University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

Medical Plan Comparison Charts
Plan Years 2020 and 2021

While the medical plan options available to UM System faculty and staff and general structure of those options are the same as they were in previous years, most categories of charges/costs of services will change in 2021.

The following tables outline what enrollees pay for covered expenses for the 2020 and 2021 plan year for purposes of comparison.

For questions, contact your local HR Generalist (umurl.us/cbr) or the HR Service Center (umurl.us/hrsc) at (573) 882-2146, toll free at (800) 488-5288, or at HRServiceCenter@umsystem.edu.

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HEALTHY SAVINGS PLAN | What You Pay for Covered Expenses in 2020/2021

		2020 HEALTHY SAVINGS PLAN		2021 HEALTHY SAVINGS PLAN	
		In-network	*Out-of-network***	In-network	Out-of-network**
DEDUCTIBLE	**Medical deductible** **Rx deductible**	*$1,500/self coverage $3,000/family* coverage (combined)*	*$3,000/self coverage $6,000/family* coverage (combined)*	$1,750/self; $3,500/family* (combined)	$3,500/self; $7,000/family* (combined)
SERVICES	**Preventive care**	*$0*	*30% or more after deductible*	$0	35% or more after deductible
	Primary care	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Specialist care	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Urgent care	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Lab and x-ray	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Outpatient care	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Inpatient care *(incl. maternity delivery)*	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Durable medical equipment	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Emergency room	*10% after deductible*	*10% or more after deductible*	15% after deductible	15% or more after deductible
	Ambulance	*10% after deductible*	*10% or more after deductible*	15% after deductible	15% or more after deductible
Rx	**Rx drug: Retail** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
	Rx drug: Mail*** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*10% after deductible*	*30% or more after deductible*	15% after deductible	35% or more after deductible
OUT-OF-POCKET**	**Medical limit** **Rx limit**	*$3,000/self coverage $6,000/family* coverage (combined)*	*$6,000 or more /self coverage $12,000 or more /family* coverage (combined)*	$3,500/self; $7,000/family* (combined)	$7,000 or more/self; $14,000 or more/family* (combined)

*Considerations for “self” and “family” are different for the Healthy Savings Plan than for the Custom Network and PPO Plans. See the glossary (umurl.us/glossary) for details.

**Refer to the Summary Plan Description (SPD) for additional details on allowable and eligible expenses when using an out-of-network provider.

***90-day fill/refill at Mizzou pharmacies at same cost as mail order.

CUSTOM NETWORK PLAN | What You Pay for Covered Expenses in 2020/2021

		2020 CUSTOM NETWORK PLAN		2021 CUSTOM NETWORK PLAN	
		In-network	Out-of-network**	In-network	Out-of-network**
DEDUCTIBLE	**Medical deductible**	*$0*	*$500/self coverage $1,500/family* coverage*	$200/self; $600/family	$1,500/self; $4,500/family*
	Rx deductible	*Retail: $50/person Mail order: $0/person*	*Retail: $50/person Mail order: $0/person*	Retail: $50/person Mail order: $0/person	Retail: $50/person Mail order: $0/person
SERVICES	**Preventive care**	*$0*	*30% or more after deductible*	$0	50% or more after deductible
	Primary care	*$10 copay/visit*	*30% or more after deductible*	$15 copay/visit	50% or more after deductible
	Specialist care	*$30 copay/visit*	*30% or more after deductible*	$40 copay/visit	50% or more after deductible
	Urgent care	*$50 copay/visit*	*$50 copay/visit or more*	$50 copay/visit	$50 copay/visit or more
	Lab and x-ray*****	*$0*	*30% or more after deductible*	$5 (basic)/$100 (advanced)	50% or more after deductible
	Outpatient care	*$100 copay/visit*	*30% or more after deductible*	10% after deductible	50% or more after deductible
	Inpatient care *(incl. maternity delivery)*	*$300 copay/confinement*	*30% or more after deductible*	10% after deductible	50% or more after deductible
	Durable medical equipment	*$0*	*30% or more after deductible*	$75 copay	50% or more after deductible
	Emergency room	*$250 copay/visit*	*$250 copay/visit or more*	$250 copay/visit after deductible	$250 copay/visit or more after deductible
	Ambulance	*$100 copay/occurrence*	*$100 copay/occurrence or more*	$200 copay/occurrence after deductible	$200 or more copay/occurrence after deductible
Rx	**Rx drug: Retail** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of (after Rx deductible):* ▪ *$7 copay/20% coinsurance* ▪ *$15 copay/25% coinsurance* ▪ *$30 copay/50% coinsurance*	*Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible*****	Greater of (after Rx deductible): ▪ $7 copay/20% coinsurance ▪ $15 copay/25% coinsurance ▪ $30 copay/50% coinsurance	Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible****
	Rx drug: Mail*** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of:* ▪ *$15 copay/20% coinsurance* ▪ *$30 copay/25% coinsurance* ▪ *$60 copay/50% coinsurance*	*Greater of: $30 copay or 50% network costs after annual deductible*****	Greater of: ▪ $15 copay/20% coinsurance ▪ $30 copay/25% coinsurance ▪ $60 copay/50% coinsurance	Greater of: $30 copay or 50% network costs after annual deductible****
OUT-OF-POCKET**	**Medical limit**	*$3,500/self coverage $7,000/family* coverage*	*$10,500 or more /self coverage $21,000 or more /family* coverage*	$3,500/self; $7,000/family*	$10,500 or more/self; $21,000 or more/family*
	Rx limit	*$4,650/self coverage $9,300/family* coverage*		$5,050/self; $10,100/family*	

