
 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 <http://www.springfieldmo.gov/2035/Insurance> or call (417) 864-1607. 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.cciio.cms.gov or call (417) 864-1607 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Network: \$500 per person/ \$1,000 per family; Non-Network: \$1,000 per person/ \$2,000 per family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you have not yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You do not have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Network Medical: \$2,500 per person/ \$5,000 per family; Non-Network Medical: \$7,000 per person/ \$14,000 per family; Network Prescription Drugs: \$4,100 per person/ \$8,200 per family (with \$1,500 <u>out-of-pocket limit</u> per Calendar Year for <u>specialty drugs</u>).	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>out-of-network prescription drug copays</u> and <u>coinsurance</u> , <u>precertification</u> penalties, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See http://healthplan.mercy.net/healthplans/dyn_EmployerProviderSearch.aspx?emp=City%20of%20Springfield or call 417-888-8888 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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)	Non-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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist visit</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.springfieldmo.gov/2035/Insurance or https://www.medtrakrx.com/Members .	Generic drugs	\$5 <u>copay</u> + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	Not covered	Mandatory Generic program applies: If brand drug is selected when generic is available, participant pays <u>copay</u> (<u>copay</u> waived for mail order) plus <u>coinsurance</u> and the difference between the generic and brand name drugs.
	Preferred brand drugs	\$5 <u>copay</u> + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	Not covered	Maximum fill 90 days from a <u>network provider</u> at retail pharmacy or through mail order.
	Non-preferred brand drugs	\$5 <u>copay</u> + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	Not covered	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Network scripts must be obtained through a Network Provider. <u>Non-Network drugs</u> may be covered under medical benefits.
	<u>Specialty drugs</u>	20% <u>copay</u> per 30-day supply	Not covered	Must be obtained through MedTrak. <u>Non-Network specialty drugs</u> may be covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				under medical benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Emergency hospitalizations must be certified within 72 hours of admission. \$100 penalty per visit is applied if the emergency room is used for a condition that is not an <u>emergency medical condition</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required, call 1-800-777-9087. Benefit payment will be reduced by \$100 if the stay is not pre-certified. Charges limited to semi-private room rates.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required, call 1-800-777-9087. Benefit payment will be reduced by \$100 if the stay is not pre-certified. Charges limited to semi-private room rates.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Two ultrasounds will be considered an eligible expense for a routine pregnancy. <u>Cost sharing</u> does not apply for <u>preventive services</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				Expenses for dependent children, but not grandchildren, are covered.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Expenses for dependent children, but not grandchildren, are covered.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maximum of 60 visits per calendar year Precertification is recommended, call 1-800-777-9087.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is recommended, call 1-800-777-9087. For inpatient <u>rehabilitation services</u> , precertification is required. Benefit payment will be reduced by \$100 if the stay is not pre-certified.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even in <u>network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Charges limited to semi-private room rates. Maximum of 60 days per calendar year. Precertification is required, call 1-800-777-9087. Benefit payment will be reduced by \$100 if the stay is not pre-certified.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is recommended, call 1-800-777-9087.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maximum of 90 days per calendar year. Precertification is required for inpatient services, call 1-800-777-9087. Benefit payment will be reduced by \$100 if the stay is not pre-certified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in <u>network</u> .
	Children's glasses	Not covered	Not covered	Not covered unless following eye surgery. You must pay 100% of this service, even in <u>network</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in <u>network</u> .

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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Habilitation Services
- Hearing Aids (except for newborn children as required under Missouri State Statutes and the initial purchase if loss of hearing is a result of a covered surgical procedure)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (including exam and glasses) (Adult & Child) (Limited coverage exceptions apply)

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

- Bariatric Surgery (criteria apply)
- Private-Duty Nursing (criteria apply)
- Weight Loss Programs (criteria apply)
- Routine Foot Care (for diabetics)

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: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: The City's Human Resources Department at (417) 864-1607 or Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087.

Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Division of Insurance, 301 W. High St., Room 350, Jefferson City, MO 65101, (573) 751- 4126.

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) 864-1607.

————— *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 \$500
- Specialist coinsurance 20%
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$2,010
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,560

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

- The plan's overall deductible \$500
- Specialist coinsurance 20%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$370
Coinsurance	\$1,240
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$2,140

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

- The plan's overall deductible \$500
- Specialist coinsurance 20%
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$790