MISSOURI **Custom**
A collaborative care plan

3-TIER PLAN DESIGNS

Benefits	Plan 8 - $500 PPO			Plan 9 - $1,500 PPO			Plan 10 - $2,500 PPO			Plan 11 - $6,000 HSA		
	Tier I MU Preferred*	Tier II Wrap Network	Tier III Out-of-Network**	Tier I MU Preferred*	Tier II Wrap Network	Tier III Out-of-Network**	Tier I MU Preferred*	Tier II Wrap Network	Tier III Out-of-Network**	Tier I MU Preferred*	Tier II Wrap Network	Tier III Out-of-Network**
Deductible (Calendar Year)												
Individual	$500	$1,500	$12,000	$1,500	$4,500	$12,000	$2,500	$4,500	$12,000	$6,000	$6,000	$12,000
Family	$1,500	$4,500	$24,000	$3,000	$9,000	$24,000	$7,500	$9,000	$24,000	$12,000	$12,000	$24,000
Out-of-Pocket Maximum												
Individual	$3,000	$6,000	Unlimited	$4,500	$7,350	Unlimited	$7,350	$7,350	Unlimited	$6,650	$6,650	Unlimited
Family	$6,000	$12,000	Unlimited	$9,000	$14,700	Unlimited	$14,700	$14,700	Unlimited	$13,300	$13,300	Unlimited
Coinsurance												
Plan Pays	90%	70%	40%	90%	70%	40%	80%	70%	40%	80%	70%	40%
You Pay	10%	30%	60%	10%	30%	60%	20%	30%	60%	20%	30%	60%
Physician Office Services												
Primary Care Office Visit	$5	$30	60% after Deductible	$5	30% after Deductible	60% after Deductible	$5	$30	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible
Special Care Office Visit	$10	$60		$10			$10	$60				
Inpatient Services												
Medical and Surgical	10% after Deductible	30% after Deductible	60% after Deductible	10% after Deductible	30% after Deductible	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible
Mental Health / Substance Abuse												
Outpatient Services												
Urgent Care	$75 Copay	$100 Copay	60% after Deductible	$75 Copay	$100 Copay	60% after Deductible	$75 Copay	$100 Copay	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible
Outpatient Surgical Services	10% after Deductible; Mental Health Substance abuse Office Visit Copay $5	30% after Deductible; Mental Health Substance abuse Office Visit Copay $30	60% after Deductible	10% after deductible; Mental Health substance abuse Office Visit Copay $5	30% after Deductible	60% after Deductible	20% after Deductible; Mental Health Substance abuse Office Visit Copay $5	20% after Deductible; Mental Health Substance abuse Office visit Copay $30	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible
Diagnostic Services / Lab / Pathology												
Chiropractic Services (Limit 12 visits)												
Mental Health or Substance Abuse												
Rehabilitation Services (Limit 40 visits)												
Skilled Nursing (Limit 60 visits)												
Preventive Care Services												
Well-Child Care & Immunizations	100% Covered	100% Covered	Not Covered	100% Covered	100% Covered	Not Covered	100% Covered	100% Covered	Not Covered	100% Covered	100% Covered	Not Covered
Periodic Health Exams												
Annual GYN Exams												
Prostate Screening												
Emergency Services												
Emergency Room*** (Copay waived if admitted to hospital)	$250	$250	$250	$250	$250	$250	$250	$250	$250	20% after Deductible	20% after Deductible	20% after Deductible
Home Health Care												
Hospice Care Provided at Home	10% after Deductible	30% after Deductible	60% after Deductible	10% after Deductible	30% after Deductible	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible	20% after Deductible	30% after Deductible	60% after Deductible
Home Health Care (Limit 60 visits)												
Durable Medical Equipment												
Lifetime Maximum Benefit	Unlimited			Unlimited			Unlimited			Unlimited		
Pharmacy	Mizzou Pharmacies & HyVee	Network Pharmacies	Non-Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Non-Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Non-Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Non-Network Pharmacies
Tier 1 - Generic	$5	$10	60% after Deductible	$5	$10	60% after Deductible	$5	$10	60% after Deductible	$5	$10	60% after Deductible
Tier 2 - Brand	$25	$40	60% after Deductible	$25	$40	60% after Deductible	$25	$40	60% after Deductible	$25	$40	60% after Deductible
Tier 3 - Non-formulary Brand	$50	$75	60% after Deductible	$50	$75	60% after Deductible	$50	$75	60% after Deductible	$50	$75	60% after Deductible
Tier 4 - Specialty	$75	$100	60% after Deductible	$75	$100	60% after Deductible	$75	$100	60% after Deductible	$75	$100	60% after Deductible

* MU Preferred includeds providers from MU Health, Capital Region and other preferred providers

**Out-of-network Deductibles and Out-of-pocket amounts accumulate separate form In-network Deductibles and Out-of-pocket amounts.

