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2026 Plan Year

Summary of Benefits and Coverage

Public Entity

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, visit www.mchcp.org or call 1-800-487-0771. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms, please refer to the Glossary starting on page 24.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,800** individual/$**3,600** family (network) Does not apply to preventive care **$3,300** individual/**$6,600** family (non-network)	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible. Certain expanded preventive drugs are covered subject to cost-sharing.	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/. This plan covers certain drugs prior to meeting the deductible as allowed by the IRS. For coverage please refer to state regulation.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,400** individual/**$10,800** family (network) **$9,900** individual/**$19,800** family (non-network)	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, the overall family out-of-pocket limit must be met, unless an individual exceeds $8,500.
What is not included in the out-of-pocket limit?	Premium, balance bill charges, penalties and health care services 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. Contact ESI or Anthem 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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	40% 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. Non-network immunizations have no charge from birth to 72 months.
If you have a test…	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization (PA) required. If you fail to get PA, the service may not be covered.
If you need drugs to treat your illness or condition… (More information about **prescription drug coverage** is available at www.mchcp.org, or by calling 1-800-487-0771.)	Preferred generic drugs	10% coinsurance up to **$50**	40% coinsurance	Some prescriptions are subject to PA, quantity level limits or step therapy requirements. If you fail to follow requirements, the prescription may not be covered. Network: No charge for preventive preferred prescriptions and flu/shingles vaccinations. Specialty drugs must be filled through Accredo, except for the first fill of drugs needed immediately. Members who go to a retail pharmacy will be charged the full discounted price of the drug. The amounts shown for what you will pay is for a 31-day supply.
	Preferred brand drugs	20% coinsurance up to **$100**	40% coinsurance	
	Non-preferred brand drugs	40% coinsurance up to **$200**	50% coinsurance	
	Specialty drugs	20% coinsurance up to **$100**	No coverage	
If you have outpatient surgery…	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

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 room care	20% coinsurance	20% coinsurance after network deductible	PA required for non-emergent use of emergency medical transportation. If you fail to get PA, the service may not be covered.
	Emergency medical transportation	20% coinsurance	20% coinsurance after network deductible	
	Urgent care	20% coinsurance	20% coinsurance after network deductible	
If you have a hospital stay…	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	PA required, except for an observation stay or if admitted from the ER. If you fail to get PA, the service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health or substance abuse services…	Outpatient services	20% coinsurance	40% coinsurance	PA required for services provided at hospital, except for an observation stay. If you fail to get PA, the service may not be covered.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant…	Office visits	20% coinsurance	40% coinsurance	No charge for routine prenatal care.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering, or have other special health needs…	Home health care	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per calendar year. PA required for some services. If you fail to get PA, the service may not be covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Hospice services	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be 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 your child needs dental or eye care…	Children's eye exam	20% coinsurance	40% coinsurance	Coverage limited to one exam/calendar year.
	Children's glasses	20% coinsurance	40% coinsurance	Coverage limited to fitting of eye glasses or contact lenses following cataract surgery.
	Children's dental check-up	Not covered	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
- Cosmetic surgery
- Dental care (adult)
- Exercise equipment
- Weight-loss programs
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This IS NOT a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S. covered as a non-network benefit
- Routine eye care (adult)
- Infertility treatment

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: Department of Health & Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext. 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 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 Anthem at 844-516-0248, or Express Scripts at 800-797-5754. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High St., Room 530, Jefferson City, MO 65101; call 800-726-7390; visit www.insurance.mo.gov; or email consumeraffairs@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 a premium tax credit.

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 1-800-487-0771.]

