

 **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/BenefitDocuments or call 1-877-903-0070 toll free or TTY/Hearing Impaired: 1-800-688-2534 toll free. For 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/ or call 1-877-903-0070 toll free or TTY/Hearing Impaired: 1-800-688-2534 toll free to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network: \$700/Individual; \$1,400/Family. Non-network: \$1,400/Individual; \$2,800/Family.	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 plan, 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 <u>deductible</u>?	Yes. <u>Preventive services</u> , ER and office visits. Formulary drugs except non-preferred brand and specialty. Limitations apply. <u>Copayments</u> don't apply to <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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,850/Individual; \$3,700/Family. No <u>out-of-pocket limit</u> for non-network services.	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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , all non-network services, non-network balance-billed charges, and health care services this <u>plan</u> doesn't cover.	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 <u>network provider</u>?	Yes. See ucare.org/ifp-directory or call 1-877-903-0070 toll free or TTY: 1-800-688-2534 toll free 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 plan's <u>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 <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	Out-of-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	\$30 copayment first 3 visits before deductible is met. Then 25% coinsurance . No charge for online and convenience/retail visits. Deductible does not apply.	50% coinsurance	First 3 visits can be a combination of eligible office visits.
	Specialist visit	\$30 copayment first 3 visits before deductible is met. Then 25% coinsurance .	50% coinsurance	First 3 visits can be a combination of eligible office visits.
	Preventive care/screening/immunization	No charge. Deductible does not apply.	50% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services are preventive . Then check what your plan will pay for. With a prescription, some over-the-counter drugs are no charge.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)			

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ucare.org/BenefitDocuments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at ucare.org/ifp-druglist .	Preferred generic drugs	\$10 copayment per 30-day supply. \$20 for 31 to 90-day supply. Deductible does not apply.	Not covered	Must be on formulary or receive a formulary exception. Drugs and drug tiers on the formulary may change with notice. Up to 90-day supply at in-network retail or mail-order pharmacy. *You will pay no more than \$25 for insulin on the formulary. Your cost could be less if you have met your plan deductible or out-of-pocket limit.
	Non-preferred generic drugs	\$20 copayment per 30-day supply. \$40 for 31 to 90-day supply. Deductible does not apply.		
	Preferred brand drugs*	\$175 copayment per 30-day supply. Deductible does not apply.		
	Non-preferred brand drugs	40% coinsurance after deductible		
	Specialty drugs	40% coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	\$250 copayment first visit before deductible is met. Then 25% coinsurance .	\$250 copayment first visit before deductible is met. Then 25% coinsurance after in-network deductible .	None
	Emergency medical transportation	25% coinsurance	25% coinsurance after in-network deductible .	None
	Urgent care	\$30 copayment first 3 visits before deductible is met. Then 25% coinsurance after deductible .	50% coinsurance	First 3 visits can be a combination of eligible office visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Notification required.
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ucare.org/BenefitDocuments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment first 3 visits before deductible is met. Then 25% coinsurance after deductible .	50% coinsurance	First 3 visits can be a combination of eligible office visits. Authorization or notification may be required.
	Inpatient services	25% coinsurance	50% coinsurance	Coverage includes residential treatment services. Authorization or notification may be required.
If you are pregnant	Office visits	No charge for routine prenatal and postnatal preventive services .	50% coinsurance	Non-routine office visits require cost-sharing.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	Notification required.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Authorization required. Limited to 120 home visits per calendar year.
	Rehabilitation services	\$30 copayment first 3 visits before deductible is met. Then 25% coinsurance after deductible .	50% coinsurance	First 3 visits can be a combination of eligible office visits. Authorization required.
	Habilitation services			
	Skilled nursing care	25% coinsurance	50% coinsurance	Authorization required. Limited to 120 days per admission.
	Durable medical equipment	25% coinsurance	50% coinsurance	Authorization may be required.
	Hospice services	25% coinsurance	50% coinsurance	Limit 30 days per episode.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	Limit 1 routine eye exam per calendar year.
	Children's glasses	25% coinsurance	Not covered	Limit 1 per calendar year.
	Children's dental check-up	No charge. Deductible does not apply.	50% coinsurance	Limit 2 per calendar year.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ucare.org/BenefitDocuments.

Excluded Services & Other Covered Services

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- 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
- 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
- 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

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 1-877-903-0070 toll free. 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 1-800-318-2596.

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 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.

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? Not Applicable

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](#).

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 prenatal care and a hospital delivery)

■ The plan's overall deductible	\$700
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$600
The total Peg would pay is	\$2,500

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$700
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$700
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$700
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 **612-676-3200 (voice)** or toll free at **1-800-203-7225 (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 **612-676-3200** or toll free at **1-800-203-7225 (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 **612-676-3200** or toll free at **1-800-203-7225 (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: 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).

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

ማሰታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶቻችን በ12 ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 612-676-6500/1-866-457-7144 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟံသုင်ဟံသး-နမ့်ကတိ၊ ကညီ ကျိင်အလိ၊ နမန့် ကျိင်အတိ၊မ၊စ၊လ၊ တလင်ဘုင်လ၊ ဝိစု၊ နီတံတံဘုင်သုနုင်လိ၊ ကိး 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, រសវាជំនួយវិជ្ជាជីវៈ 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).