Summary of Benefits and Coverage: What this **Plan** Covers & What You Pay For Covered Service **Coverage for:** Employee/Family | **Plan Type:** PS1

Coverage Period: 01/01/2023-12/31/2023

MVP

Midwest Veterinary Partners dba Mission Vet Partners

$3,000 Deductible Plan

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 1-833-437-1598. 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 1-833-437-1598 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: $3,000 Individual / $6,000 Family Non-Network*: $6,000 Individual / $12,000 Family per calendar year. *Deductibles cross- apply	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 primary care services with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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 preventive services at https://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?	For network provider*: $6,850 Individual / $13,700 Family For out-of-network providers*: $13,700 Individual / $27,400 Family per calendar year *Out-of-pockets cross-apply	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.
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 prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-833-437- 1598 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	$40 copay/visit	40% coinsurance	Virtual visit - Network subject to $40 copay by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. No virtual visit coverage out-of-network.
	Specialist visit	$60 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	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	Prior Authorization required out-of-network for sleep studies or benefit reduced to 0%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required out-of-network or benefit reduced to 0%.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com	Generic Drugs (Tier 1)	Retail: $20 copay up to 30-day supply; $40 copay 31-90-day supply Mail Order: $40 copay deductible does not apply	Retail: 30-day supply $20 copay 25% coinsurance, deductible does not apply. Retail: 31-90-day supply $40 copay 25% coinsurance, deductible does not apply. Mail Order: Not Covered	Certain drugs may require Prior Authorization. Certain preventive medications (including certain contraceptives) are covered at No Charge. Network Specialty retail up to 30-day: 20% with a $200 maximum: no minimum. Out-of-network retail: no minimum or maximum.
	Preferred brand drugs (Tier 2)	Retail: $60 copay up to 30-day supply; $120 copay 31-90-day supply Mail Order: $120 copay deductible does not apply	Retail: 30-day supply $60 copay 25% coinsurance, deductible does not apply. Retail: 31-90-day supply $120 copay 25% coinsurance, deductible does not apply. Mail Order: Not Covered	Certain drugs may require Prior Authorization. Network Specialty retail up to 30-day: 20% with a $200 maximum: no minimum. Out-of-network retail: no minimum or maximum.

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)	
	Non-preferred brand drugs (Tier 3)	Retail: 1-90-day supply 50% coinsurance deductible does not apply. Mail Order: 1-90-day supply, 50% coinsurance, deductible does not apply	Retail: 1-90-day supply 75% coinsurance, deductible does not apply Mail Order: Not Covered	Certain drugs may have a Prior Authorization. Network retail: $80 minimum and $100 maximum. Out-of-network Retail: $100 minimum and $125 maximum; up to 30-day supply. Network retail: $160 minimum and $200 maximum; 31-90-day supply. Out-of-network Retail $200 minimum and $250 maximum. Mail order minimum $160 maximum $100 covered up to 90-day supply. Network Specialty Retail up to 30-day: 25% with $300 maximum; no minimum
	Specialty drugs	See Limitations and	Not Covered	Certain drugs may have a Prior Authorization. Specialty Pharmacy is covered through OptumRx only up to

	(Tier 4)	Exceptions section		30-days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required out-of-network or benefit reduced to 0%.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	None
	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	Prior Authorization required out-of-network or benefit reduced to 0%.
	Physician/surgeon fees	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit	40% coinsurance	Prior Authorization is required out-of-network for certain treatments or benefit reduced to 0%. Partial Hospitalization/ Intensive Outpatient Treatment is covered network 20% after the deductible and out-of-network 40% after the deductible. Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA) out-of- network ABA or benefit is reduced to 0%. Prior Authorization required for non-network or benefit reduced to 0%. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization inpatient services - required out-of-network or benefit reduced to 0%.
If you are pregnant	Office visits	$40 copay/initial visit only	40% coinsurance	Prior Authorization required out-of-network for inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or benefit reduced to 0%. Routine pre-natal care is covered at no charge.
	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	20% coinsurance	Prior Authorization required out-of-network for certain services (skilled nursing by RN or LPN) or benefit reduced to 0%.

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)	
	Rehabilitation services	20% coinsurance	40% coinsurance	Unlimited visits for Cardiac and Pulmonary Rehabilitation per calendar year. Occupational, Physical, Speech and Cognitive Therapies is limited to 30 visits per therapy per calendar year combined network and out-of-network. Habilitative Services is combined with Rehabilitation Services. Treatment of Autism Spectrum Disorder Services is

				covered through age 18.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	120-day limit per calendar year, combined in and out-of-network. Prior Authorization required out-of-network for Skilled Nursing Facility or benefit reduced to 0%.
	Durable medical equipment	20% coinsurance	20% coinsurance	Prior authorization required for costs greater than $1,000 or benefits reduced to 0%.
	Hospice services	No charge	No charge	Prior Authorization required out-of-network before admission for an inpatient stay in a hospice facility or benefit reduced to 0%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)		
Acupuncture Adult routine vision exam (i.e. refraction) Cosmetic Surgery	Dental Care (Adult) Hearing aids 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.)		
Bariatric Surgery Chiropractic care	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 https://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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-833-437-1598 or visit www.welcometouhc.com or the Employee Benefits Security Administration at 1- 866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 1-833-437-1598.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-437-1598
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-437-1598 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-437-1598

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

image

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.

About these Coverage Examples:

The plan's overall deductible $3,000 ■ The plan's overall deductible $3,000 ■ The plan's overall deductible $3,000

Specialist copayment $60 ■ Specialist copayment $60 ■ Specialist copayment $60

Hospital (facility) coinsurance 20% ■ Hospital (facility) coinsurance 20% ■ Hospital (facility) coinsurance 20%

Other coinsurance 20% ■ Other coinsurance 20% ■ Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)* Primary care physician office visits *(including disease education)* Childbirth/Delivery Professional Services *(including medical supplies)* Childbirth/Delivery Facility Services Diagnostic tests *(blood work)* Diagnostic test *(x-ray)* Diagnostic tests *(ultrasounds and blood work)* Durable medical equipment *(crutches)* Prescription drugs Rehabilitation services *(physical therapy)* Specialist visit *(anesthesia)* Durable medical equipment *(glucose meter)*

Total Example Cost $12,700
In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,970**

Total Example Cost $5,600
In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Total Example Cost $2,800
In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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:
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).

ةيطغتلاو ايازملا صلخم لخادب جردملا يناجملا فتاهلا مقرب لاصتلاا ىجر (Summary of
ةيبرعلا (Arabic)، لكل ةحاتم ةيناجملا ةيوغللا ةدعاسملا تامدخ نإف :هيبنت ثدحتت تنك اذإ.
اذه (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。**

یسراف (Farsi) :هجوت ناميشن ناباز رگا ش،شوپ و ايازم هصالخ نيا رد هدش ركذ نانگيار نفلت هرامش ابا افطل .دشاب يم امش رايتخا رد نانگيار روط هب ناباز دادما تامدخ ،تسا Summary of)
ديريگب سامت. (Benefits and Coverage، SBC

ध्यान द�: य�द आप **�हं द�** (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, न:शु ल्क उपलब्ध ह�। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सचीबद्ध 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.

image

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).