The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-990-9058 or visit us at www.mycoresource.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $2,000/Individual or $4,000/family Out-of-network providers: $2,000/Individual or $4,000/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 policy, 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.	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?	Medical - Network providers $2,000 individual / $4,000 family; for Out-of-network providers $6,000 individual / $12,000 family RX - Network providers $2,000 individual / $2,000 family; for Out-of-network providers $2,000 individual / $4,000 family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care 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. See www.healthlink.com or call 1-800-624-2356 for 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 permission from this plan.

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	0% coinsurance after deductible/visit	30% coinsurance after deductible	None
	Specialist visit	0% coinsurance after deductible/visit	30% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	Not Covered	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 (x-ray, blood work)	0% coinsurance after deductible/test	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible/test	30% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Deductible, then $10 copay/prescription (retail), Deductible, then $25 copay/prescription (Performance 90 Network) Deductible, then $25 copay/prescription (mail order)		Medical Deductible applies Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription); 30-day supply (specialty) Performance 90 Network (retail) allows for 90-day fills at contracted Performance 90 pharmacies. Rx out-of-pocket: In-Network: $2,000 person / $2,000 family; Out-of-Network: $2,000 person / $4,000 family. When Rx out-of-pocket is met, prescriptions are covered at 100%.
	Preferred brand drugs	Deductible, then 20% up to $200/prescription (retail), Deductible, then 20% up to $500/prescription (Performance 90 Network) Deductible, then 20% up to $500/prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	Deductible, then 20% up to $300/prescription (retail), Deductible, then 20% up to $750/prescription (Performance 90 Network) Deductible, then 20% up to $750/prescription (mail order)		
	Specialty drugs	Deductible, then 20% up to $300/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required for certain procedures
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible		None
	Emergency medical	0% coinsurance after	20% coinsurance after	Preauthorization is required for air ambulance.

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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)	
	transportation	deductible	deductible	
	Urgent care	0% coinsurance after deductible	30% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	30% coinsurance after deductible	None
	Inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required.
If you are pregnant	Office visits	0% coinsurance after deductible	30% coinsurance after deductible	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).
	Childbirth/delivery professional services	0% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required
	Rehabilitation services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required
	Habilitation services	0% coinsurance after deductible	30% coinsurance after deductible	Coverage for Pervasive Developmental Disorders limited to $44,760 annually through age 18.
	Skilled nursing care	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required. Limited to 60 visits/plan year
	Durable medical equipment	0% coinsurance after deductible	30% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required.
	Hospice services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required for home hospice.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage is limited to health risk assessments required by PPACA.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Coverage is limited to health risk assessments

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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)	
				required by PPACA

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
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care

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 and Human Services, Center for Consumer Information and Insurance Oversight, 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:

CoreSource
P.O. Box 25946
Overland Park, KS 66225
1-800-990-9058.

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.*———————————

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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

The plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,490
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,060

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

The plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,930

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

Columbia Public Schools Notice of Nondiscrimination under Section 1557 of the Affordable Care Act

Discrimination is Against the Law

Columbia Public Schools complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Columbia Public Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Columbia Public Schools:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Nickie Smith, Chief Human Resources Officer, telephone (573) 214-3473.

If you believe that Columbia Public Schools has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Nickie Smith, Chief Human Resources Officer, 1818 W. Worley St., Columbia, MO 65203. Telephone: (573) 214-3423, fax (573) 214 3403 or Email: nsmith@cpsk12.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Nickie Smith, Chief Human Resources Officer, 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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak a different language, language assistance services are available to you free of charge. Call 1-800-990-9058.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-990-9058.

繁體中文 (Chinese)
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 1-800-990-9058.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-1-800-990-9058.

Srpsko-hrvatski (Serbo-Croatian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-990-9058.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-990-9058.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم هاتف الصم والبكم رقم (1-800-990-9058-:

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-990-9058 번으로 전화해 주십시오.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-990-9058.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-990-9058.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-990-9058.

Deitsch (Pennsylvania Dutch)

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-990-9058.

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با تماس بگیرید 1-800-990-9058.

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-990-9058.

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-990-9058.

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-990-9058.