*Considerations for "self" and "family" are different for the Healthy Savings Plan than for the Custom Network and PPO Plans. See the glossary (umurl.us/glossary) for details.
**Refer to the Summary Plan Description (SPD) for additional details on allowable and eligible expenses when using an out-of-network provider.
***90-day fill/refill at Mizzou pharmacies at same cost as mail order.
****Member will be required to pay the difference between non-participating pharmacy and participating pharmacy charge.
***** For lab and x-ray services, "Basic" includes services such as x-ray, blood work, lipid panel, etc. "Advanced" includes services such as CT scan, PET scan, MRI, etc.

PPO Plan (Columbia, Rolla, St. Louis) | What You Pay for Covered Expenses in 2020/2021

		2020 PPO PLAN		2021 PPO PLAN	
		In-network	*Out-of-network***	In-network	Out-of-network**
DEDUCT-IBLE	**Medical deductible**	*Rolla: $350/self; $1,050/family* Columbia and St. Louis: $500/self; $1,500/family **	*Rolla: $700/self; $2,100/family* Columbia and St. Louis: $1,000/self; $3,000/family **	*Rolla:* $500/self; $1,500/family* *Columbia and St. Louis:* $800/self; $2,400/family *	*Rolla:* $1,000/self; $3,000/family* *Columbia and St. Louis:* $1,600/self; $4,800/family*
	Rx deductible	*Retail: $75/person Mail order: $0/person*	*Retail: $75/person Mail order: $0/person*	Retail: $75/person Mail order: $0/person	Retail: $75/person Mail order: $0/person
SERVICES	**Preventive care**	*$0*	*20% or more after deductible*	$0	40% or more after deductible
	Primary care	*$20 copay/visit*	*20% or more after deductible*	$20 copay/visit	40% or more after deductible
	Specialist care	*$30 copay/visit*	*20% or more after deductible*	$40 copay/visit	40% or more after deductible
	Urgent care	*$50 copay/visit*	*20% or more after deductible*	$50 copay/visit	40% or more after deductible
	Lab and x-ray	*Applicable coinsurance after deductible^*	*20% or more after deductible*	Applicable coinsurance after deductible^	40% or more after deductible
	Outpatient care	*$100 copay/visit after deductible*	*20% or more after deductible*	Applicable coinsurance after deductible^	40% or more after deductible
	Inpatient care *(incl. maternity delivery)*	*$300 copay/confinement after deductible*	*20% or more after deductible*	Applicable coinsurance after deductible^	40% or more after deductible
	Durable medical equipment	*Applicable coinsurance after deductible^*	*20% or more after deductible*	$75 copay	40% or more after deductible
	Emergency room	*$250 copay/visit or more after deductible*		$250 copay/visit after deductible	
	Ambulance	*$100 copay/occurrence or more after deductible*		$200 copay/occurrence after deductible	
Rx	**Rx drug: Retail** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of (after Rx deductible): ▪ $7 copay/20% coinsurance ▪ $15 copay/25% coinsurance ▪ $30 copay/50% coinsurance*	*Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible*****	Greater of (after Rx deductible): ▪ $7 copay/20% coinsurance ▪ $15 copay/25% coinsurance ▪ $30 copay/50% coinsurance	Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible****
	Rx drug: Mail*** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of: ▪ $15 copay/20% coinsurance ▪ $30 copay/25% coinsurance ▪ $60 copay/50% coinsurance*	*Greater of: $30 copay or 50% network costs after annual deductible*****	Greater of: ▪ $15 copay/20% coinsurance ▪ $30 copay/25% coinsurance ▪ $60 copay/50% coinsurance	Greater of: $30 copay or 50% network costs after annual deductible****
OUT-OF-POCKET **	**Medical limit**	*$3,500/self $7,000/family**	*$10,500 or more /self $21,000 or more /family**	$3,500/self; $7,000/family*	$10,500 or more/self; $21,000 or more/family*
	Rx limit	*$4,650/self coverage $9,300family* coverage*		$5,050/self; $10,100/family*	