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

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

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$1,800**
Specialist copayment	**$0**
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	**$12,700**

In this example, Peg would pay:

Cost-Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$2,180
What isn't covered?	
Limits or exclusions	$0
The total Peg would pay is	**$3,980**

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

The plan's overall deductible	**$1,800**
Specialist copayment	**$0**
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	**$5,600**

In this example, Joe would pay:

Cost-Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$760
What isn't covered?	
Limits or exclusions	$60
The total Joe would pay is	**$2,620**

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

The plan's overall deductible	**$1,800**
Specialist copayment	**$0**
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	**$2,800**

In this example, Mia would pay:

Cost-Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$200
What isn't covered?	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** individual/**$1,500** family (network) Does not apply to preventive care **$1,500** individual/**$3,000** family (non-network)	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, nutrition counseling, certified diabetes education, a preferred glucometer and test strips, and prescriptions 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,250** individual/**$4,500** family (network medical) **$4,500** individual/**$9,000** family (non-network medical) **$4,150** individual/**$8,300** family (network prescription)	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. Note: there is no maximum for non-network pharmacies.
What is not included in the out-of-pocket limit?	Premium, balance bill charges, penalties and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. Contact ESI or Anthem 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.	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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% 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. Non-network immunizations have no charge from birth to 72 months.
If you have a test…	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization (PA) required. If you fail to get PA, the service may not be 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 drugs to treat your illness or condition… (More information about **prescription drug coverage** is available at www.mchcp.org, or by calling 1-800-487-0771.)	Preferred generic drugs	**$15/$30/$45** copayment for up to 31/60/90 days (retail) **$37.50** copayment 61–90 days	You pay the full price of the prescription and file a claim. You are reimbursed the cost of the drug based on the network discounted amount, less the applicable network copayment.	Some prescriptions are subject to PA, quantity level limits or step therapy requirements. If you fail to follow requirements, the prescription may not be covered. Network: No charge for preventive preferred prescriptions and flu/shingles vaccinations. If members purchase a brand-name drug when a generic is available, they pay the generic copayment plus the difference in the cost of the drugs.
	Preferred brand drugs	**$50/$100/$150** copayment for up to 31/60/90 days (retail) **$125** copayment 61–90 days (mail order)		
	Non-preferred brand drugs	**$120/$240/$360** copayment for up to 31/60/90 days (retail) **$300** copayment 61–90 days (mail order)		
	Specialty drugs	**$100** for up to 31 days	No coverage	Specialty drugs must be filled through Accredo, except for the first fill of drugs needed immediately. Members who go to a retail pharmacy will be charged the full discounted price.
If you have outpatient surgery…	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention…	Emergency room care	**$250** copayment plus 20% coinsurance	**$250** copayment plus 20% coinsurance after network deductible	Copayment applies to the out-of-pocket maximum, but not the deductible. The copayment is waived if admitted to the hospital, or if the service is considered a "true emergency".
	Emergency medical transportation	20% coinsurance	20% coinsurance after network deductible	PA required for non-emergent use of emergency medical transportation. If you fail to get PA, the service may not be 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.)	
	Urgent care	20% coinsurance	20% coinsurance after network deductible	None
If you have a hospital stay…	Facility fee (e.g., hospital room)	**$200** copayment plus 20% coinsurance	**$200** copayment plus 40% coinsurance	PA required except for an observation stay, or if admitted from the ER. If you fail to get PA, the service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health or substance abuse services…	Outpatient services	20% coinsurance	40% coinsurance	PA required for services provided at hospital, except for an observation stay. If you fail to get PA, the service may not be covered.
	Inpatient services	**$200** copayment plus 20% coinsurance	**$200** copayment plus 40% coinsurance	
If you are pregnant…	Office visits	20% coinsurance	40% coinsurance	No charge for routine prenatal care.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering, or have other special health needs…	Home health care	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per calendar year. PA required for some services. If you fail to get PA, the service may not be covered.

