




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, call 1-866-565-2700 or visit [www.655hw.org](http://www.655hw.org). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-866-565-2700 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-network</a> : <b>\$1,250</b> /person; <b>\$3,750</b> /family. <a href="#">Out-of-network</a> : <b>\$2,500</b> /person; <b>\$7,500</b> /family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , <a href="#">in-network</a> office visit fees, dental and vision services, and wellness care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>\$200</b> per person for <a href="#">prescription drugs</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical: <a href="#">In-network</a> : <b>\$2,500</b> /person; <b>\$6,250</b> /family; <a href="#">Out-of-network</a> : <b>\$5,000</b> /person; <b>\$12,500</b> /family. Medical <a href="#">copayment</a> : <a href="#">In-network</a> : <b>\$1,600</b> /person; <b>\$3,200</b> /family; <a href="#">Out-of-network</a> : <b>no limit</b> . <a href="#">Prescription drugs</a> : <a href="#">In-network</a> : <b>\$3,000</b> /person; <b>\$5,000</b> /family; <a href="#">Out-of-network</a> : <b>not covered</b> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Medical: <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, <a href="#">copayments</a> to in-	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	network physicians, and health care this <a href="#">plan</a> doesn't cover. <a href="#">Prescription drugs</a> : <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, medical benefits, and health care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.655hw.org">www.655hw.org</a> or call 1-866-565-2700 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network-provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network-provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> ; \$20 <a href="#">copay</a> + 30% <a href="#">coinsurance</a> for chiropractic office visits; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> ; \$20 <a href="#">copay</a> + 40% <a href="#">coinsurance</a> for chiropractic office visits	Chiropractic office visits limited to 20 visits/year.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Chiropractic x-rays and labs limited to one set per year.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.

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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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.655hw.org">www.655hw.org</a>.</p>	Generic drugs	Retail: Greater of 15% <a href="#">coinsurance</a> or \$10 <a href="#">copay</a> (\$50 maximum <a href="#">copay</a> )  Mail Order: Greater of 10% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> (\$150 maximum <a href="#">copay</a> )	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order).  You may also fill your maintenance prescriptions (up to a 90-day supply) at all Schnucks, Dierbergs, Shop n' Save and Kroger stores that have pharmacies. You must have filled at least one 30-day supply of the prescription at retail before you are eligible to fill the 90-day supply. Mail order <a href="#">copays</a> will apply. Specialty drugs are payable as preferred brand drugs. <a href="#">Preauthorization</a> of specialty drugs may be required.
	Preferred brand and specialty drugs	Retail: Greater of 25% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> (\$100 maximum <a href="#">copay</a> )  Mail Order: Greater of 25% <a href="#">coinsurance</a> or \$40 <a href="#">copay</a> (\$300 maximum <a href="#">copay</a> )	Not covered	
	Non-preferred brand drugs	Retail: Greater of 25% of generic cost or \$20 <a href="#">copay</a> + difference between brand name and generic price  Mail Order: Greater of 25% of generic cost or \$40 <a href="#">copay</a> + difference between brand name and generic price	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> free standing surgical centers not covered.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for in-network and out-of-network outpatient surgery. Failure to

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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)	
				<a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> + \$200 <a href="#">copay</a>	30% <a href="#">coinsurance</a> + \$200 <a href="#">copay</a>	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a> + \$50 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> + \$50 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for nonemergency admissions. Failure to <a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">copay</a> /office visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is not required for an office visit. However, <a href="#">preauthorization</a> is required for other outpatient services and all inpatient services. Failure to <a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered. Please refer to your insurance card for information regarding out-of-network providers and obtaining <a href="#">preauthorization</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$15 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent child pregnancy is excluded, except for mandated preventive care services.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum 40 visits per 12 month period.

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Rehabilitation services</a> and <a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a>	40% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a>	<a href="#">Preauthorization</a> is required for rehabilitation admissions. Failure to <a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered. <a href="#">Deductible</a> does not apply to physical, speech or occupational therapy visits. Maximum 40 visits (combined with other therapies) per calendar year.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum 60 days per episode. <a href="#">Preauthorization</a> is required. Failure to <a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$1,000 maximum per piece of equipment per date of service. <a href="#">Preauthorization</a> is required for anything over \$1,000. Wigs and prosthesis for hair loss due to a medical diagnosis or treatment covered by the Plan limited to \$150 lifetime maximum per person.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Must be terminally ill with a life expectancy of 6 months or less.
<b>If your child needs dental or eye care</b>	Children up to age 19, eye exam	No charge	Not covered	Coverage limited to Unit 1 dependents only. Coverage limited to one exam per year as recommended by The Bright Futures/American Academy of Pediatrics
	Children's glasses	\$50 <a href="#">copay</a> for lenses; no charge for frames up to \$130, then 100% <a href="#">coinsurance</a> with a 20% discount	Not covered	Coverage limited to Unit 1 dependents only. Coverage limited to one pair of glasses every other year.
	Children up to age 19, dental check-up	No charge	No charge	Coverage limited to Unit 1 dependents only. Limit of 2 exams and 1 x-ray per year.

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## 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, unless directly related to recovery from an injury or where required by law
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Services rendered out-of-geographical area

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

- Bariatric surgery ([preauthorization](#) is required)
- Chiropractic care (maximum 20 visits/yer)
- Dental care (adult) (Unit 1 employees only, maximum \$3,000/year)
- Hearing aids (maximum \$500/ear every 5 years)
- Infertility treatment (maximum \$10,000/lifetime, not covered for dependent child)
- Routine eye care (adult) (1 exam every other calendar year)
- Routine foot care
- Weight loss programs ([preauthorization](#) is required, maximum \$1,500/lifetime)

**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 Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 Plan at 1-866-565-2700 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Department of Insurance, 301 West High Street, Room 830, Harry S. Truman State Office Building, Jefferson City, MO 56101, 1-800-726-7390, [www.insurance.mo.gov](http://www.insurance.mo.gov).

### 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](#).

-----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](#) \$1,250
- [Specialist copayments](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,530</b>

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayments](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,560</b>

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayments](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- Diagnostic test (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$230
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

# Plan D

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.