


Cape Girardeau School District Health Care Plan: MRP & ACP Coverage Period: 1/1/2018-12/31/2018


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: 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](#) 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 employer's benefits personnel. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$0 person/\$0 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? | NO | 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 ? | NA | 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 ? | NA | 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 your other health care plan's PPO | 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 ? | Your other plan may require a referral to see a specialist. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

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 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 | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Specialist visit | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Preventive care/screening/immunization | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Imaging (CT/PET scans, MRIs) | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | |

| 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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com | Generic drugs (Tier 1) | Rx co-payments on your other plan are 100% reimbursable | Not covered | None |
| | Preferred brand drugs (Tier 2) | Rx co-payments on your other plan are 100% reimbursable | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Rx co-payments on your other plan are 100% reimbursable | Not covered | |
| | Specialty drugs (Tier 4) | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |
| | Physician/surgeon fees | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| If you need immediate medical attention | Emergency room care | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Emergency medical transportation | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |
| | Urgent care | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |

| 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) | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |
| | Physician/surgeon fees | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |
| | Inpatient services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |
| If you are pregnant | Office visits | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C Non PPO Hospital charges, Non covered charges, charges over R&C |
| | Childbirth/delivery professional services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | |
| | Childbirth/delivery facility services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | 100% coinsurance | Non PPO Hospital charges, Non covered charges, charges over R&C |

| 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 help recovering or have other special health needs | Home health care | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Rehabilitation services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Habilitation services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Skilled nursing care | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Durable medical equipment | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| | Hospice services | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Deductibles, Co-payments, and Co-insurance payments on your other plan are 100% reimbursable | Non covered charges, charges over R&C |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | |
| | Children's glasses | Not Covered | Not Covered | |
| | Children's dental check-up | Not Covered | Not Covered | |

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](#).)

- Refer to your primary plan for details. If your other plan does not cover a service, neither does the MRP unless specifically noted.
- Non PPO Hospital Charges on your other plan are not reimbursable by the MRP.

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

See your primary plan for details. The MRP and ACP covers the Deductibles, Coinsurance, and Copayments for covered services on your other Primary Insurance except for Non PPO Hospital Charges.

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: Claim Administrator at 800-448-4689. 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 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: Mutual Medical Plans, Inc. 800-448-4689 –or- 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.**

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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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](#) \$500
- [Specialist copayment](#) \$50
- [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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------|
| Deductibles | \$500 |
| Copayments | \$300 |
| Coinsurance | \$2,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$60 |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- [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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------|
| Deductibles* | \$800 |
| Copayments | \$1,200 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$60 |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- [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:

| <i>Cost Sharing</i> | |
|-----------------------------------|------------|
| Deductibles* | \$700 |
| Copayments | \$50 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.