# Missouri State University Group Medical Plan - Buy-Up Plan

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

**Coverage Period: 01/01/2024 – 12/31/2024**

**Coverage for: EE, EE/SP,EE/CH,Family | Plan Type: PPO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (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, go to http://www.missouristate.edu/human/3876.htm or call **(417) 836-5102**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. **http://www.missouristate.edu/human/3876.htm** or call **(417) 836-5102**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers<br>$800 person / $1,600 family<br>For out-of-network providers<br>$1,600 person/ $3,200 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. For Health and Wellness Center & Other On-Campus Facilities – the deductible is waived. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services athttps://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Emergency room care $250 per visit | 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. (NOTE: Waived if admitted on an emergency basis directly from the ER or if treatment is substantiated by severity of the Sickness or Injury.) |
| **What is the out-of-pocket limit for this plan?** | For network providers<br>$5,000 person / $10,000 family<br>For out-of-network providers<br>Unlimited | 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.<br>Maximum Coinsurance network providers: $2,000 per person / $4,000 per family<br>Maximum Coinsurance out-of-network providers: $4,000 per person / $8,000 per family<br>Additional Deductibles + copays network providers: $700 per person / $1,400 per family<br>Additional Deductibles + copays out-of-network providers: Unlimited<br>Maximum RX (OOP): $1,500 per individual / $3,000 per family |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, penalties and ineligible expenses, including amounts over the usual and customary or contracted rates. | 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. Primary: http://mercyoptions.net<br>Wrap: www.healthlink.com, www.phpkc.com, www.firsthealth.com<br>for a list of network providers. Refer to the plan document for when network or non-network benefits apply for the wrap networks. | 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 |
|---|---|---|---|---|---|
| | | Health and Wellness Center & Other On-Campus Clinical Facilities | Network Provider | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $5 copayment | $20 copayment | 40% coinsurance | Chiropractic services limited to 10 visits per Calendar Year. Copay only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance. |
| | Specialist visit | $5 copayment | $30 copayment | 40% coinsurance | Copay only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance. |
| | Preventive care/screening/ immunization | 0%, deductible waived | 0%, deductible waived | 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. |
| **If you have a test** | Diagnostic test Physician's office (x-ray, blood work) | 20% coinsurance (deductible waived) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | Not Available | 20% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** **More information about prescription drug coverage is available at www.elixirsolutions.com (800) 771-4648 and https://www.missouristate.edu/Human/prescription-drug-plan.htm** | Generic drugs (Tier 1) | 20% coinsurance | 30% coinsurance | Allowed at contracted rate. | Maximum of $1,500 out-of-pocket per person per Calendar Year ($3,000 max per family) then 100% paid by plan. Medications that are preventive care services under the Affordable Care Act will be covered at 100% and not require coinsurance. This includes all Generic and certain Brand Name oral contraceptives, aspirin, certain vitamins and supplements, smoking deterrents, certain vaccinations / immunizations, etc. Contact Elixir for the list of the $0 coinsurance items. |
| | Preferred brand drugs (Tier 2) | 20% coinsurance | 30% coinsurance | | |
| | Non-preferred brand drugs (Tier 3) | 20% coinsurance | 30% coinsurance | | |
| | Specialty drugs (Tier 4) | 20% coinsurance | 30% coinsurance | | |
| | Affordable Care Act preventive services | $0 copayment | $0 copayment | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Available | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | Not Available | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | Not Available | 20% coinsurance* | 20% coinsurance* | *$250 Emergency Room Deductible may apply. |
| | Emergency medical transportation | Not Available | 20% coinsurance | 40% coinsurance | None |
| | Urgent care | $5 copayment | $20 copayment | 40% coinsurance | Copay only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Health and Wellness Center & Other On-Campus Clinical Facilities | Network Provider | Out-of-Network Provider | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Available | 20% coinsurance at the semiprivate rate | 40% coinsurance at the semiprivate rate | Precertification is required. If you don't get precertification, benefit payment will be reduced by $200. |
| | Physician/surgeon fees | Not Available | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance (deductible waived) | 20% coinsurance | 40% coinsurance | Copay only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance. |
| | Physician services | copayment per visit (based upon provider) | copayment per visit (based upon provider) | 40% coinsurance | |
| | Inpatient services | Not Available | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | Not Available | 20% coinsurance | 40% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Two ultrasounds will be considered an eligible expense for a routine Pregnancy (age determination and routine screening). Pregnancy not covered for dependent daughters. |
| | Childbirth/delivery professional services | Not Available | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | Not Available | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | Not Available | 20% coinsurance | 40% coinsurance | 40 visits per Calendar Year |
| | Rehabilitation services | 20% coinsurance (deductible waived) | 20% coinsurance | 40% coinsurance | None |
| | Habilitation services | Not Available | 20% coinsurance | 40% coinsurance | 90 days per Calendar Year |
| | Skilled nursing care | Not Available | 20% coinsurance | 40% coinsurance | At the facility's semiprivate room rate.<br>40 days per Calendar Year maximum |
| | Durable medical equipment | Not Available | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | Not Available | 20% coinsurance | 40% coinsurance | $10,000 Lifetime maximum;<br>3 bereavement visits Lifetime maximum |
| **If your child needs dental or eye care** | Children's eye exam | Not covered. | Not covered. | Not covered. | Routine exam not covered. |
| | Children's glasses | Not covered. | Not covered. | Not covered. | Not covered unless following eye surgery. |
| | Children's dental check-up | Not covered. | Not covered. | Not covered. | Dental care not covered. Refer to the separate dental plan. |

## 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 (Limited coverage exceptions apply.)
- Dental Care
- Hearing Aids, except for newborn children as required under Missouri Revised Statutes
- Infertility Treatment
- Long-term care (other than medically necessary skilled nursing care)
- Routine Eye Care (including exam) and glasses (Limited coverage exceptions apply.)

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

- Bariatric Surgery
- Habilitative Services
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (criteria applies).
- Routine Foot Care (i.e., for diabetics)
- Tobacco Use Cessation (criteria applies).
- Weight Loss Programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Human Resources department at (417) 836-5102. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for-any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Human Resources department at (417) 836-5102 or Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High Street, Room 830, Jefferson City, MO 65101, (800) 726-7390, www.insurance.mo.gov. Other states' contact information can be obtained at www.dol.gov/ebsa/healthreform (under Consumer Assistance Programs) above or at https://www.cms.gov/cciio/resources/consumer-assistance-grants.

**Does this plan provide Minimum Essential Coverage?** **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?** **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $800 |
| Specialist copayment | $30 |
| 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 | $800 |
| Copayments | $0 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,860** |

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

| | |
|---|---|
| The plan's overall deductible | $800 |
| Specialist copayment | $30 |
| 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* | $100 |
| Copayments | $1,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,620** |

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

| | |
|---|---|
| The plan's overall deductible | $800 |
| Specialist copayment | $30 |
| 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* | $1,000 |
| Copayments | $60 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,360** |