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 1-844-634-1237 or visit universitymissouri.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.cciio.cms.gov or call 1-866-487-2365 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $350 Individual / $1,050 Family  Non-Network: $700 Individual / $2,100 Family  Per calendar year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, Retail Prescription Drugs: $75 per person</td>
<td>You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network Medical: $3,500 Individual / $7,000 Family  Non-Network Medical: $10,500 Individual / $21,000 Family  Per calendar year.  Pharmacy: $4,400 Individual / $8,800 Family  Per calendar per year.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain preauthorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 1-844-634-1237 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</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>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><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>$20 copay per visit, deductible does not apply</td>
<td>20% coinsurance per visit after deductible</td>
<td>Virtual visits (Telehealth) - $15 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage non-network. If you receive services in addition to office visit, additional copays, or coinsurance may apply e.g. surgery.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay per visit, deductible does not apply</td>
<td>20% coinsurance per visit after deductible</td>
<td>If you receive services in addition to office visit, additional copays, or coinsurance may apply e.g. surgery.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance per visit after deductible</td>
<td>Cost share applies to manipulative (chiropractic) services only. Limited to 26 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No Charge</td>
<td>20% coinsurance per visit after deductible</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copay after deductible</td>
<td>20% coinsurance per visit after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% copay after deductible</td>
<td>20% coinsurance per visit after deductible</td>
<td>None</td>
</tr>
</tbody>
</table>
| **If you need drugs to treat your illness or condition** | Formulary Generic | Retail: Non-Maintenance: greater of $7 copay or 20% coinsurance after deductible. Maintenance: greater of $10 copay or 25% coinsurance after deductible. Mail-Order: greater of $15 copay or 20% coinsurance (no deductible.) | 50% co-insurance, min. $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge. | **Mail-Order**
* Up to 90-day supply with mail order prescription
* 90-day supply can be filled at retail if a University of Missouri pharmacy is used. Mail Order copay/coinsurance will apply
**Specialty**
* 31-day limit on all specialty medications.
* First fill can be made at any pharmacy, but all subsequent fills must be made through Accredo |

* For more information about limitations and exceptions, see the plan or policy document at universitymissouri.welcometouhc.com.
<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></td>
<td></td>
<td>Network Provider</td>
<td>Non-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>Retail: Non-Maintenance: greater of $15 copay or 25% coinsurance after deductible. Maintenance: greater of $20 copay or 30% coinsurance after deductible. Mail-Order: greater of $30 copay or 25% coinsurance (no deductible.)</td>
<td>50% co-insurance, min. $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>Retail: Non-Maintenance: greater of $30 copay or 50% coinsurance after deductible. Maintenance: greater of $40 copay or 55% coinsurance after deductible. Mail-Order: greater of $60 copay or 50% coinsurance (no deductible.)</td>
<td>50% co-insurance, min. $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge.</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Formulary Generic at retail: 20% coinsurance after deductible. Formulary Brand at Retail: 25% coinsurance after deductible. Non-Formulary Brand at Retail: 50% coinsurance after deductible</td>
<td>50% coinsurance, min. $30 in addition to the difference between the non-participating pharmacy charge and the participating pharmacy charge.</td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 copay per visit after deductible</td>
<td>20% coinsurance per visit after deductible</td>
<td>Pre-authorization is required for out-of-network or benefit reduces by $500.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>$0 copay after deductible</td>
<td>20% coinsurance per visit after deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Network Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$250 copay per visit after deductible</td>
<td><strong>Copay is waived if patient is admitted.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>*$250 copay per visit after deductible</td>
<td><strong>Network deductible applies. Must meet emergency criteria.</strong></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 copay per trip after deductible</td>
<td>*Network deductible applies. Must meet emergency criteria.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay per visit deductible does not apply</td>
<td>If you receive services in addition to Urgent care visit, additional copays, or coinsurance may apply, e.g. surgery.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300 copay per admission after deductible</td>
<td>Preauthorization is required for non-network or benefit reduces by $500. Limited to one copay per 60-day period for same diagnosis.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0 copay after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$30 copay per visit, deductible does not apply</td>
<td>Preauthorization is required for non-network for certain services or benefit reduces by $500.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$300 copay per admission after deductible</td>
<td>Preauthorization is required for non-network or benefit reduces by $500.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$30 initial visit only, deductible does not apply</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$0 copay after deductible</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces by $500.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$300 copay per admission after deductible</td>
<td>Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces by $500.</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Home health care</td>
<td>$0 copay after deductible</td>
<td>Preauthorization is required for non-network or benefit reduces by $500.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>other special health needs</td>
<td></td>
<td></td>
<td>Physical, Speech and Occupational: 60 visits combined per calendar year; Cardiac and Pulmonary: 36 visits each per 12-week period. Preauthorization required for non-network for certain services or benefit reduces by $500.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No charge for outpatient cardiac or pulmonary rehab.</td>
<td>$30 copay per visit, deductible does not apply. $300 copay per inpatient stay after deductible</td>
<td>Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required non-network for certain services or benefit reduces by $500.</td>
</tr>
<tr>
<td>Habilitative services</td>
<td></td>
<td>$30 copay per visit, deductible does not apply</td>
<td>Limited to 90 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required for non-network or benefit reduces by $500.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>$0 copay after deductible</td>
<td>Preauthorization is required for non-network for DME over $1,000 or benefit reduces by $500.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>$0 copay after deductible</td>
<td>Preauthorization is required for non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces by $500.</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>$0 copay after deductible</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s eye exams.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s glasses.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>No coverage for Children’s Dental check-up.</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.)**

- Acupuncture
- Glasses
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care – Except as covered for Diabetes

* For more information about limitations and exceptions, see the plan or policy document at universitymissouri.welcometouhc.com.
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic (Manipulative care) – 26 visits per calendar year
- Hearing aids
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cdio.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 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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? 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.

* For more information about limitations and exceptions, see the plan or policy document at universitymissouri.welcometouhc.com.
Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-634-1237.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-634-1237.
Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijjigo holne' 1-844-634-1237.

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**: $350
- **Specialist copay**: $30
- **Hospital (facility) copay**: $300
- **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

In this example, Peg would pay:
- **Deductibles**: $350
- **Copayments**: $300
- **Coinsurance**: $0
- **What isn’t covered**: $200

The total Peg would pay is **$880**

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

- **The plan’s overall deductible**: $350
- **Specialist copay**: $30
- **Hospital (facility) copay**: $300
- **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

In this example, Joe would pay:
- **Deductibles**: $425
- **Copayments**: $840
- **Coinsurance**: $0
- **What isn’t covered**: $40

The total Joe would pay is **$1,305**

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

- **The plan’s overall deductible**: $350
- **Specialist copay**: $30
- **Hospital (facility) copay**: $300
- **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

In this example, Mia would pay:
- **Deductibles**: $350
- **Copayments**: $480
- **Coinsurance**: $0
- **What isn’t covered**: $0

The total Mia would pay is **$830**

The plan would be responsible for the other costs of these EXAMPLE covered services.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**请注意：**如果您说中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**XIN LUУ:** Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đại thể bảo hiểm (Summary of Benefits and Coverage, SBC) này.
알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하시십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

VINIAMINE: бесплатные услуги перевода доступны для людей, чьи родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all’interno di questo Sommario dei Benefici e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」（Summary of Benefits and Coverage, SBC）に記載されているフリー ダイヤルにてお電話ください。
Summary of Benefits and Coverage (SBC)