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least.)	Out-of-Network Provider (You will pay the most.)	
	Durable medical equipment	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered. No charge for breast pumps.
	Hospice services	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
If your child needs dental or eye care…	Children's eye exam	20% coinsurance	40% coinsurance	Coverage limited to one exam/calendar year.
	Children's glasses	20% coinsurance	40% coinsurance	Coverage limited to fitting of eye glasses or contact lenses following cataract surgery.
	Children's dental check-up	Not covered	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
- Cosmetic surgery
- Dental care (adult)
- Exercise equipment
- Weight-loss programs
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This IS NOT a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S. covered as a non-network benefit
- Routine eye care (adult)
- Infertility treatment

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: Department of Health & Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext: 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 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 Anthem at 844-516-0248, or Express Scripts at 800-797-5754. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High St., Room 530, Jefferson City, MO 65101; call 800-726-7390; visit www.insurance.mo.gov; or email consumeraffairs@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 a premium tax credit.

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.

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 prenatal care and a hospital delivery)

■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$0**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$12,700**

In this example, Peg would pay:

Cost-Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$2,330
What isn't covered?	
Limits or exclusions	$0
The total Peg would pay is	**$2,320**

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

■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$0**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$5,600**

In this example, Joe would pay:

Cost-Sharing	
Deductibles	$750
Copayments	$1,040
Coinsurance	$760
What isn't covered?	
Limits or exclusions	$60
The total Joe would pay is	**$2,610**

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

■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$0**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$2,800**

In this example, Mia would pay:

Cost-Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$410
What isn't covered?	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

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

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, visit www.mchcp.org or call 1-800-487-0771. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms, please refer to the Glossary starting on page 22.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,250** individual/**$2,500** family (network) Does not apply to preventive care **$2,500** individual/**$5,000** family (non-network)	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, office visits, nutrition counseling, certified diabetes education, a preferred glucometer and test strips, and prescriptions 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,750** individual/**$7,500** family (network medical, which includes copayments) **$7,500** individual/**$15,000** family (non-network medical) **$4,150** individual/**$8,300** family (network prescription)	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. Note: there is no maximum for non-network pharmacies.
What is not included in the out-of-pocket limit?	Premium, balance bill charges, penalties and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. Contact ESI or Anthem 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.	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** copayment and/or 20% coinsurance	40% coinsurance	Copayment covers office visit only. Coinsurance will be applied to labs, x-rays or other services associated with the visit. Chiropractor copayment may be less than $20 if it is more than 50% of the total cost of the service. Preauthorization (PA) required for some visits. If you fail to get PA, the service may not be covered.
	Specialist visit	**$40** copayment and/or 20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% 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. Non-network immunizations have no charge from birth to 72 months.

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 test…	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
If you need drugs to treat your illness or condition… (More information about **prescription drug coverage** is available at www.mchcp.org, or by calling 1-800-487-0771.)	Preferred generic drugs	**$15/$30/$45** copayment for up to 31/60/90 days (retail) **$37.50** copayment 61–90 days	You pay the full price of the prescription and file a claim. You are reimbursed the cost of the drug based on the network discounted amount, less the applicable copayment.	Some prescriptions are subject to PA, quantity level limits or step therapy requirements. If you fail to follow requirements, the prescription may not be covered. Network: No charge for preventive preferred prescriptions and flu/shingles vaccinations If members purchase a brand-name drug when a generic is available, they pay the generic copayment plus the difference in the cost of the drugs.
	Preferred brand drugs	**$50/$100/$150** copayment for up to 31/60/90 days (retail) **$125** copayment 61–90 days (mail order)		
	Non-preferred brand drugs	**$120/$240/$360** copayment for up to 31/60/90 days (retail) **$300** copayment 61–90 days (mail order)		
	Specialty drugs	**$100** for up to 31 days	No coverage	Specialty drugs must be filled through Accredo, except for the first fill of drugs needed immediately. Members who go to a retail pharmacy will be charged the full discounted price.

