

**MISSOURI
BENEFIT SCHEDULE**

| | PREFERRED PROVIDER | NON-PREFERRED PROVIDER |
|--|---|---|
| Covered Services | Copayment, Deductible, Coinsurance and Limitations | Copayment, Deductible, Coinsurance and Limitations |
| X-ray and other Radiology Procedures | Deductible | Deductible then 20% Coinsurance <i>Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a \$200 Calendar Year Maximum</i> |
| 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 <i>\$300 Calendar Year Maximum</i> UNLIMITED |
| Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA Tests | No Copayment | Deductible then 20% Coinsurance |
| Emergency Services | Deductible | 20% Coinsurance after Deductible |
| Ambulance | Deductible <i>Ground Ambulance limited to \$500 maximum allowable charge per use</i> | Preferred Provider Deductible <i>Ground Ambulance limited to \$500 maximum allowable charge per use</i> |
| Inpatient Hospital Services | Deductible | Deductible then 20% Coinsurance <i>Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day and are limited to a 30 day Calendar Year Maximum</i> |

11. Diagnostic Services

We provide Benefits for diagnostic services including x-ray examinations, laboratory services, other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service. Covered Services do not include screening examinations or routine physical examinations unless these services are specifically listed as Covered Services under the Routine Preventive Care Benefit in this section.

**Non-participating
Provider Outpatient
Facility Benefits inside
Our Service Area**

The following provisions apply to Covered Services received from Non-Participating Provider outpatient facilities including an imaging center.

- a. Your Benefit for an outpatient service at a Non-Participating Provider outpatient facility including an imaging center inside Our Service Area will be limited to a maximum of \$200 per Calendar Year.
- b. Benefits for services received from a Non-Participating Provider Outpatient facility including an imaging center inside Our Service Area will not be subject to any Deductible or Coinsurance requirements.

Except for Non-Participating Providers in Our Service Area, Benefits for Diagnostic Services are paid the same as any other services unless otherwise indicated in the Benefit Schedule.

Prostate Specific Antigen (PSA) Tests, Pap Smears, and Mammograms

The lab and x-ray services related to Prostate Specific Antigen (PSA) tests, pap smears, and mammograms will be covered at 100% of the Allowable Charge when provided by a Preferred Provider.

12. Dialysis

We provide Benefits for hemodialysis and peritoneal dialysis services.

**13. Durable Medical
Equipment**

We provide Benefits for the rental or purchase of durable medical equipment (DME) for use outside a Hospital subject to the following conditions:

- a. Use of DME will be authorized for a limited period of time;
- b. We retain the right to possess the equipment and You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and
- c. We have the right to stop covering the rental when the item is no longer Medically Necessary.

Covered Services may be limited to a lifetime maximum if indicated in the Benefit Schedule.

Inpatient Hospice services must be Approved in Advance by Us.

20. Immunizations for Children

We provide Benefits for routine and necessary childhood immunizations for covered Dependent children. Covered Services include: (1) at least 5 doses of vaccine against diphtheria, pertussis, tetanus; (2) at least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); (3) at least 3 doses of vaccine against Hepatitis B; (4) 2 doses of vaccine against measles, mumps, and rubella; (5) 2 doses of vaccine against varicella; (6) at least 4 doses of vaccine against pediatric pneumococcal (PCV7); (7) 1 dose of vaccine against influenza; (8) at least one dose of vaccine against Hepatitis A; (9) 3 doses of vaccine against Rotavirus; and (10) such other vaccines and dosages as may be prescribed by the State Department of Health. Covered Services are limited to immunizations administered to each covered Dependent child age 5 and under.

Covered Services for routine and necessary immunizations will be provided at 100% of the Allowable Charge and will not be subject to any Copayment requirements.

Any office visit charges incurred in conjunction with these immunizations will be subject to the office visit Copayment, Coinsurance, and Deductible requirements of the Contract, the same as any other services.

For information regarding Benefits for other immunizations, if any, see the Routine Preventive Care Benefit in the Covered Services Section.

