



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



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	In-Network Tier 1 Provider (You will pay the least) - UCM Custom Plan	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network Tier 2 Provider - BlueSelect Plus	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	No charge, Deductible does not apply	\$30 copay /visit, Deductible does not apply	50% coinsurance	Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab).
	Specialist visit	\$60 copay /visit, Deductible does not apply	\$60 copay /visit, Deductible does not apply	50% coinsurance	Same limitations as primary care.
	Preventive care/screening/immunization	No charge, Deductible does not apply	No charge, Deductible does not apply	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	50% coinsurance	Blood Work: No charge if performed in In-Network provider's office/ independent lab.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain approval

Common Medical Event

Services You May Need

In-Network Tier 1
Provider (You will
pay the least) - UCM

What You Will Pay

Common Medical Event

Services You May Need

In-Network Tier 1
Provider (You will
pay the least) - UCM
Custom Plan

What You Will Pay

In-Network Tier 2
Provider -
BlueSelect Plus

Out-of-Network
Provider (You will
pay the most)

Limitations, Exceptions, & Other
Important Information

If you need immediate

Common Medical Event	Services You May Need	In-Network Tier 1 Provider (You will pay the least) - UCM Custom Plan	What You Will Pay In-Network Tier 2 Provider - BlueSelect Plus	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your

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 the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/agencies/ebsa. Or, you may also contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.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 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 your [plan](#) at 1-888-989-8842 or you can contact the Missouri Department of Commerce and Insurance at 800-726-7390 or at www.insurance.mo.gov. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa.

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? 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](#).

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PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average

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)	Ma's Simple Fracture (in-network emergency room visit and followup care)				
<ul style="list-style-type: none"> The plan's overall deductible \$1,000 Specialist copayment \$60 Hospital (facility) coinsurance 20% Other coinsurance 20% 	<ul style="list-style-type: none"> The plan's overall deductible \$1,000 Specialist copayment \$60 Hospital (facility) coinsurance 20% Other coinsurance 20% 	<ul style="list-style-type: none"> The plan's overall deductible \$1,000 Specialist copayment \$60 Hospital (facility) coinsurance 20% Other coinsurance 20% 				
<p>This EXAMPLE event includes services like: Specialist office visits (dfYbUW VWFY) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (j hUgci bXg'UbX VccX'k cf_) Specialist (UbYgh.YgU)</p>	<p>This EXAMPLE event includes services like: Primary care physician office visits fjbVW Xjb[' XlgYUgYXi VUfcbk Diagnostic tests fVccX'k cf_ Prescription drugs Durable medical equipment fl' i Vdzg'a YfYfL</p>	<p>This EXAMPLE event includes services like: Emergency room care fjbVW Xjb[' a YXWU gi dd]Ygk Diagnostic test fl' fUht Durable medical equipment fVfV hWYgk Rehabilitation services fWVngjWU' h.YfUcht</p>				
<table border="1"> <tr> <td>Total Example Cost</td> <td>\$12,700</td> </tr> </table>	Total Example Cost	\$12,700	<table border="1"> <tr> <td>Total Example Cost</td> <td>\$5,600</td> </tr> </table>	Total Example Cost	\$5,600	
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<p>In this example, Peg would pay:</p>	<p>In this example, Joe would pay:</p>					
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

