



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, by calling your Human Resources department. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at www.HealthCare.gov or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For network providers \$1,000 person / \$2,000 family For out-of-network providers \$2,000 person / \$4,000 family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Some preventive care services are covered before you meet your deductible.</p>	<p>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.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For network providers \$3,500 person / \$7,000 family For out-of-network providers \$7,000 person / \$14,000 family</p>	<p>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. Network Providers Max Coinsurance and all copays: \$2,500 per individual / \$5,000 per family Out-of-Network Providers Max Coinsurance and all copays: \$5,000 per individual / \$10,000 per family</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, copayments, penalties and ineligible expenses, including amounts over the usual and customary or contracted rates.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. Search web site or call for list of network providers. Primary: HealthLink www.healthlink.com or Freedom Network Select www.phkcc.com or call 800-624-2356. Wrap: Multiplan www.multipian.com or call 800-922-4362. Refer to the plan document for when network or out-of-network benefits apply for the wrap networks.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</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)	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	\$25 <u>copayment</u>	40% <u>coinsurance</u>	Telemedicine Visit \$15 (855) 717-6800
	Specialist visit	\$50 <u>copayment</u>	40% <u>coinsurance</u>	None
	Chiropractic visit	\$25 <u>copayment</u>	40% <u>coinsurance</u>	Spinal manipulation limited to 26 per Calendar Year.
	Preventive care/ <u>screening/immunization</u>	Covered at 100%	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Vision Exam	Covered at 100%	40% <u>coinsurance</u>	1 per calendar year. Refractions not covered.
	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Quest Diagnostics/Lab Card	Covered at 100%	Covered at 100%	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	One Call Radiology	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Generic drugs (Tier 1)	\$10 <u>copayment</u>	Allowed at contracted rate.	Generic Incentive: Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Brand Name drug is dispensed. However, the brand name drug will be considered a covered expense if a Generic drug is not available, or if the Physician writes "DAW" (dispense as written) on the prescription. In addition to the <u>copayment</u> , the Covered Person must pay the difference between the cost of the Generic drug and the Brand Name drug. Medications that are <u>preventive</u> care services under the Affordable Care Act will be covered at 100% and not require a <u>copayment</u> . Contact ProAct for the list of the \$0 <u>copayment</u> items.
Preferred brand drugs (Tier 2)	\$40 <u>copayment</u>	Allowed at contracted rate.		
Non-preferred brand drugs (Tier 3)	\$70 <u>copayment</u>	Allowed at contracted rate.		
<u>Specialty drugs</u> (Tier 4)	50% <u>copayment</u> with a maximum of \$100 out-of-pocket per prescription	Allowed at contracted rate.		
Affordable Care Act <u>preventive</u> services	\$0 <u>copayment</u>	\$0 <u>copayment</u>		
Diabetic Supplies: Lancet Devices Lancets Blood Glucose Test Strips	\$0 <u>copayment</u>	Allowed at contracted rate.		
Note: Glucose meters are not eligible under the Prescription Benefits; however, Pro-Act will provide manufacturers coupons and member may file out-of-pocket expense under the Medical Benefits.				

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)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
	<u>Emergency room care</u>	\$200 copayment then 10% coinsurance	\$200 copayment then 10% coinsurance	None
If you need immediate medical attention	<u>Emergency medical transportation</u>			
	Emergency	10% coinsurance	10% coinsurance	None
	Non-Emergent	10% coinsurance	40% coinsurance	None
	Urgent care	\$75 copayment	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Benefit payment will be reduced by \$500 if the stay is not precertified.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment	40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	Benefit payment will be reduced by \$500 if the stay is not precertified.
	Office visits (PCP)	\$25 copayment	40% coinsurance	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	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
	Home health care	10% coinsurance	40% coinsurance	90 visits per Calendar Year maximum
If you need help recovering or have other special health needs	Rehabilitation services	\$25 copayment	40% coinsurance	20/36 visits per Calendar Year maximum
	Habilitation services	\$25 copayment	40% coinsurance	20 visits per Calendar Year maximum
	<u>Skilled nursing care</u>	10% coinsurance	40% coinsurance	At the facility's semiprivate room rate. 60 days per Calendar Year maximum.
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	Covered at 100%	40% coinsurance	Coverage limited to one routine exam/year. Refractions not included.
	Children's glasses	Not covered	Not covered	Not covered unless following eye surgery.
	Children's dental check-up	Not covered	Not covered	Dental care not covered.

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
- Dental Care
- Routine Eye Care and glasses
- Bariatric Surgery
- Infertility Treatment
- Weight loss programs
- Cosmetic Surgery
- Long-term care (other than medically necessary skilled nursing care)

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

- Chiropractic Care
- Hearing Aids
- Habilitative Services (criteria apply)
- Routine Eye Exam
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care (i.e., for diabetics)
- Private Duty Nursing (criteria apply)
- Tobacco Use Cessation (criteria apply).

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact your Human Resources department. There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (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: MIRMA Health Board of Directors at (573) 817-2554; Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087; or Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the 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>.

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** \$50
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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 \$12,570

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$3,340

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** \$50
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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 \$7,390

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$130
Copayments	\$1,440
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,630

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

- **The plan's overall deductible** \$1,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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 \$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1,000
Copayments	\$100
Coinsurance	\$148
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,248

