Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered
MISSOURI DEPT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL
Anthem Blue Access - Non-Medicare Plan

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual + 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, **www.HealthReformPlanSBC.com** or by calling **1-800-490-6145.** 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 **https://www.healthcare.gov/sbc-glossary/** or call 1-800-490-6145 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $600 / Family $1,800. Out-of-Network: Individual $600 / Family $1,800.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network office visits & 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?	Yes. Pharmacy $100	You must pay all of the costs for these services up to the deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,950 / Family $5,850. Out-of-Network: Individual $2,955 / Family $8,865.	The out–of–pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, non-network transplant benefits, balance-billing, prescription charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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.anthem.com or call 1(800)490-6145 for a list of in-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 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
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit only, deductible doesn't apply; 10% coinsurance for all other services	20% coinsurance	Includes Telemedicine. Coinsurance is after deductible.
	Specialist visit	$25 copay/office visit only, deductible doesn't apply; 10% coinsurance for all other services	20% coinsurance	Includes Telemedicine. Coinsurance is after deductible.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	Coinsurance is after deductible.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Coinsurance is after deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs Preferred brand drugs	30% co-insurance with a minimum $5 copay/script	Not covered	Pharmacy deductible applies. Certain drugs require step therapy, quantity limits, and/or prior authorization. Some drugs are excluded from coverage.
	Non-preferred brand drugs	30% co-insurance of the brand cost plus the difference between the cost of the brand and generic		
	Specialty drugs	30% co-insurance with a minimum $5 copay/script		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Coinsurance is after deductible.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Coinsurance is after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
If you need immediate medical attention **If you need immediate medical attention**	Emergency Room Care	$75 co-pay then 10% coinsurance		Copay is waived if patient is admitted or accidental injury. 20% coinsurance for out-of-network non-emergency use. Coinsurance is after deductible.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Coinsurance is after deductible.
	Urgent care	$25 copay/office visit only, deductible doesn't apply; 10% coinsurance for all other services	10% coinsurance	20% coinsurance for out-of-network non-urgent use. Coinsurance is after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Penalty of $1,000 (or 20% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Coinsurance is after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay/visit, deductible doesn't apply; other outpatient services: 10% coinsurance	Office & other outpatient services: 20% coinsurance of allowed amount	Coinsurance is after deductible.
	Inpatient services	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Penalty of $1,000 (or 20% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge; except $25 copay for initial visit to confirm pregnancy, deductible doesn't apply	20% coinsurance	None.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound)..

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Prior authorization is required.
	Rehabilitation services	10% coinsurance	20% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Coinsurance is after deductible.
	Habilitation services	$25 co-pay/visit	20% coinsurance	Coinsurance is after deductible.
	Skilled nursing care	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Prior authorization is required.
	Durable medical equipment	10% coinsurance	20% coinsurance	Coinsurance is after deductible. Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Prior authorization required on some devices.
	Hospice services	10% coinsurance	20% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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 (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Chiropractic care
- Hearing Services
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing

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:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- Anthem directly by calling the toll free number on your Medical ID Card, .
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 Standard? **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	$600
Specialist copayment	$25
Hospital (facility) copayment	$0
Other coinsurance	10%

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$25
Coinsurance	$1200
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1975**

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

The plan's overall deductible	$600
Specialist copayment	$25
Hospital (facility) copayment	0%
Other coinsurance	10%

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$600
Copayments/Coinsurance	$500
Prescription Costs	$1200
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$2380**

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

The plan's overall deductible	$600
Specialist copayment	$25
Hospital (facility) copayment	$0
Other coinsurance	10%

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$100
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$820**

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