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 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.healthcare.gov/sbc-glossary/ or call 1-877-903-0070 or TTY/Hearing Impaired: 1-800-688-2534 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-network: $2,800/Individual; $5,600/Family. Non-network: $5,600/Individual; $11,200/Family. <strong>Deductible</strong> doesn’t apply to in-network preventive care. <strong>Copayments</strong> don’t apply to <strong>deductible</strong>.</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. <strong>Preventive services</strong>. Limitations apply.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without cost sharing and before you meet your <strong>deductible</strong>. See a list of covered <strong>preventive services</strong> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$5,800/Individual; $11,600/Family. No <strong>out-of-pocket limit</strong> for non-network services.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td><strong>Premiums</strong>, all non-network services, non-network balance-billed charges, and health care services this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See ucare.org/searchnetwork or call toll-free 1-877-903-0070 or TTY/Hearing Impaired: 1-800-688-2534 for a list of <strong>network providers</strong>.</td>
<td>This <strong>plan</strong> uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the plan’s <strong>network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the <strong>provider’s</strong> charge and what your <strong>plan</strong> pays (<strong>balance billing</strong>). Be aware your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the in-network <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least): 15% coinsurance after deductible is met. Non-Network Provider (You will pay the most): 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For online and convenience/retail visits, 15% coinsurance after deductible is met.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)</td>
<td>In-Network Provider (You will pay the least): 15% coinsurance after deductible is met. Non-Network Provider (You will pay the most): 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition.</strong> More information about <strong>prescription drug coverage</strong> is at <a href="http://ucare.org/searchdruglist">ucare.org/searchdruglist</a>.</td>
<td>Preferred generic drugs</td>
<td>In-Network Provider (You will pay the least): 15% coinsurance after deductible is met. Non-Network Provider (You will pay the most): Not covered</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>15% coinsurance after deductible is met.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>Must be on formulary or receive a formulary exception. Some specialty drugs must be filled at Fairview Specialty Pharmacy.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.ucare.org/BenefitDocuments](http://www.ucare.org/BenefitDocuments).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees | 15% coinsurance after deductible | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care  
Emergency medical transportation  
Urgent care | 15% coinsurance after deductible | 15% coinsurance after in-network deductible. | None |
| If you have a hospital stay | Facility fee (e.g., hospital room)  
Physician/surgeon fees | 15% coinsurance after deductible | 50% coinsurance | Notification required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services  
Inpatient services | 15% coinsurance after deductible | 50% coinsurance | None |
| If you are pregnant | Office visits  
Childbirth/delivery professional services  
Childbirth/delivery facility services | No charge for routine prenatal and postnatal preventive services  
15% coinsurance after deductible | 50% coinsurance | Non-routine office visits require cost-sharing.  
Notification required. |

* For more information about limitations and exceptions, see the plan or policy document at [www.ucare.org/BenefitDocuments](http://www.ucare.org/BenefitDocuments).
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Authorization required. Limited to 120 home visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Authorization required.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Authorization required. Limited to 120 days per admission.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Authorization may be required.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Limit 30 days per episode.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>15% coinsurance after deductible</td>
<td>50% coinsurance</td>
<td>Limit 30 days per episode.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge. Deductible does not apply.</td>
<td>50% coinsurance</td>
<td>Limit 1 routine eye exam per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>15% coinsurance after deductible</td>
<td>Not covered</td>
<td>Limit 1 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge. Deductible does not apply.</td>
<td>50% coinsurance</td>
<td>Limit 2 per calendar year.</td>
</tr>
</tbody>
</table>

**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)

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

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.
### Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- **The plan’s overall deductible**: $2,800
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $600

**The total Peg would pay is**: $4,700

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

- **The plan’s overall deductible**: $2,800
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 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)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$50</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Joe would pay is**: $3,200

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

- **The plan’s overall deductible**: $2,800
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 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)

**Total Example Cost**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,900

---

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 612-676-6500 (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: 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)

ATTENTION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (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 612-676-3200/1-800-203-7225 (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 612-676-3200/1-800-203-7225（TTY: 612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телефон: 612-676-6810/1-800-688-2534).

โปรดทราบ: ถ้าคุณพูดภาษาจีน ขอให้คุณทราบว่าคุณสามารถขอรับบริการแปลฟรีได้ ที่ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

Melhorada: اذ كیت تنتحت انکر الیقه، فإئ خاردات المساعدة اللغوية تتواتر تک بالمجان.

 atención بر رقم 612-676-3200/1-800-203-7225 (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 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (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 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).