



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, visit [www.uhcsr.com/macalester](http://www.uhcsr.com/macalester) or call 1-866-948-8472. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-948-8472 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Preferred Providers</u> \$50 (Person) Out of Network \$50 (Person)	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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Preferred Providers</u> \$4,000 (Person) Out of Network \$20,000 (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.uhcsr.com/macalester">www.uhcsr.com/macalester</a> or call 1-866-948-8472 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 <u>plan's 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Preferred 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	\$15 <u>Copay</u> per visit	\$25 <u>Copay</u> per visit	May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$15 <u>Copay</u> per visit	\$25 <u>Copay</u> per visit	
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% <u>Coins</u>	30% <u>Coins</u>	—————none—————
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$10 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	30% <u>Coins</u> \$15 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: Mail order prescription drugs are available at 2.5 times the retail <u>Copay</u> up to a 90 day supply. Out of Network: up to a 31 day supply per prescription You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. *See UHCP Prescription Drug Benefit for additional information.
	Tier 2 - Your Midrange-Cost Option	\$30 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	30% <u>Coins</u> \$15 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	
	Tier 3 - Your Highest-Cost Option	\$30 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	30% <u>Coins</u> \$15 <u>Copay</u> per prescription generic drug \$30 <u>Copay</u> per	

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/macalester](http://www.uhcsr.com/macalester)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			prescription brand-name drug <u>ded</u> does not apply	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	Physician/surgeon fees	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>Coins</u> \$100 <u>Copay</u> per visit	10% <u>Coins</u> \$100 <u>Copay</u> per visit	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	<u>Emergency medical transportation</u>	No Charge	No Charge	_____none_____
	<u>Urgent care</u>	10% <u>Coins</u> \$15 <u>Copay</u> per visit	30% <u>Coins</u> \$25 <u>Copay</u> per visit	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	Physician/surgeon fees	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$15 <u>Copay</u> per visit Other: 10% <u>Coins</u>	Office Visits: \$25 <u>Copay</u> per visit Other: No Charge	_____none_____
	Inpatient services	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
If you are pregnant	Office visits	\$15 <u>Copay</u> per visit	\$25 <u>Copay</u> per visit	<u>Cost sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>Coins</u>	30% <u>Coins</u>	
	Childbirth/delivery facility services	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
If you need help recovering or have other special health	<u>Home health care</u>	10% <u>Coins</u>	30% <u>Coins</u>	120 visits maximum (Per Policy Year)
	<u>Rehabilitation services</u>	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/macalester](http://www.uhcsr.com/macalester)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>needs</b>	<u>Skilled nursing care</u>	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	10% <u>Coins</u>	30% <u>Coins</u>	_____none_____
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered <u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

## 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
- Dental care (Adult) except as specifically provided in the policy.
- Long-term care
- Routine foot care
- Bariatric surgery except as specifically provided in the policy.
- Hearing aids except as specifically provided in the policy.
- Private-duty nursing except as specifically provided in the policy.
- Weight loss programs
- Cosmetic surgery except as specifically provided in the policy.
- Infertility treatment
- Routine eye care (Adult)

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

- Chiropractic care
- Non-emergency care when traveling outside the U.S. except as specifically provided in the policy.

**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 Commerce at 1-800-657-3602 or visit <http://mn.gov/commerce/>. 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](http://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: Minnesota Department of Commerce at 1-800-657-3602 or visit <http://mn.gov/commerce/>.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

—————*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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$50	■ The plan's overall deductible	\$50	■ The plan's overall deductible	\$50
■ Specialist copayment	\$15	■ Specialist copayment	\$15	■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%	■ Other coinsurance	10%	■ Other coinsurance	10%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$50	Deductibles	\$50	Deductibles	\$50
Copayments	\$40	Copayments	\$700	Copayments	\$50
Coinsurance	\$1,000	Coinsurance	\$100	Coinsurance	\$90
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$1,150	The total Joe would pay is	\$910	The total Mia would pay is	\$190

The plan would be responsible for the other costs of these EXAMPLE covered services.

## NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does 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:

Stacy Chalupsky  
Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written 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 member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

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>

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

**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 also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

**We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.**

## 1 of 2

