UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare
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July 18, 2013

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Dear Customer:

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

If you are an Employer, you can find your group's SBC documents by logging into www.employereservices.com and select "Summary of Benefits and Coverage" under the Resources menu.

For more information regarding this document, please visit uhc.com/summary or contact the Member Services number on the back of your ID card.

Very truly yours,

Andrew R Heim

UnitedHealthcare

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 **www.myuhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Network: $5,000 Indiv / $15,000 Family Non-Network: $8,000 Indiv / $24,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	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, 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.
Is there an **out of pocket limit** on my expenses?	Network: $5,000 Indiv/ $15,000 Family Non-Network: $14,000 Indiv/ $28,000 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**?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services , copays and prescription drugs.	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 insurer pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of providers?	Yes. This plan uses network providers. For a list of network providers, see www.myuhc.com or call 1-800-782-3740.	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 don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	20% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	20% co-ins	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 for Manipulative (Chiropractic) Services	20% co-ins for Manipulative (Chiropractic) Services	Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunizati-on	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)	No Charge	20% co-ins	None
	Imaging (CT/PET scans, MRIs)	0% co-ins	20% co-ins	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you need drugs to treat your illness or condition. More information about drug coverage is at www.myuhc.com	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay. Mail-Order: $30 copay.	Retail : $10 copay. Mail-Order: $30 copay.	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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.
	Tier 2 - Your Midrange-Cost Option	Retail : $30 copay. Mail-Order: $90 copay.	Retail : $30 copay. Mail-Order: $90 copay.	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay. Mail-Order: $150 copay.	Retail : $50 copay. Mail-Order: $150 copay.	
	Tier 4 (if applicable) - Additional High-Cost Options	Retail : $100 copay. Mail-Order: $300 copay.	Retail : $100 copay. Mail-Order: $300 copay.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins	20% co-ins	None
	Physician/surgeon fees	0% co-ins	20% co-ins	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% co-ins	0% co-ins	None
	Urgent care	$100 copay per visit	20% co-ins	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)	0% co-ins	20% co-ins	Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins	20% co-ins	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$50 copay per visit	20% co-ins	Limited to 52 visits per policy period. Pre-Notification required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins	20% co-ins	Limited to 30 days per policy period. Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$60 copay per visit	20% co-ins	Limited to 20 visits per policy period. Pre-Notification required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins	20% co-ins	Limited to 30 days per policy period. Pre-Notification required for non-network or benefit reduces to 50% of allowed.
If you become pregnant	Prenatal and postnatal care	0% co-ins	20% co-ins	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins	20% co-ins	Inpatient Notification may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	0% co-ins	20% co-ins	Limited to 60 visits per policy period. Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$30 copay per outpatient visit	20% co-ins	Depending on the type of therapy, there is a limit of 20-36 visits per policy period.
	Habilitation services	Not Covered	Not Covered	No Coverage for Habilitation Services.
	Skilled nursing care	0% co-ins	20% co-ins	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Notification required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Durable medical equipment	0% co-ins	20% co-ins	$2,500 maximum per policy period if device determined to be non-essential. Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Notification required for non-network DME over $1000 or no coverage.
	Hospice service	0% co-ins	20% co-ins	Inpatient Pre-Notification required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	Limited to 1 exam every 2 years. No coverage non-Network.
	Glasses	Not Covered	Not Covered	No Coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No Coverage for Dental check-up

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	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult/Child)
• Glasses	• Habilitation services	• Infertility treatment	• Long-term care
• Non-emergency care when travelling outside the U.S.	• Private-duty nursing	• Routine foot care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).		
• Chiropractic Services - may be covered with limitations	• Hearing aids - may be covered with limitations	• Routine eye care (Adult) - may be covered with limitations

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 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Mississippi Insurance Department at 1-800-562-2957 or visit www.mid.state.ms.us.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码。

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Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

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 $2,340**
- **Patient pays $5,200**

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	$5,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	**$5,200**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,620**
- **Patient pays $1,780**

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	$1,000
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,780**

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**, **co-payments**, and **co-insurance** 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?

✱ **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?

✱ **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 **co-payments**, **deductibles**, and **co-insurance**. 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.

Questions: Call 1-800-782-3740 or visit us at www.myuhc.com. If you aren't clear about any of the bolded 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.