Cape Girardeau School District Health Care Plan: Maxi & Maxi II Plan Coverage Period: 1/1/2018-12/31/2018

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Family | **Plan Type:** PPO

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 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, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** person/**$0** 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	PPO providers: **N/A** Non-PPO providers: **N/A**	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?	Does not apply	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. See **www.HealthLink.com** or call 1-800-624-2356	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.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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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	$0	$0	Non PPO amounts over R&C
	Specialist visit	$0	$0	Non PPO amounts over R&C
	Preventive care/screening/ immunization	$0	$0	Non PPO amounts over R&C
If you have a test	Diagnostic test (x-ray, blood work)	$0	50% facility	Non PPO amounts over R&C
	Imaging (CT/PET scans, MRIs)	$0	50% facility	Non PPO amounts over R&C
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	$10 copay retail $20 copay mail **(Reimbursed under Maxi Plan)**	No Covered	30-day retail supply/90 day mail order. Up to 3-30 day refills at retail on maintenance drugs. Certain non-Formulary band name drugs are only covered if the Formulary brand name drug has been used unsuccessfully. If you purchase a brand name when a generic is available you pay the copay plus the difference in ingredient price. Injectables other than insulin require prior authorization.
	Preferred brand drugs (Tier 2)	$30 copay retail $60 copay mail **(Reimbursed under Maxi Plan)**	No Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay retail $100 copay mail **(Reimbursed under Maxi Plan)**	No Covered	
	Specialty drugs (Tier 4)	Not Covered	Not Covered	Requires Prior Authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	50% coinsurance	Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II
	Physician/surgeon fees	$0	50% coinsurance	Non PPO amounts over R&C
If you need immediate medical attention	Emergency room care	$0	$0	Non PPO amounts over R&C
	Emergency medical transportation	$0	$0	
	Urgent care	$0	$0	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	$0	Charges over $1,500 per admission. Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II

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)	
	Physician/surgeon fees	$0	$0	Non PPO amounts over R&C
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0	$0	Non PPO amounts over R&C
	Inpatient services	$0	$0	Charges over $1,500 per admission. Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II
If you are pregnant	Office visits	$0	$0	Non PPO amounts over R&C
	Childbirth/delivery professional services	$0	$0	Charges over $1,500 per admission. Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II
	Childbirth/delivery facility services	$0	$0	
If you need help recovering or have other special health needs	Home health care	$0	$0	Non PPO amounts over R&C
	Rehabilitation services	$0	$0	Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II
	Habilitation services	$0	$0	Non PPO amounts over R&C, Hospital charges not covered under Maxi Plan II
	Skilled nursing care	$0	$0	Non PPO amounts over R&C, Not covered under Maxi Plan II
	Durable medical equipment	$0	$0	Non PPO amounts over R&C
	Hospice services	$0	$0	Non PPO amounts over R&C
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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
- Bariatric surgery
- Cosmetic surgery
- Dental Care or Hearing Aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs
- **Maxi Plan II does not cover inpatient or outpatient hospital or facility billed charges, oncology expenses, or prescription drugs.**

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Chiropractic care	Most coverage provided outside the United States.	**Maxi Plan II will reimburse Medicaid RX co-payments**

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: Claim Administrator at 800-448-4689. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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: Mutual Medical Plans, Inc. 800-448-4689 –or- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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