- Patient pays \$5,150

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	\$4,890
Copays	\$180
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,150

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- 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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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.

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.

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.

Can I use Coverage Examples to compare plans?

- ✓ **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.

Are there other costs I should consider when comparing plans?

- ✓ **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 **copayments**, **deductibles**, and **coinsurance**. 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.

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