

**High Deductible Plan 3 – Missouri
BENEFIT PPO SCHEDULE**

High Deductible Plan 3 Missouri PBHD3A	Dependent Limiting Age: 26
Preexisting Condition Exclusion Period: None	

Covered Services	PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Calendar Year Deductible (Individual/Family)	\$2,500/\$5,000	\$2,500/\$5,000
Out-of-Pocket Maximum (Individual/Family) <i>Includes Deductible</i>	\$2,500/\$5,000	\$5,000/\$10,000
Primary Care Office Visit	Deductible	Deductible then 20% Coinsurance
Specialty Care Office Visit	Deductible	Deductible then 20% Coinsurance
Lab Services	Deductible	Deductible then 20% Coinsurance
X-ray and other Radiology Procedures*	Deductible	Deductible then 20% Coinsurance
Routine Preventive Care (See the Routine Preventive Care Benefit under the Covered Services Section for a description of Routine Preventive Services for which you have Benefits)	No Copayment	Deductible then 20% Coinsurance
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests	No Copayment	Deductible then 20% Coinsurance
Emergency Services	Deductible	Deductible
Urgent Care	Deductible	Deductible then 20% Coinsurance
Ambulance	Deductible	Deductible
Inpatient Hospital Services**	Deductible	Deductible then 20% Coinsurance*
Outpatient Surgery in Hospital or other Outpatient Facility**	Deductible	Deductible then 20% Coinsurance*
Durable Medical Equipment**	Deductible	Deductible then 20% Coinsurance
Formula and Food Products for Phenylketonuria	Deductible	Deductible then 20% Coinsurance but never greater than 50% of the cost of the formula or food product
Home Health Services**	Deductible	Deductible then 20% Coinsurance
	<i>60 visit Calendar Year Maximum</i>	
Skilled Nursing Facility**	Deductible	Deductible then 20% Coinsurance
	<i>30 day Calendar Year Maximum</i>	
Outpatient Therapy (Speech, Hearing, Physical, and Occupational Therapy)**	Deductible	Deductible then 20% Coinsurance
	<i>Physical and Occupational: 40 visit Calendar Year Maximum Speech and Hearing: 20 visit Calendar Year Maximum</i>	
Chiropractic Services	Deductible	Deductible then 20% Coinsurance**

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Covered Services		PREFERRED PROVIDER	NON-PREFERRED PROVIDER
		Copayment, Deductible, Coinsurance and limitations	Deductible, Coinsurance and limitations
Outpatient Mental Illness		Deductible	Deductible then 20% Coinsurance*
Inpatient Mental Illness**		Deductible	Deductible then 20% Coinsurance*
Organ Transplant**		Deductible	Deductible then 20% Coinsurance
Contraceptive devices, implants, injections and elective sterilization for women		Covered at 100%	Not Covered
Outpatient Prescription Drugs** Includes oral and injectable contraceptives, and contraceptive devices and implants		Covered. Not subject to Calendar Year Maximum.	
Short-Term Supply	Tier 1	\$12 Copayment/contraceptives covered at 100%	\$12 copayment then 50% coinsurance
	Tier 2	\$35 Copayment	\$35 copayment then 50% coinsurance
	Tier 3	\$60 Copayment	\$60 copayment then 50% coinsurance
Long-Term Supply	Tier 1	\$30 Copayment/contraceptives covered at 100%	\$30 copayment then 50% coinsurance
	Tier 2	\$87.50 Copayment	\$87.50 copayment then 50% coinsurance
	Tier 3	\$150 Copayment	\$150 copayment then 50% coinsurance
All other Covered Services		Deductible	Deductible then 20% Coinsurance
Vision Care***		\$20 Copayment	\$20 Copayment, \$45 benefit maximum
Lifetime Maximum		Unlimited	

* Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to \$200 per day. Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day. Outpatient Services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside Our Service Area are limited to \$200 per day.

**Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), high-tech diagnostic testing, infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hearing therapy, prosthetics and appliances, mental health and substance abuse, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

***Vision Care provided by Vision Service Plan (VSP)

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. **Maternity – Covered**