



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 (this call is free) or TTY/Hearing Impaired: 1-800-688-2534 (this call is free). 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 (this call is free) or TTY/Hearing Impaired: 1-800-688-2534 (this call is free) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible? | In-network: \$450/Individual; \$900/Family. Non-network: \$20,000/Individual; \$40,000/Family. | 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 . |
| Are there services covered before you meet your deductible? | Yes. Preventive services , office visits and some formulary drugs. Limitations apply. Copayments don't apply to deductible. | This plan covers some items and services even if you haven't yet met the 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 . Refer to the 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? | \$3,350/Individual; \$6,700/Family. No out-of-pocket limit for non-network services. | 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, most non-network services, balance billing charges (unless balance billing is prohibited), 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. Refer to ucare.org/ifp-directory or call 1-877-903-0070 (this call is free) or TTY: 1-800-688-2534 (this call is free) for a 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 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 |
|--|--|---|--|---|
| | | 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 for first 4 visits. Then \$25 copayment per visit. Deductible does not apply. | 50% coinsurance after deductible | First 4 visits can be a combination of eligible office visits. |
| | Specialist visit | \$60 copayment per visit. Deductible does not apply. | 50% coinsurance after deductible | None. |
| | Preventive care/screening/immunization | No charge. Deductible does not apply. | 50% coinsurance after deductible | 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. With a prescription, some over-the-counter drugs are no charge. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 50% coinsurance after deductible | Authorization may be required. |
| | 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 |
|---|--|---|--|---|
| | | In-Network Provider (You will pay the least) | Non-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 . | Tier 1 | \$15 copayment for each 30-day supply. Deductible does not apply. | Not covered | Preventive medications are covered without member cost sharing as specified on the formulary. Drugs must be on formulary or receive a formulary exception. Drugs and drug tiers on the formulary may change if a new generic drug becomes available or new information about the safety of a drug is released. Up to 90-day supply at in-network retail or mail-order pharmacy. Restrictions may apply. You will pay no more than \$25 for each 30-day supply of drugs to treat diabetes (including insulin), asthma, and allergies requiring the use of epinephrine auto-injectors (EpiPens). Your cost could be less if you have met your out-of-pocket limit . Most Tier-4 drugs must be filled at Fairview Specialty Pharmacy. Manufacturer savings card, coupon or rebate dollar amounts will count toward your plan deductible and/or out-of-pocket limit . |
| | Tier 2 | \$30 copayment for each 30-day supply. Deductible does not apply. | | |
| | Tier 3 | \$90 copayment for each 30-day supply. Deductible does not apply. | | |
| | Tier 4 | \$360 copayment for each 30-day supply. | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 50% coinsurance after deductible | Authorization and notification may be 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 |
|---|--|---|---|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance after deductible | 20% coinsurance after in-network deductible . | None. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after in-network deductible . | None. |
| | Urgent care | \$45 copayment per visit. Deductible does not apply. | 50% coinsurance after deductible | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 50% coinsurance after deductible | Notification required. |
| | Physician/surgeon fees | | | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge for first 4 visits. Then \$25 copayment per visit. Deductible does not apply. | 50% coinsurance after deductible | First 4 visits can be a combination of eligible office visits. |
| | Inpatient services | 20% coinsurance after deductible | 50% coinsurance after deductible | 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 after deductible | Non-routine office visits require cost sharing. |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 50% coinsurance after deductible | Notification required. |
| | Childbirth/delivery facility services | | | Notification required. |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance after deductible | 50% coinsurance after deductible | Authorization required. Limited to 120 home visits per calendar year. |
| | Rehabilitation services | \$30 copayment per visit. Deductible does not apply. | 50% coinsurance after deductible | Authorization required. |
| | Habilitation services | \$30 copayment per visit. Deductible does not apply. | | |

* 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 |
|--|---|--|--|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | Skilled nursing care | 20% coinsurance after deductible | 50% coinsurance after deductible | Authorization required. Limited to 120 days per admission. |
| | Durable medical equipment | 20% coinsurance after deductible | 50% coinsurance after deductible | Authorization may be required. |
| | Hospice services | 20% coinsurance after deductible | 50% coinsurance after deductible | 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 after deductible | Limit 1 routine eye exam per calendar year. |
| | Children's glasses | 20% coinsurance after deductible | Not covered | Limit 1 per calendar year. |
| | Children's dental check-up | No charge. Deductible does not apply. | 50% coinsurance after deductible | Limit 2 per calendar year. |

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
- Bariatric surgery
- Cosmetic surgery
- 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 are covered to train hospital staff for a ventilator-dependent patient)
- Routine dental care (Adults)
- Routine eye care (Adults)
- 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)
- Hearing Aids
- Abortion

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 (this call is free). For more information on your rights to continue coverage, contact UCare at 612-676-6600 or 1-877-903-0070 (this call is 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 1-855-366-7873 (this call is free).

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 (this call is 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 | \$450 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 | \$450 |
| Copayments | \$10 |
| Coinsurance | \$2,200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$600 |
| The total Peg would pay is | \$3,300 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$450 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 | \$100 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,100 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$450 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 | \$450 |
| Copayments | \$200 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,100 |

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

Notice of Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ልብ ይበሉ:- የአማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎት ለእርስዎ ቀርቦልዎታል። ተደራሽ በሆኑ ቅርፀቶች መረጃዎችን ለማቅረብ ተገቢ የሆኑ አጋዥ ድጋፍ ሰጪ መሳሪያዎች እና አገልግሎቶችም እንዲሁ በነፃ ቀርበዋል። በ 612-676--3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) ይደውሉ.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. يمكنك الاتصال على الرقم 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

សូមជ្រាបជាដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃអាចត្រូវបានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏ត្រូវបានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ ទូរសព្ទទៅលេខ 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534)។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 612-676-3200/1-800-203-7225 (聽障專線 612-676-6810/1-800-688-2534)。

请注意：如果您说普通话，我们可为您提供免费的语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534)。

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके ललए नन: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के ललए उपयुक्त सहायक साधन और सेवाएं भी नन: शुल्क उपलब्ध हैं। 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາແມ່ນຜູ້ຮັບຮອງໃຫ້ບໍລິການແກ້ໄຂ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ຜູ້ອື່ນກໍາ. ໂທ 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

HUBACHIISA: Afaan Oromo kan dubbattan yoo ta'e, tajaajila gargaarsa afaanii bilisaan ni argattu. Odeeffannoo bifa dhaqqabamaa ta'een dhiheessuf, gargaarsii fi tajaajiloonna dabalataa mijatoo ta'anis bilisaan ni kennamu. Bilbilaa 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa lagu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si macluumaadka laguugu siiyo qaabab la isticmaali karo ayaa sidoo kale lagu heli karaa weliba si lacag la'aan ah. Wac 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libheng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).