This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.modot-mshp-cvty.com or by calling 1-800-627-6406 (medical) or 1-844-513-6005 (pharmacy).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual: $450 Family: $1,350 Does not apply to preventive care. Out-of-network (OON): Individual: $450 Family: $1,350	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductibles**.
Are there other deductibles for specific services?	Yes. Pharmacy: $100	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: Individual: $1,600 Family: $4,800 Out-of-network: Individual: $2,425 Family: $7,275	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Pharmacy cost shares, costs above the allowed amount, non-covered services and supplies, utilization review penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.modot-mshp-cvty.com or call 1-800-627-6406 (medical) or 1-844-513-6005 (pharmacy).	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (includes telemedicine)	$25 co-payment (co-pay)/visit	20% co-insurance	Copayment is limited to office visit only. All other services subject to deductible then 10% co-insurance.
	Specialist visit (includes telemedicine)	$25 co-pay/visit	20% co-insurance	
	Other practitioner office visit	Nurse Practitioners and Physician Assistants: $25 co-pay/visit	20% co-insurance	
	Preventive care/screening/immunization	$0 co-pay/visit	Not Covered	Limitations are based on the American Cancer Society and the Centers for Disease Control and Prevention recommendations.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	20% co-insurance	---None---
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.catamaranrx.com.	Generic drugs	30% co-insurance with a minimum $5 co-pay/script	Not covered	Pharmacy deductible applies. Certain drugs require step therapy, quantity limits, and/or prior authorization. Some drugs are excluded from coverage.
	Preferred brand drugs			
	Non-preferred brand drugs	30% co-insurance of the brand cost plus the difference between the cost of brand and generic		
	Specialty drugs	30% co-insurance with a minimum $5 co-pay/script		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	20% co-insurance	Preauthorization is required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$75 co-pay then deductible then 10% co-insurance		Co-pay is waived if patient is admitted. Must meet emergency criteria. Failure: Additional charges equal to 20% of the OON rate.
	Emergency medical transportation	10% co-insurance	10% co-insurance	Services are excluded if they do not meet emergency criteria.
	Urgent care	$25 copay/visit	10% co-insurance	Must meet urgent care criteria. Failure: Additional charges equal to 20% of the OON rate.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance	Preauthorization is required unless Emergency admission. Failure: Additional charges equal to 20% of the OON rate, up to $1,000 penalty.
	Physician/surgeon fee			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	20% co-insurance	Preauthorization may be required. Outpatient hospital: 10% coinsurance
	Mental/Behavioral health inpatient services	10% co-insurance	20% co-insurance	Preauthorization is required unless Emergency admission. Failure: Additional charges equal to 20% of the OON rate, up to $1,000 penalty.
	Substance use disorder outpatient services	$25 co-pay/visit	20% co-insurance	Preauthorization may be required. Outpatient hospital: 10% coinsurance
	Substance use disorder inpatient services	10% co-insurance	20% co-insurance	Preauthorization is required unless Emergency admission. Failure: Additional charges equal to 20% of the OON rate, up to $1,000 penalty.
If you are pregnant	Prenatal and postnatal care	$25 co-pay first visit only	20% co-insurance	---None---
	Delivery and all inpatient services	10% co-insurance	20% co-insurance	Preauthorization is required unless Emergency admission. Failure: Additional charges equal to 20% of the OON rate, up to $1,000 penalty.
If you need help recovering or have other special health needs	Home health care	10% co-insurance	20% co-insurance	Preauthorization required.
	Rehabilitation services	10% co-insurance	20% co-insurance	Outpatient: 10% co-insurance Preauthorization is required. Limit: 60 visits/benefit year for physical, speech, and occupational therapies.
	Habilitation services	$25 co-pay/visit		
	Skilled nursing care	10% co-insurance	20% co-insurance	Preauthorization required.
	Durable medical equipment	10% co-insurance	20% co-insurance	Preauthorization is required for medical equipment over $1,000.
	Hospice service	10% co-insurance	20% co-insurance	Preauthorization required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Excluded service
	Glasses	Not Covered	Not Covered	Excluded service

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	Excluded service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Glasses (Child)
- Hearing Screenings
- Infertility treatment
- Long-term care
- Out-of-Network Prescription Drugs
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-627-6406. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may contact 1-800-627-6406. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or your state department of insurance at Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) E-mail: consumeraffairs@insurance.mo.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-627-6406 or your state department of insurance at Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) Email: consumeraffairs@insurance.mo.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-627-4872.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-4872.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-627-4872.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-627-4872.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,380
- **Patient pays** $1,160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$470
Copays	$30
Coinsurance	$510
Limits or exclusions	$150
Total	**$1,160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,610
- **Patient pays** $1,790

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$550
Copays	$230
Coinsurance	$930
Limits or exclusions	$80
Total	**$1,790**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

û **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

û **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

ü **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

ü **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.