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, see your Human Resources Department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Tier 1 - Mercy Southeast, Missouri Delta Medical Center, Ste. Genevieve County Hospital, SEMO Health Network, BJC COE, Bootheel Behavioral Health, Consociate Care Missouri:** $3,400 Person / $6,600 Family **Tier 2 – 6 Degrees:** $6,600 Person / $13,200 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 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?	No.	There are no additional specific deductible amounts before this plan begins to pay for services.
What is the out-of-pocket limit for this plan?	**Tier 1 - Mercy Southeast, Missouri Delta Medical Center, Ste. Genevieve County Hospital, SEMO Health Network, BJC COE, Bootheel Behavioral Health, Consociate Care Missouri:** $3,750 Person / $7,500 Family **Tier 2 – 6 Degrees:** $7,500 Person / $15,000 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-billed charges, copayments, ineligible charges 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.consociate.com or call 1-800-798-2422 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.	A referral is not required to see a specialist for covered services.

All **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
		Tier 1: (You will pay the least)	Tier 2: (You will pay the least)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible then $10 copayment	Deductible then $30 copayment	Telehealth / Virtual visits are covered as any other office visit.
	Specialist visit	Deductible then $10 copayment	Deductible then $30 copayment	
	Preventive care/ screening/immunization	100% covered	100% covered	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)	0% coinsurance	30% coinsurance	Services performed by LabCorp are covered under Tier 1
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 844-592-1108.	Generic drugs	Retail: $10 copayment Mail Order: $20 copayment	Not Covered (unless emergency)	Covers up to a 30-day supply (retail) or 90-day supply (mail order) **Prescription Drug Copayments apply after Tier 2 deductible has been met, accumulate to Tier 2 Out-of-Pocket maximum, and will not apply after Tier 2 Out-of-Pocket maximum has been reached.**
	Preferred brand drugs	Retail: $35 copayment Mail Order: $70 copayment		
	Non-preferred brand drugs	Retail: $60 copayment Mail Order: $120 copayment		
	Specialty drugs	25% copay to a maximum of $200.	Not Covered	Optum Specialty Pharmacy must be used to fill Specialty Medications for up to a 30-day supply. Please register at Optum Specialty Pharmacy or call 1-877-656-9604.
		Certain members will be prescribed medications that may be available at no cost to you through manufacturer direct programs and for which these drugs will not be covered by the Plan. In these situations, members will be contacted by ImpaxRx representatives in partnership with Aphora Health, who will help walk you through the process and assist you with qualifying for the free drug program.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	Preauthorization is required for outpatient surgeries unless performed in physician's office.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care - True emergency	Deductible then $200 copayment		Preauthorization is required if admitted to Hospital from ER. Copay is waived if admitted as inpatient within 24 hours.
	Emergency room care - Non-emergency	Deductible then $200 copayment		
	Emergency medical transportation	0% coinsurance, after Tier 1 deductible.		Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Tier 1: (You will pay the least)	Tier 2: (You will pay the least)	
If you need immediate medical attention	Urgent care	Deductible then $50 copayment	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization is required for all inpatient stays.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	Deductible then $10 copayment	Deductible then $30 copayment	Telehealth / Virtual visits are covered as any other office visit.
	Outpatient services	0% coinsurance	30% coinsurance	Preauthorization is required for inpatient services and for Intensive Outpatient services.
	Inpatient services	0% coinsurance	30% coinsurance	
If you are pregnant	Office visits	Deductible then $10 copayment	Deductible then $30 copayment	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). Not covered for dependent daughter. Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Preauthorization is required. Limited to 100 visits per calendar year.
	Rehabilitation services	Deductible then $10 copayment	Deductible then $30 copayment	Preauthorization is required for Physical Therapy, Occupational Therapy and Speech Therapy over 15 visits. Limited to 60 visits for OT/PT and ST combined.
	Habilitation services	0% coinsurance	30% coinsurance	None
	Skilled nursing care	0% coinsurance	30% coinsurance	Preauthorization is required. Limited to 90 days per calendar year.
	Durable medical equipment	0% coinsurance	30% coinsurance	Preauthorization is required for DME/Prosthetics /Orthotics in excess of $500 billed per date of service.
	Hospice services	0% coinsurance	30% coinsurance	Preauthorization is required for all inpatient stays
If your child needs dental or eye care	Children's eye exam	Not Covered		None
	Children's glasses	Not Covered		None
	Children's dental check-up	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 (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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 31 visits per year
- Hearing Aids
- 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: Consociate Health: 1-800-798-2422. 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 x 61565 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 on how 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: Consociate Health: 1-800-798-2422. You can also contact the 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	**$3,400**
OB copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,410**

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

The plan's overall deductible	**$3,400**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,400
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,750**

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

The plan's overall deductible	**$3,400**
Specialist copayment	**$210**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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