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, please contact your Human Resources office by calling (573) 642-0750. 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 www.dol.gov/ebsa/healthreform or call the Human Resources office at (573) 642-0750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $1,000 person/ $3,000 family For out-of-network providers: $2,000 person/ $6,000 family	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 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $7,150 person / $15,300 family; For out-of-network providers Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. **Medical Coinsurance network providers: $2,000 per person/ $2,000 per family** **Maximum Medical and RX Copays: $4,150 per person / $10,300 per family** **Medical Coinsurance out-of-network providers: Unlimited**
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Primary Network: Healthlink OAIII www.healthlink.com or call 1-800-624-2356 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 copayment/office visit	40% coinsurance	None
	Telemedicine	$15 copayment/office visit	Not applicable	Telemedicine visit: (855) 717-6800
	Specialist visit	$60 copayment/visit	40% coinsurance	None
	Spinal Manipulation/ Chiropractic Services	$10 copayment visits 1-6 $20 copayment visits 7-20 $30 copayment X-rays	40% coinsurance	20 visits per Calendar Year
	Preventive care/screening/ immunization	Covered at 100%	40% coinsurance Only well child care, mammograms and colorectal screenings are covered.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic testing (x-ray, imaging, blood work) related to: -Physician's Office -Quest Diagnostic -Fulton Medical Center (Labs Only) -Outpatient surgery -Inpatient stay	 $30 copayment 100% covered 100% covered 20% coinsurance 20% coinsurance	 40% coinsurance N/A N/A 40% coinsurance 40% coinsurance	(including Pre-Admission testing)
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.elixirsolutions.com (800) 771-4648**	Generic drugs (Tier 1)	Greater of $10 copayment / prescription or 25% coinsurance	Allowed at contracted rate	Generic Incentive: If a generic is available & you choose to purchase the brand, you will pay the copayment plus the difference in the cost between the brand and generic prescriptions. Copayment for 90-day fills at the pharmacy are the greater of 3x the copayment or 25%. No mail order option. Medications that are preventive care services under the Affordable Care Act will be covered at 100% and not require a copayment. This includes all Generic and certain Brand Name oral contraceptives, aspirin, certain vitamins and supplements, smoking deterrents, certain vaccinations/ immunizations, etc. Contact Elixir for the list of the $0 copayment items.
	Preferred brand drugs (Tier 2)	Greater of $50 copayment / prescription or 25% coinsurance	Allowed at contracted rate	
	Specialty drugs (Tier 4) (Must be obtained through the Specialty Drug provider.)	25% copayment	Allowed at contracted rate	
	Affordable Care Act preventive services	$0 copayment	Allowed at contracted rate.	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$150 penalty per visit will apply to all Emergency Room visits prior to application of deductible and coinsurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$30 copayment /visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance at the semiprivate room rate	40% coinsurance at the semiprivate room rate	Benefit payment will be reduced by $300 if the stay is not precertified.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Physician services: Outpatient services:	$30 copayment /office visit 20% coinsurance	40% coinsurance 40% coinsurance	If telemedicine is available: (855) 717-6800 ($15 copayment)
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$30 copayment /office visit	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Two ultrasounds will be considered an eligible expense for a routine Pregnancy.
	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	60 visits per Calendar Year maximum
	Rehabilitation services	20% coinsurance	40% coinsurance	20 visits per Calendar Year maximum.
	Habilitation services	20% coinsurance	40% coinsurance	90 visits per Calendar Year maximum
	Skilled nursing care	20% coinsurance	40% coinsurance	At the facility's semiprivate room rate. 60 days per Calendar Year maximum
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Bereavement counseling not covered.
If your child needs dental or eye care	Children's eye exam	$30 copayment /visit	$30 copayment /visit	Coverage limited to one exam/year.
	Children's glasses	Not covered.	Not covered.	Not covered unless following cataract surgery.
	Children's dental check-up	Not covered.	Not covered.	Dental care not covered. Refer to the separate dental plan.

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.)

- Cosmetic Surgery
- Dental Care
- Hearing Aid
- Infertility Treatment
- Long-term care (other than medically necessary skilled nursing care)
- Routine Eye Care: glasses (Limited coverage exceptions apply.)

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

- Acupuncture
- Bariatric Surgery and Weight loss programs.
- Chiropractic Care
- Habilitative Services (criteria apply)
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (criteria applies).
- Routine Foot Care (i.e., for diabetics)
- Tobacco Use Cessation (Limited coverage exceptions apply).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Contact your HR/Benefit Specialists at (573) 642-0750; Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087. The contact information for other agencies is: Missouri Department of Insurance, 301 W. High Street, Room 830, Jefferson City, MO 65101, (800) 726-7390, www.insurance.mo.gov. Other states' contact information can be obtained at www.dol.gov/ebsa/healthreform (under Consumer Assistance Programs) above or at http://cciio.cms.gov/programs/consumer/capgrants/index.html. Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform, DOL, and/or other applicable agencies. 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: Contact your HR/Benefit Specialists at (573) 642-0750; Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087. 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: Missouri Department of Insurance, 301 W. High Street, Room 830, Jefferson City, MO 65101, (800) 726-7390, http://insurance.mo.gov/consumers/, or consumeraffairs@insurance.mo.gov . Other states' contact information can be obtained at www.dol.gov/ebsa/healthreform (under Consumer Assistance Programs) above or at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 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.

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	$1,000
Specialist copayment	$60
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**