

# Missouri State University Group Medical Plan - Base Plan

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

Coverage Period: 01/01/2027 – 12/31/2027

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 <a href="#">deductible</a> ?                                | For <a href="#">network providers</a><br>\$1,600 person / \$3,200 family<br>For <a href="#">out-of-network providers</a><br>\$3,200 person / \$6,400 family                                                                                                                                                                                                                                                          | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . For <b>Health and Wellness Center &amp; Other On-Campus Facilities</b> – the <a href="#">deductible</a> is waived.                                                                                                                                                                                                                                  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                                                                                                                                                                                                                                                                                                          | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                                                                |
| Are there other <a href="#">deductibles</a> for specific services?              | <a href="#">Emergency room care</a> \$500 per visit                                                                                                                                                                                                                                                                                                                                                                  | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services. (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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a><br>\$7,350 person / \$14,700 family<br>For <a href="#">out-of-network providers</a><br>Unlimited                                                                                                                                                                                                                                                                               | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.<br>Maximum <a href="#">Coinsurance network providers</a> : \$2,000 per person / \$4,000 per family<br>Maximum <a href="#">Coinsurance out-of-network providers</a> : \$4,000 per person / \$8,000 per family<br>Additional <a href="#">Deductibles + copays network providers</a> : \$1,750 per person / \$3,500 per family<br>Additional <a href="#">Deductibles + copays out-of-network providers</a> : Unlimited<br>Maximum RX (OOP): \$2,000 per individual / \$4,000 per family |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> 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 <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. Primary: <a href="http://mercyoptions.net">http://mercyoptions.net</a><br>Wrap: <a href="http://www.healthlink.com">www.healthlink.com</a> , <a href="http://www.phpkc.com">www.phpkc.com</a> , <a href="http://www.firsthealth.com">www.firsthealth.com</a> for a list of <a href="#">network providers</a> . Refer to the plan document for when network or non-network benefits apply for the wrap networks. | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.                                                                                                                                          |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                                                                                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                                                                                                                                                                                          | Services You May Need                                                  | What You Will Pay                                                     |                                       |                                   | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | Health and Wellness Center & Other On-Campus Clinical Facilities      | Network Provider                      | Out-of-Network Provider           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's office or clinic</a>                                                                                                                                                                                                                                                                                                        | Primary care visit to treat an injury or illness                       | \$10 <a href="#">copayment</a>                                        | \$40 <a href="#">copayment</a>        | 40% <a href="#">coinsurance</a>   | 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.                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Specialist</a> visit                                       | \$10 <a href="#">copayment</a>                                        | \$60 <a href="#">copayment</a>        | 40% <a href="#">coinsurance</a>   | <a href="#">Copayment</a> only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance.                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Preventive care/screening/immunization</a>                 | 0%, <a href="#">deductible</a> waived                                 | 0%, <a href="#">deductible</a> waived | 40% <a href="#">coinsurance</a>   | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                                                                                                                                                               |
| If you have a test                                                                                                                                                                                                                                                                                                                                                            | <a href="#">Diagnostic test</a> Physician's office (x-ray, blood work) | 20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> waived)* | 20% <a href="#">coinsurance</a> *     | 40% <a href="#">coinsurance</a>   | *Breast examination services subject to Missouri Revised Statutes 376.1183 will be covered at 100%, <a href="#">deductible</a> waived.                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                                           | Not Available                                                         | 20% <a href="#">coinsurance</a> *     | 40% <a href="#">coinsurance</a>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.elixirsolutions.com">www.elixirsolutions.com</a> (800) 771-4648 and <a href="https://www.missouristate.edu/Human/prescription-drug-plan.htm">https://www.missouristate.edu/Human/prescription-drug-plan.htm</a> | Generic drugs (Tier 1)                                                 | 20% <a href="#">coinsurance</a>                                       | 30% <a href="#">coinsurance</a>       | Allowed at contracted rate.       | Maximum of \$2,000 out-of-pocket per person per Calendar Year (\$4,000 max per family) then 100% paid by plan.<br>Medications that are <a href="#">preventive</a> care services under the Affordable Care Act will be covered at 100% and not require <a href="#">coinsurance</a> . This includes all Generic and certain Brand Name oral contraceptives, aspirin, certain vitamins and supplements, smoking deterrents, certain vaccinations / immunizations, etc. Contact PBM for the list of the \$0 <a href="#">coinsurance</a> items. |
|                                                                                                                                                                                                                                                                                                                                                                               | Preferred brand drugs (Tier 2)                                         | 20% <a href="#">coinsurance</a>                                       | 30% <a href="#">coinsurance</a>       |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                               | Non-preferred brand drugs (Tier 3)                                     | 20% <a href="#">coinsurance</a>                                       | 30% <a href="#">coinsurance</a>       |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Specialty drugs</a> (Tier 4)                               | 20% <a href="#">coinsurance</a>                                       | 30% <a href="#">coinsurance</a>       |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                               | Affordable Care Act <a href="#">preventive</a> services                | \$0 <a href="#">copayment</a>                                         | \$0 <a href="#">copayment</a>         |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you have outpatient surgery                                                                                                                                                                                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)                         | Not Available                                                         | 20% <a href="#">coinsurance</a>       | 40% <a href="#">coinsurance</a>   | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                               | Physician/surgeon fees                                                 | Not Available                                                         | 20% <a href="#">coinsurance</a>       | 40% <a href="#">coinsurance</a>   | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need immediate medical attention                                                                                                                                                                                                                                                                                                                                       | <a href="#">Emergency room care</a>                                    | Not Available                                                         | 20% <a href="#">coinsurance</a> *     | 20% <a href="#">coinsurance</a> * | *\$500 Emergency Room Deductible may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Emergency medical transportation</a>                       | Not Available                                                         | 20% <a href="#">coinsurance</a>       | 40% <a href="#">coinsurance</a>   | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Urgent care</a>                                            | \$10 <a href="#">copayment</a>                                        | \$40 <a href="#">copayment</a>        | 40% <a href="#">coinsurance</a>   | <a href="#">Copayment</a> 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% <a href="#">coinsurance</a> at the semiprivate rate              | 40% <a href="#">coinsurance</a> at the semiprivate rate | <a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefit payment will be reduced by \$200.                                                                                                                                                                                                                                                                                                     |
|                                                                           | Physician/surgeon fees                    | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> waived) | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | <a href="#">Copayment</a> only applies to the visit charge. All other services provided in the office are subject to deductible and/or coinsurance.                                                                                                                                                                                                                                                                                             |
|                                                                           | Physician services                        | \$10 <a href="#">Copayment</a> per visit                             | Applicable <a href="#">Copayment</a> per visit (based upon provider) | 40% <a href="#">coinsurance</a>                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                        | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                             | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 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% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery facility services     | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | 40 visits per Calendar Year                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> waived) | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Habilitation services</a>     | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | 90 days per Calendar Year                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | <a href="#">Skilled nursing care</a>      | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | At the facility's semiprivate room rate. 40 days per Calendar Year maximum                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Durable medical equipment</a> | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Hospice services</a>          | Not Available                                                        | 20% <a href="#">coinsurance</a>                                      | 40% <a href="#">coinsurance</a>                         | \$10,000 Lifetime maximum; 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](http://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](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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](http://www.insurance.mo.gov). Other states' contact information can be obtained at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) (under Consumer Assistance Programs) above or at <https://www.cms.gov/ccio/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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,600        |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,660</b> |

### Managing Joe's type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$1,700        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,820</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,100        |
| Copayments                        | \$100          |
| Coinsurance                       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |

## Missouri State University Group Base Medical Plan

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.