

MoDOT & MSHP Medical Plan

Benefits-at-a-Glance for Non-Medicare Participants

Effective January 1, 2019

Listed below is a partial outline of health services covered under the MoDOT/MSHP Summary Plan Document (SPD). This should not be relied upon to fully determine coverage. See the MoDOT/MSHP SPD for applicable limits and exclusions to coverage for these health services. If differences exist between this document and the SPD, the SPD governs.

Benefit	Anthem PPO Plan Member's Responsibility		Anthem HDHP Plan Member's Responsibility	
	In Network Provider	Out-of-Network Provider *	In Network Provider	Out-of-Network Provider *
Annual Deductible				
Individual	\$ 600	\$ 600	\$1,700	\$3,500
Family	\$1,800 maximum	\$1,800 maximum	\$3,500	\$7,000
Coinsurance (applies after deductible) Up to out-of-pocket maximum	10%	20%	30%	50%
Annual Out-of-Pocket Maximum <i>Does not include cost above out-of-network rate.</i>	Includes copayments, coinsurance, and deductible.	Includes copayments, coinsurance, and deductible.	Includes copayments, coinsurance and deductible.	Includes copayments, coinsurance, and deductible.
Individual	\$1,950	\$2,955	\$3,300	\$5,000
Family	\$5,850	\$8,865	\$6,600	\$10,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit	\$25 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of out-of-network rate after deductible.	30% (up to out-of-pocket maximum)	50% (up to out-of-pocket maximum)
Emergency Room Services	\$75 copayment then 10% coinsurance after deductible.	If deemed emergency; \$75 copayment then 10% coinsurance. If not deemed emergency; \$75 copayment then 20% coinsurance of out-of-network rate after deductible.	30% (up to out-of-pocket maximum)	50% (up to out-of-pocket maximum)
	Copayment waived if admitted or accidental injury			
Immunizations According to CDC Recommended Schedules	Covered 100%	<u>Not covered</u>	Covered 100%	<u>Not covered</u>
Inpatient Hospital Care	10% coinsurance after deductible. Pre-admission certification required.	20% coinsurance of out-of-network rate after deductible. Pre-admission certification required.	30% coinsurance after deductible. Pre-admission certification required.	50% coinsurance of out-of-network rate after deductible. Pre-admission certification required.
Maternity	10% coinsurance after deductible.	20% coinsurance of out-of-network rate after deductible.	30% coinsurance after deductible.	50% coinsurance of out-of-network rate after deductible.
Preventive Care	Covered 100%	<u>Not covered</u>	Covered 100%	<u>Not covered</u>
Surgery Inpatient and Outpatient	10% coinsurance after deductible. Pre-admission certification required.	20% coinsurance of out-of-network rate after deductible. Pre-admission certification required.	30% coinsurance after deductible. Pre-admission certification required.	50% coinsurance of out-of-network rate after deductible. Pre-admission certification required.
Urgent Care	\$25 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of out-of-network rate after deductible.	30% (up to out-of-pocket maximum)	50% (up to out-of-pocket maximum)

* Out-of-Network Provider service insurance payments are subject to Out-of-Network Rate only. The Member will be responsible 100% for amounts above Out-of-Network Rate.

Pharmacy Benefit - Available Through Participating Pharmacies Only

Deductible	\$100 per participant per calendar year.	Included in medical deductible.
Coinsurance	30% of costs after deductible is met (minimum \$5).	30% of costs after deductible is met.
Annual Out-of-Pocket Maximum	Includes copayments, coinsurance, and deductible.	Includes copayments, coinsurance, and deductible.
Individual	\$5,000	Included in medical Annual Out-of-Pocket Maximum
Family	\$8,400	
Starter Quantity	30 day starter quantity for new medication, including change in strength, or the medication has not been filled for the previous six months.	30 day starter quantity for new medication, including change in strength, or the medication has not been filled for the previous six months.
Brand over Generic Policy	If a generic is available: 30% coinsurance of brand drug's cost plus the difference between the brand and generic after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment. If no generic is available: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment. If brand is medically necessary and approved by MedImpact Health Systems: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment.	If a generic is available: 30% coinsurance of brand drug's cost plus the difference between the brand and generic after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment. If no generic is available: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment. If brand is medically necessary and approved by MedImpact Health Systems: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment.
Quantity	Purchase 90 days at participating retail pharmacies or the mail order pharmacy for maintenance medications.	Purchase 90 days at participating retail pharmacies or the mail order pharmacy for maintenance medications.
Prior Authorization	Some drugs may require a prior authorization. Contact the pharmacy benefits number on your prescription drug card.	Some drugs may require a prior authorization. Contact the pharmacy benefits number on your prescription drug card.