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 deductible?	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 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. Network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you have not 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	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** out-of-pocket limit per Calendar Year for specialty drugs).	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, out-of-network prescription drug copays and coinsurance, precertification penalties, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See http://healthplan.mercy.net/healthplans/dyn_EmployerProviderSearch.aspx?emp=City%20of%20Springfield or call 417-888-8888 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)	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% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	40% coinsurance	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 http://www.springfieldmo.gov/2035/Insurance or https://www.medtrakrx.com/Members.	Generic drugs	$5 copay + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	40% coinsurance	Mandatory Generic program applies: If brand drug is selected when generic is available, participant pays copay (copay waived for mail order) plus coinsurance and the difference between the generic and brand name drugs. Maximum fill 90 days from a network provider at retail pharmacy or through mail order. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs	$5 copay + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	40% coinsurance	
	Non-preferred brand drugs	$5 copay + 20% of the remainder of the total cost per 30-day supply (retail); 20% of total cost per prescription (mail order)	40% coinsurance	
	Specialty drugs	20% copay per 30-day supply	Not covered	Must be obtained through MedTrak. Non-Network specialty drugs may be covered under medical benefits.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	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 emergency medical condition.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required, except for inpatient services due to substance abuse. Call 1-800-777-9087 to pre-certify. 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% coinsurance	40% coinsurance	Two ultrasounds will be considered an eligible expense for a routine pregnancy. Cost sharing does not apply for preventive services.

				Expenses for dependent children, but not grandchildren, are covered.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Expenses for dependent children, but not grandchildren, are covered.
	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	Maximum of 60 visits per calendar year Precertification is recommended, call 1-800-777-9087.
	Rehabilitation services	20% coinsurance	40% coinsurance	Precertification is recommended, call 1-800-777-9087. For inpatient rehabilitation services, precertification is required. Benefit payment will be reduced by $100 if the stay is not pre-certified.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in network.
	Skilled nursing care	20% coinsurance	40% coinsurance	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.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification is recommended, call 1-800-777-9087.
	Hospice services	20% coinsurance	40% coinsurance	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.

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 network.
	Children's glasses	Not covered	Not covered	Not covered unless following eye surgery. You must pay 100% of this service, even in network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in network.

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 (except for reconstructive surgery following mastectomy)
- 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)
- Routine Foot Care (for diabetics)
- Weight Loss Programs (criteria apply)

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 065101, (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 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**

In this example, Peg would pay:

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

Managing Joe's type 2 Diabetes
(a year of routine 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**

In this example, Joe would pay:

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

Mia's Simple Fracture
(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**

In this example, Mia would pay:

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

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