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.myuhc.com or call UHC customer service at 844-554-5513 or the HR Support Center at 417-873-4271 Option 2. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 417-873-4271 Option 2 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,250 Individual / $2,500 Family Non-Network: $2,500 Individual / $5,000 Family per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	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 Care and categories with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	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.
What is the out-of-pocket limit for this plan?	Medical- Network: $5,000 Individual / $10,000 Family Non-Network: Unlimited Individual / Unlimited Family per calendar year	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 844-554-5513 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
		Network 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	$35 Copay/visit	40% Coinsurance	Virtual visit - In network $10 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. No virtual visit coverage for out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialist visit	$50 Copay/visit	40% Coinsurance	Chiropractor services limited to 26 visits per year.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Includes preventive health services specified in the health care reform law. 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	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic Drugs (Tier 1)	Retail: 15% ($15 min, $50 max) Mail Order: 15% ($30 min, $100 max)	Not Covered	Retail covers up to a 34-day supply. Mail Order covers up to a 90-day supply. See Formulary listing at www.express-scripts.com or call 877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. For questions contact www.express-scripts.com or 1-877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs (Tier 2)	Retail: 30% ($35 min, $125 max) Mail Order: 30% ($70 min, $250 max)	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail: 50% ($75 min, $250 max) Mail Order: 50% ($150 min, $500 max)	Not Covered	
	Specialty drugs (Tier 4)	At retail benefit in above applicable tiers.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay/visit, 20% Coinsurance	$250 Copay/visit 20% Coinsurance	$250 copay after the deductible then the plan pays 80%. Non-emergency use of an Emergency Room is not covered.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	$75 Copay/visit	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/visit	40% Coinsurance	None
	Inpatient services	20% Coinsurance	40% Coinsurance	None
If you are pregnant	Office visits	$35 Copay/initial visit only	40% Coinsurance	Initial visit for Routine Pre-Natal Care subject to office visit copayment, subsequent Routine Pre-Natal Care is covered at no cost.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Limited to 100 visits per year.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Limited to 90 days per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% Coinsurance	40% Coinsurance	The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.
	Hospice services	20% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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: 417-873-4271 Option 2 or visit Bass Pro Group LLC, 2500 East Kearney Street, Springfield, MO 65898 or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 417-873-4271 Option 2.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 417-873-4271 Option 2.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 417-873-4271 Option 2.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 417-873-4271 Option 2.

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)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$50**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$70
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,900**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$50**
■ **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$1,300
Coinsurance	$970
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,575**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$50**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$150
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,730**

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

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the 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 number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) **內所列的免付費電話號碼。**

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنويه: إذا كنت تتحدث **العربية (Arabic)** فإن خدمات المساعدة اللغوية متاحة لك بشكل مجاني. اتصل بالرقم المجاني المدرج في هذا الملخص لمزايا وتغطية (Summary of Benefits and Coverage، SBC).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。

本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー

ダイヤルにてお電話ください。

Summary of (شش ویپ ایزم ه ص خ نی در شده گ ان رینگ ن فت ارم اش ام ل ظ ا ش د ل ا ش ی م ا م ش ار ی خ ت ر د ان گ ی ر ر ط و ر ه ب ی ان د ا د ن ا م د ا م ات م د خ ، ت ل ه **Farsi(** ی س ا ر ف م ش ن ا ن ز ر گ ا ه ج و ت Benefits and Coverage، SBC) د ي ي گ ي ب گ ي ر س ا م ت.

ान द: यद आप हंद (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, न:शल् ु क उपल ह। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीब टोल फ्र नंबर पर कॉल कर।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

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.myuhc.com or call UHC customer service at 844-554-5513 or the HR Support Center at 417-873-4271 Option 2. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 417-873-4271 Option 2 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,800 Individual / $5,600 Family Non-Network: $5,600 Individual / $11,200 Family per calendar year. Does not apply to services listed below as "No Charge".	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 Care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	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.
What is the out-of-pocket limit for this plan?	Medical- Network: $6,000 Individual / $12,000 Family Non-Network: Unlimited Individual / Unlimited Family per calendar year	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 844-554-5513 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
		Network 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% Coinsurance	50% Coinsurance	Virtual visit - In network 25% coinsurance [after deductible] by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. No virtual visit coverage for out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialist visit	25% Coinsurance	50% Coinsurance	Chiropractor services limited to 26 visits per year.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Includes preventive health services specified in the health care reform law. 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)	25% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	50% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic Drugs (Tier 1)	25% Coinsurance	Not Covered	Retail covers up to a 34-day supply. Mail Order covers up to a 90-day supply. See Formulary listing at www.express-scripts.com or call 877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. For questions contact www.express-scripts.com or 1-877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs (Tier 2)	25% Coinsurance	Not Covered	
	Non-preferred brand drugs (Tier 3)	25% Coinsurance	Not Covered	
	Specialty drugs (Tier 4)	25% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	25% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	25% Coinsurance	25% Coinsurance	Non-emergency use of an Emergency Room is not covered.
	Emergency medical transportation	25% Coinsurance	25% Coinsurance	None
	Urgent care	25% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	25% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% Coinsurance	50% Coinsurance	None
	Inpatient services	25% Coinsurance	50% Coinsurance	None
If you are pregnant	Office visits	25% Coinsurance	50% Coinsurance	Initial visit for Routine Pre-Natal Care subject to deductible and coinsurance, subsequent Routine Pre-Natal Care is covered at no cost.
	Childbirth/delivery professional services	25% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	25% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	50% Coinsurance	Limited to 100 visits per year.
	Rehabilitation services	25% Coinsurance	50% Coinsurance	None
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	25% Coinsurance	50% Coinsurance	Limited to 90 days per year.
	Durable medical equipment	25% Coinsurance	50% Coinsurance	The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	25% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: 417-873-4271 Option 2 or visit Bass Pro Group LLC, 2500 East Kearney Street, Springfield, MO 65898 or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 417-873-4271 Option 2.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 417-873-4271 Option 2.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 417-873-4271 Option 2.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 417-873-4271 Option 2.

