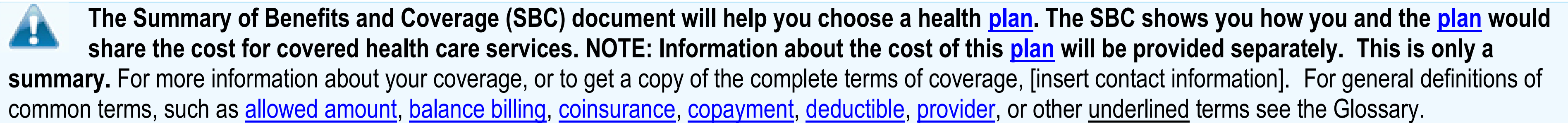
Cape Girardeau School District Health Care Plan: Major Medical Coverage Period: 1/1/18 – 12/31/18

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?	**$2,000**/person, **$4,000**/family at PPO Providers. Double for Non-PPO Doesn't apply to preventive care	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 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?	Some Prescription drug benefits are subject to the Medical Plan deductibles.	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: **$4,000/person, $8,000/family** For non-PPO providers: **No limit**	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, co-payments, amounts over reasonable & customary or over maximum allowable charges, or paid at 50%, other non-covered expenses.	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** for a list of participating providers. SMH is the preferred provider in Cape Girardeau County.	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 don't need a referral to see a specialist.	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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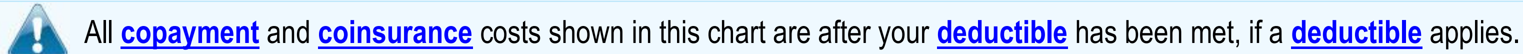
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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	**OV**: $25 Copayment **TELEMED**: $15 Copay	50% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Specialist visit	$25 Copayment	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	
If you have a test	Diagnostic test (x-ray, lab)	20% coinsurance	50% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition. More info about **prescription drug coverage** is available at expressscripts.com	Generic drugs (Tier 1)	$10 copay retail	No Benefit	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription) for double the retail copay. See SPD for other Prescription Drug Benefit limitations and provisions.
	Preferred brand drugs (Tier 2)	$30 copay retail	No Benefit	
	Non-preferred brand (Tier 3)	$50 copay retail	No Benefit	
	Specialty drugs (Tier 4)	Not Covered	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$250 Copayment 20% Coinsurance	50% coinsurance	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	50% coinsurance	——————none——————
	Urgent care	20% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copayment	50% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain

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)	
	Childbirth professional services	20% coinsurance	50% coinsurance	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).
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	See Summary Plan Description for complete details of limitations and Exceptions.
	Rehabilitation services	20% coinsurance	50% coinsurance	
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	
	Durable medical equipment	20% coinsurance	50% coinsurance	
	Hospice services	20% coinsurance	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	———————none———————
	Children's glasses	Not Covered	Not Covered	———————none———————
	Children's dental check-up	Not Covered	Not Covered	———————none———————

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care

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

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: For more information on your rights to continue coverage, contact the 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** **$2000**
- **Specialist copayment** **$25**
- **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	$2000
Copayments	$300
Coinsurance	$2100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,460**

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

- **The plan's overall deductible** **$2000**
- **Specialist copayment** **$25**
- **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*	$2000
Copayments	$1,200
Coinsurance	$828
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,088**

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

- **The plan's overall deductible** **$2000**
- **Specialist copayment** **$25**
- **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*	$0
Copayments	$250
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

*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.