




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:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><a href="#">In-network</a>: \$1,250/person; \$3,750/family.  <a href="#">Out-of-network</a>: \$2,500/person; \$7,500/family.</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a>, <a href="#">in-network</a> office visits, dental and vision services, physical, speech or occupational therapy visits, <a href="#">urgent care</a>, and wellness care are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>\$200 per person for <a href="#">prescription drugs</a>. There are no other specific <a href="#">deductibles</a>.</p>	<p>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.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>Medical: <a href="#">In-network</a>: \$2,500/person; \$6,250/family; <a href="#">Out-of-network</a>: \$5,000/person; \$12,500/family.                      Medical <a href="#">copayment</a>: <a href="#">In-network</a>: \$1,600/person; \$3,200/family; <a href="#">Out-of-network</a>: no limit.  <a href="#">Prescription drugs</a>: <a href="#">In-network</a>: \$3,000/person; \$5,000/family; <a href="#">Out-of-network</a>: no limit.</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>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>.</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit; \$20 <a href="#">copay</a> /visit + 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> /visit + 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 <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<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.

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> /fill (\$50 maximum <a href="#">copay</a> ) Mail Order: Greater of 10% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> /fill (\$150 maximum <a href="#">copay</a> /fill)	Not covered	Subject to separate <a href="#">deductibles</a> for <a href="#">prescription drugs</a> of \$100 per person, but no <a href="#">cost sharing</a> for ACA-required generic preventive drugs (or brand drugs if the generic is not medically appropriate).
	Preferred brand drugs	Retail: Greater of 25% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> /fill (\$100 maximum <a href="#">copay</a> /fill) Mail Order: Greater of 25% <a href="#">coinsurance</a> or \$40 <a href="#">copay</a> /fill (\$300 maximum <a href="#">copay</a> /fill)	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 and Dierbergs 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. <a href="#">Specialty drugs</a> are payable as preferred brand drugs. <a href="#">Preauthorization</a> of <a href="#">specialty drugs</a> may be required for these drugs to be covered.
	Non-preferred brand drugs	Retail: Greater of 25% of generic cost or \$20 <a href="#">copay</a> /fill + difference between brand name and generic price Mail Order: Greater of 25% of generic cost or \$40 <a href="#">copay</a> /fill + 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 <a href="#">Out-of-network</a> outpatient surgery. Failure to <a href="#">preauthorize</a> may result in you paying the full cost of services that are not covered.

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	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> + \$200 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a> + \$200 <a href="#">copay</a> /visit	<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> /visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> + \$50 <a href="#">copay</a> /visit; <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 preauthorize 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> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	Inpatient services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for nonemergency admissions. Failure to preauthorize may result in you paying the full cost of services that are not covered. For <a href="#">Out-of-network providers</a> , you or your <a href="#">provider</a> should obtain <a href="#">preauthorization</a> by calling Behavioral Health Pre-Cert 1-800-292-2879
If you are pregnant	Office visits	\$15 <a href="#">copay</a> /visit; <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 <a href="#">preventive care</a> services and <a href="#">emergency services</a> .
	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>	

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="#">Home health care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum 40 visits per 12 month period.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a> /visit	Maximum 40 visits per calendar year. <a href="#">Preauthorization</a> is required for rehabilitation admissions. Failure to preauthorize 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.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a> + \$20 <a href="#">copay</a> /visit	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 preauthorize 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 device. Wigs and prosthesis for hair loss due to a medical diagnosis or treatment covered by the <a href="#">Plan</a> 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's eye exam	\$10 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	Coverage limited to one exam every year.
	Children's glasses	\$20 <a href="#">copay</a> /set of lenses; no charge for frames up to \$175, then 100% <a href="#">coinsurance</a> with a 20% discount	Not covered	Coverage limited to one pair of lenses every year and one frame every other year.
	Children's dental check-up	No charge; <a href="#">deductible</a> does not apply	No charge	Coverage limited to Unit 1 dependents only. Limit of 2 exams and 1 x-ray per year.

## 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
- Long-term care
- Private duty nursing
- Cosmetic surgery, unless directly related to recovery from an injury or where required by law
- Non-emergency care when traveling outside the U.S.

### 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)
- Hearing aids (maximum \$500/ear every 5 years)
- Routine eye care (adult) (limit 1 exam and 1 pair of lenses every year; 1 frame every other year)
- Chiropractic care (maximum 20 visits/year)
- Infertility treatment (maximum \$10,000/lifetime, not covered for dependent child)
- Routine foot care
- Dental care (adult) (Unit 1 employees only, maximum \$3,000/year)
- Weight loss programs ([preauthorization](#) is required, maximum \$1,500/lifetime) for non-preventive)

**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 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: 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

[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](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayments</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,250
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,520</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayments</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$1,170
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,390</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayments</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$220
<a href="#">Coinsurance</a>	\$310
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,780</b>