

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at uhc.com/employer/small-business/shop/ms or by calling 1-877-856-2430.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: \$3,500 Indiv / \$7,000 Family Non-Network: \$7,000 Indiv / \$14,000 Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$7,150 Indiv / \$14,300 Family Non-Network: \$14,300 Indiv / \$28,600 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers , see uhc.com/find-a-physician/shopmschoiceplus or call 1-877-856-2430.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

Questions: Call 1-877-856-2430 or visit us at uhc.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay per visit	\$30 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Virtual visits (Telehealth) - \$25 copay per visit by a Designated Virtual Network Provider. No coverage for non-network
	Specialist visit	\$60 copay per visit	\$90 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$30 copay per visit	\$30 copay per visit	40% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening- / immunization	No Charge	No Charge	Not Covered	No coverage non-Network. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: 20% co-ins	Free Standing Provider: No Charge Hospital-Based: 20% co-ins	40% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	40% co-ins, after ded	\$500 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at uhc.com/rxfind	Tier 1 - Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$30 copay	Retail: \$10 copay Mail-Order: \$30 copay	Retail: \$10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or co-ins may be applied.
	Tier 2 - Your Midrange-Cost Option	Retail: \$35 copay Mail-Order: \$105 copay	Retail: \$35 copay Mail-Order: \$105 copay	Retail: \$35 copay	
	Tier 3 - Your Highest-Cost Option	Retail: \$60 copay Mail-Order: \$180 copay	Retail: \$60 copay Mail-Order: \$180 copay	Retail: \$60 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed. \$500 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	\$350 copay per visit	\$350 copay per visit	\$350 copay per visit	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	20% co-ins, after ded	Network Deductible applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	\$100 copay per visit	\$100 copay per visit	40% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed. \$500 Inpatient Stay per occurrence deductible applies to Designated prior to the Annual Deductible. \$1,000 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fee	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copay per visit	\$30 copay per visit	40% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 20% co-ins, after ded Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$30 copay per visit	\$30 copay per visit	40% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 20% co-ins, after ded Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	40% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Inpatient Authorization may apply. \$500 Inpatient Stay per occurrence deductible applies to Designated prior to the Annual Deductible. \$1,000 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$30 copay per outpatient visit	\$30 copay per outpatient visit	40% co-ins, after ded	Limits per policy period: Physical, Occupational, Speech unlimited. Pulmonary 20 visits each. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	\$30 copay per outpatient visit	\$30 copay per outpatient visit	40% co-ins, after ded	Limits per policy period: Physical, Occupational, Speech unlimited. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation) . Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	20% co-ins, after ded	20% co-ins, after ded	40% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	\$10 copay per visit	\$10 copay per visit	40% co-ins, after ded	One exam every 12 months.
	Glasses	\$25 copay per pair	\$25 copay per pair	40% co-ins, after ded	One pair every 12 months. Cost may increase depending on the frames selected.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	20% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Long-term care
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Private-duty nursing
- Dental care (Adult)
- Routine foot care
- Infertility treatment
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform or the Mississippi Insurance Department at 1-800-562-2957 or www.mid.state.ms.us. Additionally, a consumer assistance program can help you file your appeal. Contact at or

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-856-2430 .

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430 .

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-856-2430.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijigo holne' 1-877-856-2430.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,020
- Patient pays \$4,520

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,000
Copays	\$20
Coinsurance	\$300
Limits or exclusions	\$200
Total	\$4,520

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,860
- Patient pays \$1,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$200
Copays	\$1,300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,540

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

x No . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

x No . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes . An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-856-2430.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Health Insurance Marketplace, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-856-2430.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Insurance Marketplace, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-856-2430.

如果您，或是您正在協助的對象，有關於Health Insurance Marketplace 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-877-856-2430。

Si vous, ou une personne que vous aidez, avez des questions à propos du Health Insurance Marketplace, vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour parler à un interprète, appelez le 1-877-856-2430.

إذا كان لديك أو لدى شخص تساعدُه أسئلة بخصوص Health Insurance Marketplace، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-877-856-2430.

Chishno keyumvt kvna ish apelachi yvt achukmaka isht atobbi ya na ponaklo yvt im ansha hokmvt chim anumpa ya anumpa imma micha apela ya aivlli iksho ho isha hinla kvt chim aivlhpesa. Anumpa tosholi i payvt im anumpuli 1-877-856-2430.

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Health Insurance Marketplace, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-877-856-2430.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Insurance Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-856-2430 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health Insurance Marketplace에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-856-2430로 전화하십시오.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં હો તેમાંથી કોઇને Health Insurance Marketplace વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિ યા સાથે વાત કરવા માટે, 1-877-856-2430 પર કોલ કરો.

ご本人様、またはお客様の身の回りの方でも、Health Insurance Marketplace についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-877-856-2430までお電話ください。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health Insurance Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-856-2430.

ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਸੀਂ ਜਿਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Health Insurance Marketplace ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-877-856-2430 ਤੇ ਕਾਲ ਕਰੋ।

Se tu o qualcuno che stai aiutando avete domande su Health Insurance Marketplace, avete il diritto di ottenere aiuto e informazioni nella vostra lingua gratuitamente. Per parlare con un interprete, potete chiamare 1-877-856-2430.

यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Health Insurance Marketplace के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए, 1-877-856-2430 पर कॉल करें।