School District of Springfield R-12 Employee Health Care Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2020 – 12/31/2020

Coverage for: EE, EE/SP,EE/CH,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 (called the premium) will be provided separately. This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. For more information about your coverage, or to get a copy of the complete terms of coverage, you can get the complete terms in the policy or plan document and view the Glossary at http://www.springfieldpublicschoolsmo.org/pages/SPSMO/About/Departments/HR/HRLinks/Benefits or by calling (417) 523-4647 (523-GOHR).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $600 person/ $1,800 family For out-of-network providers $1,800 person/ $5,400 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, Prescription drug coverage $100 Emergency room care $100 Hospital Per Confinement $200	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 network providers $6,600 individual / $13,200 family; For out-of-network providers $19,800 individual / $39,600 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. Maximum Coinsurance network providers: $2,000 per individual / $6,000 per family Maximum Coinsurance out-of-network providers: $6,000 per individual / $18,000 per family Additional Deductibles + copays network providers: $4,000 per individual / $5,400 per family Additional Deductibles + copays out-of-network providers: $12,000 per individual / $16,200 per family
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties and ineligible expenses, including amounts over the usual and customary or contracted rates.	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. for a list of network providers.See 1) http://mercyoptions.net or call (866) 732-4453 or 2) Wrap: HealthLink or PHCS www.healthlink.com or call (800) 624-2356 Refer to the plan document for when network or out-of-network benefits apply for the wrap networks.	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	25% coinsurance	45% coinsurance	None
	Specialist visit	25% coinsurance	45% coinsurance	Chiropractic = $700 / calendar year Naturopathic = $500 / calendar year
	Preventive care/screening/ immunization	Covered at 100%	45% 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 in a Physician's office or outpatient setting (x-ray, blood work)	25% coinsurance	45% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.medtrakrx.com (800) 771-4648**	Generic drugs (Tier 1)	$5 copay + 20% coinsurance	Allowed at contracted rate.	$100 deductible per covered person / $200 per family per Calendar Year applies before copay. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). **Generic Incentive:** Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Brand Name drug is dispensed. In addition to the copay, the Covered Person must pay the difference between the cost of the Generic drug and the Brand Name drug. Medications that are preventive care services under the Affordable Care Act will be covered at 100% and not require a copayment. This includes all Generic and certain Brand Name oral contraceptives, aspirin, certain vitamins and supplements, smoking deterrents, certain vaccinations/ immunizations, etc. Contact MedTrak for the list of the $0 copay items.
	Preferred brand drugs (Tier 2)	$20 copay + 20% coinsurance		
	Non-preferred brand drugs (Tier 3)	$20 copay + 20% coinsurance		
	Specialty drugs (Tier 4) (Must be obtained through the Specialty Drug provider.)	20% copayment; $2,500 maximum copay out-of-pocket per Calendar Year. Covered at 100% thereafter.		
	Affordable Care Act preventive services	$0 copay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	None
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
	Emergency room care	25% coinsurance	45% coinsurance	$100 ER 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 need immediate medical attention	Emergency medical transportation	25% coinsurance	45% coinsurance	None
	Urgent care	25% coinsurance	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance at the semiprivate room rate	45% coinsurance at the semiprivate room rate	Hospital deductible of $200 /confinement applies. Benefit payment for room & board charges will be reduced 50% if the stay is not precertified.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	None
	Inpatient services	25% coinsurance	45% coinsurance	Hospital deductible of $200 /confinement applies. Benefit payment for room & board charges will be reduced 50% if the stay is not precertified.
If you are pregnant	Office visits	25% coinsurance	45% 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). Two ultrasounds will be considered an eligible expense for a routine Pregnancy. Not covered for Dependent Daughters.
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	45% coinsurance	100 visits Calendar Year maximum
	Rehabilitation services	25% coinsurance	45% coinsurance	None
	Habilitation services	Not covered.	Not covered.	Not covered.
	Skilled nursing care	25% coinsurance	45% coinsurance	At the facility's semiprivate room rate. 70 days per Calendar Year maximum
	Durable medical equipment	25% coinsurance	45% coinsurance	None
	Hospice services	25% coinsurance	45% coinsurance	70 visits Lifetime maximum. Bereavement counseling not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Will only be covered as allowed under the Preventive Services regulations.
	Children's glasses	Not covered	Not covered	Not covered unless following eye surgery. Refer to the separate vision plan.
	Children's dental check-up	No charge	Not covered	Dental care not covered. Refer to the separate dental plan.

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.)		
• Cosmetic Surgery	• Hearing Aids	• Routine Eye Care (including exam) and glasses (Limited coverage exceptions apply.)
• Dental Care	• Infertility Treatment	
• Habilitative Services	• Long-term care (other than medically necessary skilled nursing care)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Private Duty Nursing (criteria apply).	• Tobacco Use Cessation (criteria apply).
• Bariatric Surgery (criteria apply).	• Routine Foot Care (i.e., for diabetics)	• Weight loss programs (criteria apply).
• Non-emergency care when traveling outside the U.S.		

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: the Benefits department at (417) 523-4647 (523-GOHR). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (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 Benefits department at (417) 523-4647 (523-GOHR); Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087; or Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High Street, Room 830, Jefferson City, MO 65101, (800) 726-7390, www.insurance.mo.gov. Other states' contact information can be obtained at www.dol.gov/ebsa/healthreform (under Consumer Assistance Programs) above or at http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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	$600
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$10,710**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$830
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,840**

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

The plan's overall deductible	$600
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$7,390**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$700
Copayments	$1,700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,560**

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

The plan's overall deductible	$600
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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*	$700
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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