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 room care	**$250** copayment plus 20% coinsurance	**$250** copayment plus 20% coinsurance after network deductible	Copayment applies to the out-of-pocket maximum, but not the deductible. The copayment is waived if admitted to the hospital, or if the service is considered a "true emergency".
	Emergency medical transportation	20% coinsurance	20% coinsurance after network deductible	PA required for non-emergent use of emergency medical transportation. If you fail to get PA, the service may not be covered.
	Urgent care	**$50** copayment and/or 20% coinsurance	**$50** copayment and/or 20% coinsurance after network deductible	Copayment covers office visit only. Coinsurance will be applied to labs, x-rays or other services associated with the visit.
If you have a hospital stay…	Facility fee (e.g., hospital room)	**$200** copayment plus 20% coinsurance	**$200** copayment plus 40% coinsurance	PA required except for an observation stay, or if admitted from the ER. If you fail to get PA, the service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health or substance abuse services…	Outpatient services	**$25** copayment and/or 20% coinsurance	40% coinsurance	Copayment covers office visit only. Coinsurance will be applied to labs, x-rays or other services associated with the visit. PA required for services provided at hospital, except for an observation stay. If you fail to get PA, the service may not be covered.
	Inpatient services	**$200** copayment plus 20% coinsurance	**$200** copayment plus 40% coinsurance	
If you are pregnant…	Office visits	**$25** copayment plus 20% coinsurance	40% coinsurance	Copayment covers office visit only. No charge for routine prenatal care. Coinsurance will be applied to labs, x-rays or other services associated with the visit.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per calendar year. PA required for some services. If you fail to get PA, the service may not be covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	PA required for some services. If you fail to get PA, the service may not be covered. No charge for breast pumps.
	Hospice services	20% coinsurance	40% coinsurance	PA required. If you fail to get PA, the service may not be covered.
If your child needs dental or eye care…	Children's eye exam	**$40** copayment and/or 20% coinsurance	40% coinsurance	Copayment covers office visit only. Coinsurance will be applied to labs, x-rays or other services associated with the visit. Coverage limited to one exam/calendar year.
	Children's glasses	20% coinsurance	40% coinsurance	Coverage limited to fitting of eye glasses or contact lenses following cataract surgery
	Children's dental check-up	Not covered	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
- Cosmetic surgery
- Dental care (adult)
- Exercise equipment
- Weight-loss programs
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This IS NOT a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S. covered as a non-network benefit
- Routine eye care (adult)
- Infertility treatment

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: Department of Health & Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext: 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 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 Anthem at 844-516-0248, or Express Scripts at 800-797-5754. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High St., Room 530, Jefferson City, MO 65101; call 800-726-7390; visit www.insurance.mo.gov; or email consumeraffairs@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 a premium tax credit.

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 1-800-487-0771.]

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 prenatal care and a hospital delivery)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$12,700**

In this example, Peg would pay:

Cost-Sharing	
Deductibles	$1,250
Copayments	$300
Coinsurance	$2,230
What isn't covered?	
Limits or exclusions	$0
The total Peg would pay is	**$3,780**

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

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$5,600**

In this example, Joe would pay:

Cost-Sharing	
Deductibles	$500
Copayments	$1,240
Coinsurance	$770
What isn't covered?	
Limits or exclusions	$60
The total Joe would pay is	**$2,570**

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

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$200**
■ **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	**$2,800**

In this example, Mia would pay:

Cost-Sharing	
Deductibles	$1,250
Copayments	$30
Coinsurance	$300
What isn't covered?	
Limits or exclusions	$0
The total Mia would pay is	**$1,580**

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

(See page 6 for a detailed example.)

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

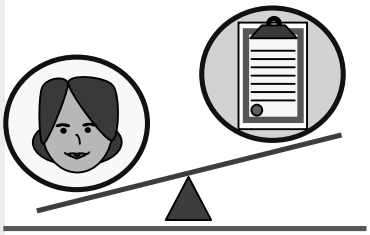
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. 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.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

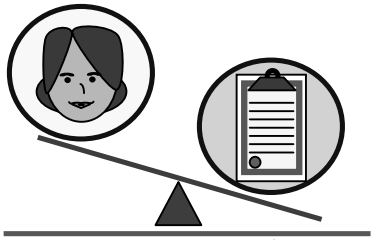
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

