



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/sxu or call 1-800-505-4160. 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 or call 1-800-505-4160 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | <u>Preferred Providers</u> \$250 (Person) <u>Out of Network</u> \$600 (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. |
| Are there services covered before you meet your <u>deductible</u>? | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | 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. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | <u>Preferred Providers</u> \$6,850 (Person) <u>Preferred Providers</u> \$13,700 (Family) <u>Out of Network</u> \$15,000 (Person) | 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> , <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> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.uhcsr.com/sxu or call 1-800-505-4160 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 charge</u> 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 |
|--|--|---|---|---|
| | | 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 | \$25 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | May not apply when related to surgery or Physiotherapy. |
| | <u>Specialist</u> visit | \$25 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | 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) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | 20% <u>Coins</u> | 40% <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 www.uhcsr.com/pdl | Tier 1 - Your Lowest-Cost Option | \$20 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply | Not Covered | <u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail <u>Copay</u> up to a 90-day supply. You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> . |
| | Tier 2 - Your Midrange-Cost Option | \$40 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply | Not Covered | |
| | Tier 3 - Your Highest-Cost Option | \$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply | Not Covered | |
| | Tier 4 - Additional High-Cost Option | Not Covered | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | Physician/surgeon fees | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you need immediate medical attention | <u>Emergency room care</u> | \$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply | \$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply | May be limited to use of emergency room and supplies. |

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/sxu

| 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) | |
| | | | | The <u>Copay</u> will be waived if admitted to the Hospital. |
| | <u>Emergency medical transportation</u> | 20% <u>Coins</u> | 20% <u>Coins</u> | _____none_____ |
| | <u>Urgent care</u> | \$50 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply | \$50 <u>Copay</u> per visit 40% <u>Coins</u> <u>ded</u> does not apply | May be limited to facility fees. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | Physician/surgeon fees | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visits: \$25 <u>Copay</u> per visit <u>ded</u> does not apply Other: 20% <u>Coins</u> | Office Visits: 40% <u>Coins</u> Other: 40% <u>Coins</u> | _____none_____ |
| | Inpatient services | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If you are pregnant | Office visits | \$25 <u>Copay</u> per visit <u>ded</u> does not apply | 40% <u>Coins</u> | <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 | 20% <u>Coins</u> | 40% <u>Coins</u> | |
| | Childbirth/delivery facility services | 20% <u>Coins</u> | 40% <u>Coins</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | <u>Rehabilitation services</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | <u>Habilitation services</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | <u>Skilled nursing care</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| | <u>Durable medical equipment</u> | 20% <u>Coins</u> | 20% <u>Coins</u> | _____none_____ |
| | <u>Hospice services</u> | 20% <u>Coins</u> | 40% <u>Coins</u> | _____none_____ |
| If your child needs dental or eye care | 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.* |

| 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) | |
| | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | | |
|--|--|--|--|
| <ul style="list-style-type: none">AcupunctureDental care (Adult) except as specifically provided in the PolicyLong-term careWeight loss programsBariatric surgeryHearing aids except as specifically provided in the PolicyRoutine eye care (Adult)Cosmetic surgeryInfertility treatmentRoutine foot care | | | |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | | |
| <ul style="list-style-type: none">Chiropractic carePrivate-duty nursingInfertility treatmentNon-emergency care when traveling outside the U.S. | | | |

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: Illinois Department of Insurance at 1-866-445-5364 or visit <http://www.insurance.illinois.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 on how 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: Illinois Department of Insurance at 1-866-445-5364 or visit <http://www.insurance.illinois.gov/>.

Additionally, a consumer assistance program can help you file your appeal, contact Illinois Department of Insurance, Office of Consumer Health Insurance at 1-877-527-9431 or visit <http://insurance.illinois.gov/>.

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 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](#).

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): Dine'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 <u>plan's overall deductible</u> | \$250 | ■ The <u>plan's overall deductible</u> | \$250 | ■ The <u>plan's overall deductible</u> | \$250 |
| ■ <u>Specialist copayment</u> | \$25 | ■ <u>Specialist copayment</u> | \$25 | ■ <u>Specialist copayment</u> | \$25 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% | ■ Hospital (facility) <u>coinsurance</u> | 20% | ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% | ■ Other <u>coinsurance</u> | 20% | ■ Other <u>coinsurance</u> | 20% |
| This EXAMPLE event includes services like: <u>Specialist office visits (prenatal care)</u> Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u> | | This EXAMPLE event includes services like: <u>Primary care physician office visits (including disease education)</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u> | | This EXAMPLE event includes services like: <u>Emergency room care (including medical supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$250 | <u>Deductibles</u> | \$250 | <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$30 | <u>Copayments</u> | \$900 | <u>Copayments</u> | \$80 |
| <u>Coinsurance</u> | \$1,900 | <u>Coinsurance</u> | \$100 | <u>Coinsurance</u> | \$400 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,240 | The total Joe would pay is | \$1,270 | The total Mia would pay is | \$730 |

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:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
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.

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