

 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 800-375-9173 or visit <https://portal.90degreebenefits.com>. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 800-375-9173 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,000 Individual / 6,000 Family Non-Network: \$6,000 Individual / \$12,000 Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Network Provider: Preventive Care	The plan covers some items and services even if you haven't met the <u>deductible</u> amount, but <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,000 Individual / \$12,000 Family Non-Network: \$12,000 Individual / \$24,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges (unless balanced billing is prohibited), penalties for failure to obtain pre-certification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. Mercy Network. To locate a provider, visit www.mercyoptions.net (select SMBC as the employer)	You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without a referral.

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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	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care visit to treat an injury or illness</u>	\$10 copay after deductible	50% coinsurance after deductible	<p>Office Surgery and Anesthesia, Therapeutic Injections, Allergy Injections and Serum, X-ray, Lab, Diagnostic Testing, Telemedicine and All Other Office Related Services: Network Provider: PCP \$10 copay after deductible Specialist \$35 copay after deductible Non-Network Provider: 50% coinsurance after deductible</p> <p>Allergy Testing: Network Provider: 20% coinsurance after deductible Non-Network Provider: 50% coinsurance after deductible</p>
	<u>Specialist visit</u>	\$35 copay after deductible	50% coinsurance after deductible	
	<u>Preventive care/screening/immunization</u>	No charge	50% coinsurance after deductible	
If you have a test	<u>Diagnostic test</u>	<u>Outpatient X-ray:</u> 20% coinsurance after deductible <u>Outpatient Lab:</u> 20% coinsurance after deductible	<u>Outpatient X-ray and Lab:</u> 50% coinsurance after deductible	<u>Independent Lab:</u> Network Provider: 20% coinsurance after deductible Non-Network Provider: 50% coinsurance after deductible
	<u>Imaging (CT/PET scans, MRIs)</u>	20% coinsurance after deductible	50% coinsurance after deductible	None.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	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.southernscripts.net or call Southernscripts at 800-710-9341.	<u>Generic drugs</u>	\$5 copay after deductible	\$5 copay after deductible	Retail - 30 day supply - copay applies to each 30 day supply.
	<u>Preferred brand drugs</u>	\$35 copay after deductible	\$35 copay after deductible	Mail Order - copay applies to each 31-90 day supply.
	<u>Non-preferred brand drugs</u>	\$75 copay after deductible	\$75 copay after deductible	Specialty Drug Program: For more information call MedVed, Inc. at 417-893-8437. After 90 days covered through Specialty Drug Program (If qualified). If not qualified, revert to copay.
	<u>Specialty drugs</u>	Subject to participation in MedVed, Inc.		
If you have outpatient surgery	<u>Facility fee (e.g., ambulatory surgery center)</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Surgeon fees</u>	20% coinsurance after deductible	50% coinsurance after deductible	None.
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance after deductible	20% coinsurance after deductible (network out-of-pocket and deductible apply)	If admitted within 24 hours, copay waived, and pre-cert required. Call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible (network out-of-pocket and deductible apply)	<u>Ambulance (Air, Water, and Ambulance Transfers for non-emergency):</u> Pre-certification is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Urgent care</u>	\$50 copay after deductible	50% coinsurance after deductible	Charges for certain diagnostic procedures such as MRI, PET, BONE Scan, Cardiac Stress Test, Radiation, Chemo, Dialysis are subject to deductible/coinsurance.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you have a hospital stay	<u>Facility fee (e.g., hospital room)</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Surgeon fees</u>	20% coinsurance after deductible	50% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	<u>Outpatient services</u>	Office Visit: \$10 copay after deductible Outpatient Services: 20% coinsurance after deductible	Office Visit/Outpatient Services: 50% coinsurance after deductible	Outpatient Services: Pre-certification is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Inpatient services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
If you are pregnant	<u>Office visits (first visit to diagnose pregnancy)</u>	\$10 copay after deductible	50% coinsurance after deductible	Cost sharing does not apply for certain Network Prenatal/Preventive services required by PPACA. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	<u>Childbirth/delivery professional services</u>	20% coinsurance after deductible	50% coinsurance after deductible	
	<u>Childbirth/delivery facility services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required for inpatient stays longer than 48 hours for vaginal delivery or 72 hours for cesarean delivery, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250 per admission.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per calendar year. Pre-cert is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Rehabilitation services</u>	\$35 copay after deductible	50% coinsurance after deductible	<u>Physical Therapy, Occupational Therapy, Speech Therapy:</u> Pre-cert is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250. Maximum benefits per calendar year 40 visits per therapy.
	<u>Habilitation services</u>	\$35 copay after deductible	50% coinsurance after deductible	
	<u>Skilled nursing care</u>	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 days per calendar year. Pre-cert is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Durable medical equipment</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required for any single line item over \$1,000, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250.
	<u>Hospice services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required, call 800-375-9173. Failure to pre-certify will result in a penalty of \$250. Bereavement counseling covered within 6 months of death.
If your child needs dental or eye care	<u>Children's eye exam</u>	\$35 copay after deductible	50% coinsurance after deductible	Limited to 1 routine eye exam per Calendar Year.
	<u>Children's glasses</u>	Not covered	Not covered	Not a covered service under this Plan.
	<u>Children's dental check-up</u>	No charge	50% coinsurance after deductible	Coverage limited to oral health risk assessment as required by PPACA.

Excluded Services & Other Covered Services:

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Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Weight loss programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Chiropractic Care – calendar year maximum of 26 visits 	<ul style="list-style-type: none"> • Diabetic Shoes – Limited to 2 pair per calendar year (paid In-Network) 	<ul style="list-style-type: none"> • Hearing aids - one aid per ear each 36-month period

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 available by calling 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: 800-375-9173. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 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 800-375-9173.
 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-375-9173.
 Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-375-9173.
 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-375-9173.

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

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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 <u>deductible</u>	\$3,000
■ <u>PCP copay</u>	\$10
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)

Total Example Cost	\$12,738
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$2,001
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,071

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$3,000
■ <u>Specialist copay</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$295
Coinsurance	\$372
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,722

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$3,000
■ <u>Specialist copay</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,397
Copayments	\$245
Coinsurance	\$283
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925