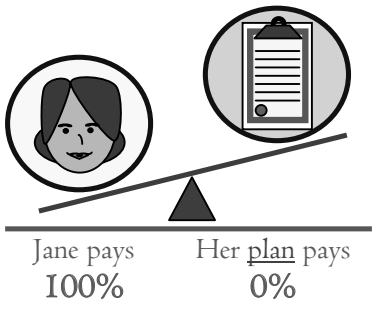
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

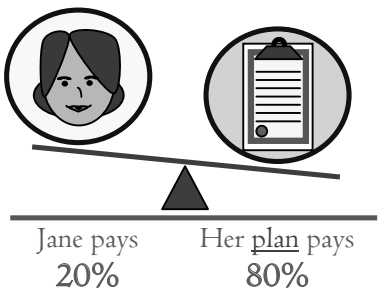
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

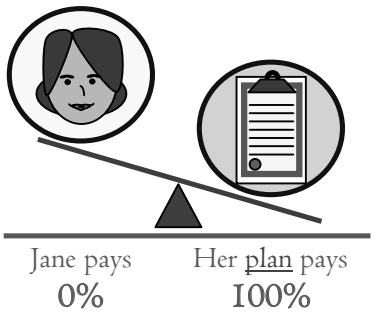
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Women's Health and Cancer Rights Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call Anthem at 844-516-0248.

Effective September 1, 2013

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact Missouri Consolidated Health Care Plan's Privacy Officer at 832 Weathered Rock Court, PO Box 104355, Jefferson City, MO 65110, or by calling 573-751-8881 or toll free 800-701-8881.

This notice describes the information privacy practices followed by workforce members of Missouri Consolidated Health Care Plan. For purposes of this notice, the pronouns "we", "us" and "our" and the acronym "MCHCP" refer to Missouri Consolidated Health Care Plan.

This notice applies to the information and records we have about your health care and the services you receive. We are required by law to maintain the privacy of your protected health information and to notify you if there has been a breach of your protected health information. We are also required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You

For Treatment

We may use or disclose protected health information about you to assist in providing you with medical treatment or services. For example, we may use and disclose protected health information with your providers (pharmacies, physicians, hospitals, etc.) to assist in your treatment.

For Payment

We may use and disclose protected health information about you so that the treatment and services you receive will be paid. For example, we may use or disclose protected health information in order for your claims to be processed, coordinate your benefits, review health care services provided to you and evaluate medical necessity or appropriateness of care or charges. We may also use or disclose your protected health information to determine whether a treatment is a covered benefit under the health plan. We may use and disclose your protected health information to determine eligibility for coverage, in order to obtain pretax payment of your premiums from your employer or sponsoring entity, and for determining wellness premium incentives. We may use and disclose your protected health information for underwriting purposes, but, if we do, we are prohibited from using your genetic information for such purposes.

For Health Care Operations

We may use and disclose protected health information for our health care operations. For example, we may use and disclose your protected health information to address or resolve complaints or appeals regarding your medical benefits. We may use or disclose protected health information with our wellness or disease management programs in which you participate. We may use your protected health information to conduct audits, for purposes of rate-making, as well as for purposes of risk management. We may also disclose your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination. In this case, we will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

Disclosures to Employer

We may also use and disclose protected health information with your employer as necessary to

perform administrative functions. Employers who receive this type of information are required by law to have safeguards in place to protect against inappropriate use or disclosure of your information.

Disclosures to Family Members or Others

We may disclose health information about you to your family members or friends if we obtain your written authorization to do so. Also, unless you object, we may disclose relevant portions of your protected health information to a family member, friend, or other person you indicate is involved in your health care or in helping you receive payment for your health care. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you to a meeting or have your spouse on the telephone while such information is discussed. We may also disclose claim and payment information of family members to the subscriber in a family plan.

If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

Disclosures to Business Associates

We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal and state law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose your health information when required to do so by federal, state or local law.

Public Health Activities

We may disclose your health information to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing disease or injury.

