
 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, go to www.ucare.org/ChoicesBenefitDocuments or call 1-877-903-0070 or TTY/Hearing Impaired: 1-800-688-2534. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-903-0070 or TTY/Hearing Impaired: 1-800-688-2534 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive services .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-network: \$0/Individual; \$0/Family. Non-network: \$0/Individual; \$0/Family.	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 , 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 .
Will you pay less if you use a network provider ?	Yes. See www.ucare.org or call toll-free 1-877-903-0070 or TTY/Hearing Impaired: 1-800-688-2534 for 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 in-network 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
		Your Cost if You Use an Indian Health Service Provider	In-Network Provider (You will pay the least)	Non-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	No charge	No charge	No charge	None
	Specialist visit				
	Preventive care/screening/Immunization				
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ucare.org .	Generic drugs	No charge	No charge	No charge	Must be on formulary or receive a formulary exception. Up to 90-day supply at in-network retail or mail-order pharmacy.
	Preferred brand drugs				
	Specialty drugs				Must use Fairview Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge	None
	Physician/surgeon fees				
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	None
	Emergency medical transportation				
	Urgent care				
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	Notification required.
	Physician/surgeon fees				

* For more information about limitations and exceptions, see the plan or policy document at www.ucare.org/ChoicesBenefitDocuments.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You Use an Indian Health Service Provider	In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	No charge	Authorization or notification may be required.
	Inpatient services				
If you are pregnant	Office visits	No charge	No charge	No charge	None
	Childbirth/delivery professional services	No charge	No charge	No charge	Notification required.
	Childbirth/delivery facility services				
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	Authorization required. Limited to 120 home visits per year.
	Rehabilitation services	No charge	No charge	No charge	Authorization required.
	Habilitation services				
	Skilled nursing care	No charge	No charge	No charge	Authorization required. Limited to 120 days per admission.
	Durable medical equipment	No charge	No charge	No charge	Authorization may be required.
	Hospice services	No charge	No charge	No charge	Limit 30 days per episode.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Limit 1 routine exam per calendar year.
	Children's glasses	No charge	No charge	No charge	Limit 1 per calendar year.
	Children's dental check-up	No charge	No charge	No charge	Limit 2 per calendar year.

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"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture Bariatric Surgery Cosmetic Surgery Hearing aids-unless age 18 or younger and requirements are met 	<ul style="list-style-type: none"> Infertility treatment 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 dental care for adults Routine eye care (Adult) Routine foot care Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.ucare.org/ChoicesBenefitDocuments.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (except when there is no measurable progress over time, and massage for comfort or convenience)

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: Minnesota Department of Health at 651-201-5100 or 1-800-657-3916 (toll free). For more information on your rights to continue coverage, contact UCare at 612-676-6600 or toll-free 1-877-903-0070. 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.mnsure.org or call 1-855-366-7873.

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 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: Minnesota Department of Health at 651-201-5100 or 1-800-657-3916 (toll free) regarding in-network services and Minnesota Department of Commerce at 651-539-1500 regarding non-network services.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards?

Does not apply. [Minimum Value Standards](#) apply to group coverage and this is non-group coverage. If you have access to a group plan that meets the Minimum Value Standards, you might be ineligible for a premium tax credit to help you pay for this plan.

—————*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 in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$0
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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

- The [plan's overall deductible](#) \$0
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$0

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

- The [plan's overall deductible](#) \$0
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-6500 (voice)** or toll free at **1-866-457-7144 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-6500** or toll free at **1-866-457-7144 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-6500** or toll free at **1-866-457-7144 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address

UCare
Attn: Complaints, Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-6500/ 1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/ 1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-6500/ 1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電612-676-6500/ 1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-6500/ 1-866-457-7144 (телетайп: 612-676-6810/ 1-800-688-2534).

ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/ 1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክሶሎ ቁጥር ይደውሉ

612-676-6500/ 1-866-457-7144 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး-နမ့ၢ်ကတိၤ ကညီ ကျိၣ်အယိ, နမန့ၢ် ကျိၣ်အတၢ်မၤစၢလၢ တလၢ်ဘျုးလၢ်စ့ၤ နိတၢ်တၢ်ဘျုးသ့န့ၣ်လီၤ. ကိ: 612-676-6500/ 1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/ 1-800-688-2534).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, រសវាជំនួយវិជ្ជាជីវៈភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/ 1-800-688-2534)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 612-676-6500/1-866-457-7144 (رقم هاتف الصم والبكم .(612-676-6810/1-800-688-2534

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-6500/ 1-866-457-7144 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).