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2-TIER PLAN DESIGNS

Benefits	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5		Plan 6		Plan 7 (HSA)	
	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**	Tier I MU Preferred*	Tier II Out-of-Network**
Deductible (Calendar Year)														
Individual	$0	$2,500	$350	$2,500	$500	$3,000	$1,000	$5,000	$1,500	$5,000	$2,500	$7,500	$5,000	$10,000
Family	$1,000	$7,500	$1,050	$7,500	$1,500	$9,000	$3,000	$10,000	$4,500	$10,000	$7,500	$22,000	$10,000	$20,000
Out-of-Pocket Maximum														
Individual	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000	$4,000	$7,500	$6,000	$10,000	$7,350	$10,000	$6,650	$10,000
Family	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000	$8,000	$15,000	$12,000	$20,000	$14,700	$20,000	$13,300	$20,000
Coinsurance														
Plan Pays	90%	70%	90%	70%	90%	70%	90%	50%	90%	50%	80%	40%	80%	40%
You Pay	10%	30%	10%	30%	10%	30%	10%	50%	10%	50%	20%	60%	20%	60%
Physician Office Services														
Primary Care Office Visit	$5	30% after Deductible	$5	$30	$5	$30	$5	$50	$5	$30	$5	60% after Deductible	20% after Deductible	60%
Special Care Office Visit	$10	deductible	$10	$60	$10	$60	$10	$75	$10	$60	$10			
Inpatient Services														
Medical and Surgical Mental Health / Substance Abuse	10% after Deductible	30% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	50% after Deductible	10% after Deductible	50% after Deductible	20% after Deductible	60% after Deductible	20% after Deductible	60% after Deductible
Outpatient Services														
Urgent Care	$75 Copay	30% after Deductible	$75 Copay	30% after Deductible	$75 Copay	30% after Deductible	$75 Copay	50% after Deductible	$75 Copay	50% after Deductible	$75 Copay	60% after Deductible	20% after Deductible	60% after Deductible
Outpatient Surgical Services Diagnostic Services / Lab / Pathology Chiropractic Services (Limit 12 visits) Mental Health or Substance Abuse Rehabilitation Services (Limit 40 visits) Skilled Nursing (Limit 60 visits)	10% after Deductible; Mental Health Substance Abuse office visit copay $5	30% after Deductible	10% after Deductible; Mental Health Substance Abuse office visit copay $5	30% after Deductible; Mental Health Substance Abuse office visit copay $30	10% after Deductible; Mental Health Substance abuse office visit copay $5	30% after Deductible, Mental Health Substance abuse office visit copay $30	10% after Deductible; Mental Health Substance Abuse office visit copay $5	50% after Deductible; Mental Health Substance Abuse office visit copay$50	10% after Deductible; Mental Health Substance Abuse office visit copy $5	10% after Deductible; Mental Health Substance abuse office visit copay $30	20% after Deductible; Mental Health Substance abuse office visits $5 copay	60% after Deductible	20% after Deductible	60% after Deductible
Preventive Care Services														
Well-Child Care & Immunizations Periodic Health Exams Annual GYN Exams Prostate Screening	100% Covered	30% after Deductible	100% Covered	30% after deductible	100% Covered	30% Covered	100% Covered	50% Covered, after deductible	100% Covered	50% Covered	100% Covered	60% after deductible	100% Covered	60% after Deductible
Emergency Services														
Emergency Room*** (Copay waived if admitted to hospital)	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	20% after Deductible	20% after Deductible
Home Health Care														
Hospice Care Provided at Home Home Health Care (Limit 60 visits) Durable Medical Equipment	10% after Deductible	30% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	50% after Deductible	10% after Deductible	50% after Deductible	20% after Deductible	60% after Deductible	20% after Deductible	60% after Deductible
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Pharmacy	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Network Pharmacies	Mizzou Pharmacies & HyVee	Non-Network Pharmacies
Tier 1 - Generic	$5	$10	$5	$10	$5	$10	$5	$10	$5	$10	$5	$10	$5	$10
Tier 2 - Brand	$25	$40	$25	$40	$25	$40	$25	$40	$25	$40	$25	$40	$25	$40
Tier 3 - Non-formulary Brand	$50	$75	$50	$75	$50	$75	$50	$75	$50	$75	$50	$75	$50	$75
Tier 4 - Specialty	$75	$100	$75	$100	$75	$100	$75	$100	$75	$100	$75	$100	$75	$100

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