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, search on the employer's Intranet site or call Robin Darringer at (573) 346-9221. 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 on the same web site or call the above number to request a copy. You can also view the Glossary on https://www.healthcare.gov/sbc-glossary/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Open Access & PPO network providers: $1,500 person/ $4,500 family For out-of-network providers: $5,000 person/ $15,000 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?	Yes. $50 for prescription drug coverage.	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?	For Open Access & PPO network providers: $6,350 person/ $12,700 family For out-of-network providers: $10,000 person/ $30,000 family	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, penalties and health care this plan doesn't cover.	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 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)	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	$30 copay/office visit and 20% OA/30% PPO coinsurance for other outpatient services; deductible does not apply	50% coinsurance	$15 copayment for Telemedicine Program: Available by calling (855) 717-6800
	Specialist visit	$40 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% OA/30% PPO coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% OA/30% PPO coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medtrakrx.com.	Generic drugs (Tier 1)	$10 copay/prescription ($20 retail 90 day)	Allowed at contracted rate. Benefits apply as indicated.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (retail through MedTrak retail Performance 90 network pharmacies). Specialty drugs through contracted specialty pharmacies.
	Preferred brand drugs (Tier 2)	$30+20% copay/prescription ($60 retail 90 day)		
	Non-preferred brand drugs (Tier 3)	$50+20% copay/prescription ($100 retail 90 day)		
	Specialty drugs (Tier 4)	10% copay up to $1,500 out-of-pocket per Calendar Year		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% OA/30% PPO coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% OA/30% PPO coinsurance	50% coinsurance	50% coinsurance for anesthesia.
If you need immediate medical attention	Emergency room care	20% OA/30% PPO coinsurance	20% coinsurance	None
	Emergency medical transportation	20% OA/30% PPO coinsurance	20% coinsurance	
	Urgent care	$30 copay/visit	50% coinsurance	

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 a hospital stay	Facility fee (e.g., hospital room)	20% OA/30% PPO coinsurance	50% coinsurance	Preauthorization/precertification is required. If you don't get preauthorization/precertification, benefit payment could be reduced by $200.
	Physician/surgeon fees	20% OA/30% PPO coinsurance	50% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services: Physician/counselor visits:	20% OA/30% PPO coinsurance $40 copay/visit	50% coinsurance	None
	Inpatient services	20% OA/30% PPO coinsurance	50% coinsurance	
If you are pregnant	Office visits	$40 copay/office visit	50% coinsurance	Cost sharing does not apply to certain 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 professional services	20% OA/30% PPO coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% OA/30% PPO coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% OA/30% PPO coinsurance	50% coinsurance	100 visits/year
	Rehabilitation services	20% OA/30% PPO coinsurance	50% coinsurance	None
	Habilitation services	Not covered.	Not covered.	
	Skilled nursing care	20% OA/30% PPO coinsurance	50% coinsurance	60 days/calendar year. Preauthorization/precertification is required. If you don't get preauthorization/precertification, benefit payment could be reduced by $200.
	Durable medical equipment	20% OA/30% PPO coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise and bathroom equipment.
	Hospice services	20% OA/30% PPO coinsurance	50% coinsurance	Bereavement counseling limited to services within 6 months following patient's death.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not covered	Not covered	Coverage limited to one pair of glasses/year.
	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 • Cosmetic Surgery • Dental Care • Habilitative Services	• Hearing Aids • Infertility Treatment • Long Term Care (other than medically necessary skilled nursing care)	• Routine eye care (Adult) (including exam) and glasses (Limited coverage exceptions apply.) • Tobacco Use Cessation (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 • Chiropractic Care	• Non-emergency care when traveling outside the U.S. • Private Duty Nursing (criteria applies)	• Routine Foot Care (i.e., for diabetics) • Weight Loss Programs (criteria applies)

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the Human Resources department at (573) 346-9221. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 Human Resources department at (573) 346-9221 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 the Missouri Department of Insurance, Truman State Office Building, Room 530, P.O. Box 690, Jefferson City, MO 65102, (800) 726-7390, http://insurance.mo.gov/consumers/, consumeraffairs@insurance.mo.gov (email). Other states' contact information can be obtained at www.dol.gov/ebsa/healthreform (under Consumer Assistance Programs) above or at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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** **$1,500**
- **Specialist copayment** **$40**
- **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	$1,500
Copayments	$100
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **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*	$1,500
Copayments	$1,000
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,960**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **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*	$1,300
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*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.