21. Infusion Therapy and Self-Injectables

Infusion Therapy

We provide Benefits for infusion therapy services and supplies. Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required You to be hospitalized. Infusion therapy in Your home or a Physician's office will be a Covered Service only if all of the following conditions are met:

- a. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility;
- b. The services are ordered by a Physician and provided by an infusion therapy provider or Physician licensed to provide such services.
- c. **Services are Approved in Advance by Us.**

35. Reconstructive Surgery/Prosthetic Devices Following a Mastectomy

We provide Benefits for prosthetic devices and/or reconstructive surgery following a mastectomy. Covered Services are limited to:
1) reconstructive surgery on the breast on which the mastectomy was performed; 2) reconstructive surgery on the unaffected breast that is required to produce a symmetrical appearance; and 3) breast prostheses. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

36. Routine Preventive Care

We provide Benefits for routine preventive care as required by state or federal law. These services are not limited and do not apply to the Calendar Year Maximum indicated in the Benefit Schedule. Covered Services are limited to the following and may be received from Preferred or Non-Preferred Providers:

- a. Prostate exams and prostate specific antigen (PSA) tests,
- b. Pelvic exams and pap smears, including those performed at the direction of a Physician in a mobile facility certified by Centers for Medicare and Medicaid Services (CMS),
- c. Mammograms if ordered by a Physician, including those performed at the direction of a Physician in a mobile facility certified by CMS,
- d. Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following:
 - (1) Fecal occult blood test;
 - (2) Flexible sigmoidoscopy;
 - (3) Colonoscopy;
 - (4) Double contrast barium enema,
- e. Newborn hearing screening, audiological assessment and follow-up, and initial amplifications,
- f. Childhood immunizations as referenced in the Immunizations for Children Benefit of this Contract,
- g. Lead testing, and
- h. The related office visit.

We also provide the following Benefits for routine preventive care received from Preferred or Non-Preferred Providers to evaluate and manage a well person's health status according to the Covered Person's

age. Covered Services are limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

Covered Services are limited as follows:

a. Physician Examinations:

- (1) Birth to Age 1: up to 7 exams
- (2) Age 1 to Age 5: up to 5 exams
- (3) Age 5 and older: 1 exam per year

b. Additional examinations, testing and services:

- (1) Hemoglobin/Complete Blood Count (CBC)
- (2) Metabolic screening
- (3) Hearing exams
- (4) Immunizations:

Covered Immunizations are limited to the age ranges and gender recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control.

- i. Catch-up for Hepatitis B
- ii. Catch-up for varicella
- iii. Catch-up for MMR
- iv. Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only
- v. Pneumococcal vaccine
- vi. Influenza virus vaccine
- vii. Meningococcal vaccine
- viii. Catch-up for Hepatitis A
- ix. HPV vaccine
- x. Zoster vaccine

- (5) Urinalysis
- (6) Glucose screening
- (7) Thyroid stimulating hormone screening
- (8) Lipid cholesterol panel
- (9) HIV Screening
- (10) HPV Testing
- (11) Chlamydia Trachomatis Testing
- (12) Gonorrhea Testing
- (13) Electrocardiogram (EKG)
- (14) Chest X-ray

Benefits for Routine Preventive Services are paid the same as any other service unless otherwise indicated in the Benefits Schedule.

37. Skilled Nursing Facility

We provide Benefits for services and supplies furnished by a Skilled Nursing Facility for the treatment of a medical or surgical condition when authorized by Your Physician. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule. These services are limited to those You are eligible to receive as a Hospital bed patient and that would otherwise require Confinement in a Hospital.

These Benefits are not available unless Approved in Advance by Us. No Benefits are available under this provision for custodial care or for the care of a nervous or mental condition, drug addiction, alcoholism or chemical dependency.

38. Urgent Care Center

We provide Benefits for Urgent Care services obtained at urgent care centers. Urgent care services are Health Care Services required in order to prevent serious deterioration of Your health as a result of an unforeseen sickness or injury. Urgent care services provided in a Physician's office on an urgent basis are covered under the Physician Services Benefit.

39. Vision Care

We provide Benefits for either the first pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery, and for eye exams including refraction, needed as a result of a covered medical illness or Accidental Injury.