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)

■ **The plan's overall deductible**	**$2,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$3,150
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$6,050**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$2,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,005**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$2,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,220
Copayments	$0
Coinsurance	$480
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the 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 number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) **內所列的免付費電話號碼**。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنويه: إذا كنت تتحدث **العربية (Arabic)** فإن خدمات المساعدة اللغوية متاحة لك بدون مقابل. يُرجى الاتصال بالرقم المجاني المدرج في ملخص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。

本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー

ダイヤルにてお電話ください。

Summary of (شوش ایزیم ه ص خ نی در شده کـ ان رایگ ن متف ار اش م لـ ظ ب اش د. ی ا ش ار خ ت ان رایگ ور ط ه ب ی ان د ا د ن ا م ات م خ د ت، ل **Farsi(** ف ا ر س ی ش م ن ا ز ی ر گـ ا ه ج و ت
.د ي ي گ ي ب گ س ا م ت)Benefits and Coverage، SBC

ान द: यद आप हंद (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, न:शल् ु क उपल ह। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीब टोल फ्र नंबर पर कॉल कर।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

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.myuhc.com or call UHC customer service at 844-554-5513 or the HR Support Center at 417-873-4271 Option 2. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 417-873-4271 Option 2 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,800 Individual / $7,600 Family Non-Network: $7,600 Individual / $15,200 Family per calendar year. Does not apply to services listed below as "No Charge".	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 Care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	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.
What is the out-of-pocket limit for this plan?	Medical- Network: $6,650 Individual / $13,300 Family Non-Network: Unlimited Individual / Unlimited Family per calendar year	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 844-554-5513 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
		Network 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	30% Coinsurance	50% Coinsurance	Virtual visit - In network 30% coinsurance [after deductible] by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. No virtual visit coverage for out-of-network.
	Specialist visit	30% Coinsurance	50% Coinsurance	Chiropractor services limited to 26 visits per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Includes preventive health services specified in the health care reform law. 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)	30% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic Drugs (Tier 1)	30% Coinsurance	Not Covered	Retail covers up to a 34-day supply. Mail Order covers up to a 90-day supply. See Formulary listing at www.express-scripts.com or call 877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. For questions contact www.express-scripts.com or 1-877-206-7431. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs (Tier 2)	30% Coinsurance	Not Covered	
	Non-preferred brand drugs (Tier 3)	30% Coinsurance	Not Covered	
	Specialty drugs (Tier 4)	30% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None
	Emergency room care	30% Coinsurance	30% Coinsurance	Non-emergency use of an Emergency Room is not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	30% Coinsurance	30% Coinsurance	None
	Urgent care	30% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% Coinsurance	50% Coinsurance	None
	Inpatient services	30% Coinsurance	50% Coinsurance	None
If you are pregnant	Office visits	30% Coinsurance	50% Coinsurance	Initial visit for Routine Pre-Natal Care subject to deductible and coinsurance, subsequent Routine Pre-Natal Care is covered at no cost.
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	Limited to 100 visits per year.
	Rehabilitation services	30% Coinsurance	50% Coinsurance	None
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	30% Coinsurance	50% Coinsurance	Limited to 90 days per year.
	Durable medical equipment	30% Coinsurance	50% Coinsurance	The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.
	Hospice services	30% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: 417-873-4271 Option 2 or visit Bass Pro Group LLC, 2500 East Kearney Street, Springfield, MO 65898 or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 417-873-4271 Option 2.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 417-873-4271 Option 2.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 417-873-4271 Option 2.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 417-873-4271 Option 2.

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)

■ The plan's overall deductible	$3,800
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,930
Copayments	$0
Coinsurance	$3,720
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$6,750**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$3,800
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,800
Copayments	$0
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,635**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$3,800
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,140
Copayments	$0
Coinsurance	$580
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,720**

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

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the 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 number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) **內所列的免付費電話號碼。**

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنويه: إذا كنت تتحدث **العربية (Arabic)** فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم المجاني المدرج في الجزء الخاص بالمزايا والتغطية من (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。

本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー

ダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان که در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) فهرست شده است تماس بگیرید.

□ ान द: यद आप हंद (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, न:शल्ु क उपल□ ह। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीब□ टोल फ्र नंबर पर कॉल कर।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).