For Research

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

To a Health Oversight Agency

We may disclose your health information to a health oversight agency for oversight activities authorized by law.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal. We may disclosure your health information in the course of any judicial or administrative proceeding in response to a subpoena, discovery request, or other lawful process if we receive satisfactory assurance that you have been given notice of the request or that there is a qualified protective order for the information.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

For Military, National Security, or Incarceration/Law Enforcement Custody

If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other Uses & Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written Authorization that complies with the law governing HIV or substance abuse records.

If we have psychotherapy notes, we will not use or disclose that information without authorization unless the use or disclosure is used to defend MCHCP in a legal action or other proceeding brought by you.

MCHCP will not use or disclose your protected health information for marketing purposes without an authorization, except if the marketing communication is in the form of a face-to-face communication made by MCHCP to you or in the form of a promotional gift of nominal value provided by MCHCP. MCHCP will not sell your protected health information without your authorization.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as enrollment, eligibility and billing records. You must submit a written request to MCHCP's Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend Incorrect or Incomplete PHI

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Member Record Amendment/Correction Form to MCHCP's Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. We did not create, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the health information that we keep;
3. You would not be permitted to inspect and copy; or
4. Is accurate and complete.

Right to an Accounting of Certain Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to MCHCP's Privacy Officer. It must state a time period, which may not go back more than six years from the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a particular health care treatment you received.

We are Not Required to Agree to Your Request

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If your request restricts us from using or disclosing information for purposes of treatment, payment or health care operations, we have the right to discontinue providing you with health care treatment and services.

Request Restrictions

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Health Care Information to MCHCP's Privacy Officer.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use and Disclosure of Health Care Information and/or Confidential Communication to MCHCP's Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact MCHCP's Privacy Officer.

Changes to This Notice

MCHCP is required to abide by the terms of the notice currently in effect. We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future.

We will post the revised notice to our website prior to the effective date of the change, and we will distribute any amended notice or information about the change and how to obtain a revised notice in the next annual communication to members, either by mail or electronically if you have agreed to receive communications in that manner. Please note that the amended notice may be part of another mailing from MCHCP. In addition, we will post the current notice in our office and on www.mchcp.org with its effective date directly under the heading. You are entitled to a copy of the notice currently in effect.

Important Notice from Missouri Consolidated Health Care Plan About Your Prescription Drug Coverage and Medicare*

Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with Missouri Consolidated Health Care Plan (MCHCP), and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. MCHCP has determined that the prescription drug coverage offered by MCHCP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare, and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current MCHCP coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

*This notice applies to Medicare-eligible members who are not enrolled in the Express Scripts Medicare Prescription Drug Plan (PDP) through MCHCP.

If you decide to join a Medicare drug plan and drop your current MCHCP coverage, you and your dependents may be able to get your MCHCP coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with MCHCP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If

you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact MCHCP Member Services for further information at 800-487-0771. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCHCP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember:

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Discrimination is Against the Law

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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Bev Barr (Compliance Specialist) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal, or by mail or phone at:

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Discrimination is Against the Law

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-487-0771 (TTY: 1-800-735-2966).

注意：如果您使用繁體中文，您可以免費獲得語言援助服 務。請致電 1-800-487-0771 (TTY: 1-800-735-2966).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-487-0771 (TTY: 1-800-735-2966).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-487-0771 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2966).

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-0771-487-800 (رقم هاتف الصم والبكم: 1-2966-735-800).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-487-0771 (телетайп: 1-800-735-2966).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-487-0771 (TTY: 1-800-735-2966) 번으로 전화해 주십시오.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-487-0771 (ATS : 1-800-735-2966).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-487-0771 (TTY: 1-800-735-2966).

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-487-0771 (TTY: 1-800-735-2966).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 0771-487-800-1 (TTY: 1-800-735-2966) تماس بگیرید.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-487-0771 (TTY: 1-800-735-2966).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-487-0771 (TTY: 1-800-735-2966).

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