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, 1-800-398-9961. 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 1-800-398-9961 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: MDMC - $0 Tier 2: SE Health/Mercy Health -$0 Tier 3: All Other HealthLink/ PHCS Individual: $1,000; Family: $2,000 Non-Network: Including St. Francis Providers Individual: $5,000; Family:$10,000	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, certain office visits, prescription drugs, and preventive services.	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?	Rx Deductible: $250 per Individual for all prescriptions filled outside of MDMC	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?	Tier 1: MO Delta Med Center: Individual $1,500; Family 3,000 Tier 2: SE Health / Mercy Health Individual $2,500; Family $5,000 Tier 3: All Other HealthLink/ PHCS Individual: $3,000; Family: $6,000 Non-Network: Including St. Francis Providers - Unlimited Rx Network Individual: $3,500; Family: $7,000 Rx Non-Network Unlimited	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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

What is not included in the out-of-pocket limit?	Premiums, prescription charges, balance-billed charges, charges for health care not covered by the policy.	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.healthscopebenefits.com or call 1-800-398-9961 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
		Missouri Delta Medical Center (You will pay the least)	Southeast Health, Mercy Health System & HealthLink/PHCS	Out-of-Network Provider & St. Francis providers (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 copay for visit and diagnostic testing; All other 10% coinsurance	$20 copay for visit and diagnostic testing; All other 20% coinsurance	50% coinsurance	B-12 injections covered 100% for pernicious anemia; Lab work performed by LabCorp will be covered at 100%, no deductible.
	Specialist visit	$20 copay for visit and diagnostic testing; All other 10% coinsurance	$20 copay for visit and diagnostic testing; All other 20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	50% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthscopebenefits.com.	Generic drugs	Retail: $8 copay Mail: $8 copay	Retail: $8 copay Mail: $8 copay	Not covered	None
	Preferred brand drugs	Retail: $25 copay Mail: $50 copay	Retail: $25 copay Mail: $50 copay	Not covered	Copay is after the $250 deductible plus the difference in cost between brand and generic drug.
	Non-preferred brand drugs	Retail: $45 copay Mail: $90 copay	Retail: $45 copay Mail: $90 copay	Not covered	
	Specialty drugs	25% coinsurance up to $150	25% coinsurance up to $150	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for specific outpatient surgeries.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Missouri Delta Medical Center (You will pay the least)	Southeast Health, Mercy Health System & HealthLink/PHCS	Out-of-Network Provider & St. Francis providers (You will pay the most)	
If you need immediate medical attention	Emergency room care Emergency	10% coinsurance	SE Health / Mercy: 20% coinsurance HealthLink/PHCS: 20% coinsurance after Tier 3 Deductible	20% coinsurance after Tier 3 Deductible	Deductible waived when patient is admitted. Participants admitted for emergency care must be transferred to a Tier 1 or Tier 2 facility upon stabilization. **Non-Emergency** claims will process as out of network at 50% coinsurance after OON deductible.
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance	Medically necessary transportation only.
	Urgent care	$20 copay for visit and diagnostic testing; All other 10% coinsurance	$20 copay for visit and diagnostic testing; All other 20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for specific outpatient surgeries.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay for visit and diagnostic testing; All other 10% coinsurance	$20 copay for visit and diagnostic testing; All other 20% coinsurance	50% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required.

If you are pregnant	Office visits	$20 copay for visit and diagnostic testing; All other 10% coinsurance	$20 copay for visit and diagnostic testing; All other 20% coinsurance	50% coinsurance	Employee and Spouse only, dependent daughters are not covered with the exception of required prenatal preventive benefits.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. Limited to 100 visits per plan year.
	Rehabilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required.
	Habilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required.
	Skilled nursing care	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. Limited to 100 days per plan year.
	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for certain equipment.
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$20 copay	$20 copay	Not covered	Screening covered for children under 5 as part of the preventive care benefit.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care (limited to 26 visits per plan year)
- Private duty nursing
- Routine eye care

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 the agency is: U.S. DOL, Employee Benefits Security Administration at 1-866-444-3272. 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: HealthSCOPE Benefits at 1-888-223-8835.

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 1-888-223-8835.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-223-8835.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-223-8835.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-223-8835.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

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 – Tier 1
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$52
Coinsurance	$1,135
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,247**

Managing Joe's type 2 Diabetes – Tier 1
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$773
Coinsurance	$173
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,001**

Mia's Simple Fracture – Tier 1
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
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	$0
Copayments	$60
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$220**

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