MoDOT & MSHP Medical Plan
Benefits-at-a-Glance for Non-Medicare Participants
Effective January 1, 2026

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	
	In Network Provider	**Out-of-Network Provider ***
Annual Deductible Individual Family	 $600 $1,800 maximum	 $600 $1,800 maximum
Coinsurance (applies after deductible) Up to out-of-pocket maximum	10%	20%
Annual Out-of-Pocket Maximum *Does not include cost above out-of-network rate.* Individual Family	Includes copayments, coinsurance, and deductible. $1,950 $5,850	Includes copayments, coinsurance, and deductible. $2,955 $8,865
Lifetime Maximum	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.
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.
	Copayment waived if admitted or accidental injury	
Immunizations According to CDC Recommended Schedules	Covered 100%	**Not covered**
Inpatient Hospital Care	10% coinsurance after deductible. Pre-admission certification required.	20% 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.
Preventive Care	Covered 100%	**Not covered**
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.
Urgent Care	$25 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of out-of-network rate after deductible.

*Out-of-Network Provider service insurance payments are subject to Out-of-Network Rate only. 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.
Coinsurance	30% of costs after deductible is met (minimum $5).
Annual Out-of-Pocket Maximum Individual Family	Includes copayments, coinsurance, and deductible. $5,000 $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.
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:** 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.
Prior Authorization	Some drugs may require a prior authorization. Contact the pharmacy benefit number on your insurance card.