^**2020 in-network coinsurance-** *Rolla:* 0%; *Columbia and St. Louis:* 10%; **2021 in-network coinsurance-** *Rolla:* 10% after deductible; *Columbia and St. Louis:* 20% after deductible.

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**Refer to the Summary Plan Description (SPD) for additional details on allowable and eligible expenses when using an out-of-network provider.

***90-day fill/refill at Mizzou pharmacies at same cost as mail order.

****Member will be required to pay the difference between non-participating pharmacy and participating pharmacy charge.

PPO Plan (Kansas City) | What You Pay for Covered Expenses in 2020/2021

		2020 PPO PLAN			2021 PPO PLAN		
		In-network		*Out-of-network***	In-network		Out-of-network**
DEDUCTIBLE	**Medical deductible**	*$350/self; $1,050/family**		*$700/self; $2,100/family**	$500/self; $1,500/family*		$1,000/self; $3,000/family*
	Rx deductible	*Retail: $75/person Mail order: $0/person*		*Retail: $75/person Mail order: $0/person*	Retail: $75/person Mail order: $0/person		Retail: $75/person Mail order: $0/person
SERVICES	**Preventive care**	*$0*		*20% or more after deductible*	$0		40% or more after deductible
	Primary care	*Tier 1 (♥♥) $10 copay/visit*	*Tier 2 (♥) $20 copay/visit*	*20% or more after deductible*	Tier 1 (♥♥) $15 copay/visit	Tier 2 (♥) $25 copay/visit	40% or more after deductible
	Specialist care	*$25 copay/visit*	*$30 copay/visit*	*20% or more after deductible*	$35 copay/visit	$40 copay/visit	40% or more after deductible
	Urgent care	*$50 copay/visit*	*$50 copay/visit*	*20% or more after deductible*	$50 copay/visit	$50 copay/visit	40% or more after deductible
	Lab and x-ray	*Applicable coinsurance after deductible^*		*20% or more after deductible*	Applicable coinsurance after deductible^		40% or more after deductible
	Outpatient care	*$0 copay/visit after deductible*	*$100 copay/visit after deductible*	*20% or more after deductible*	Applicable coinsurance after deductible^		40% or more after deductible
	Inpatient care *(incl. maternity delivery)*	*$300 copay /confinement after deductible*		*20% or more after deductible*	Applicable coinsurance after deductible^		40% or more after deductible
	Durable medical equipment	*Applicable coinsurance after deductible^*		*20% or more after deductible*	$75 copay		40% or more after deductible
	Emergency room	*$250 copay/visit or more after deductible*			$250 copay/visit after deductible		
	Ambulance	*$100 copay/occurrence or more after deductible*			$200 copay/occurrence after deductible		
Rx	**Rx drug: Retail** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of (after Rx deductible): ▪ $7 copay/20% coinsurance ▪ $15 copay/25% coinsurance ▪ $30 copay/50% coinsurance*		*Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible*** **	Greater of (after Rx deductible): ▪ $7 copay/20% coinsurance ▪ $15 copay/25% coinsurance ▪ $30 copay/50% coinsurance		Greater of (after Rx deductible): $30 copay or 50% network costs after annual deductible****
	Rx drug: Mail*** ▪ Formulary generic ▪ Formulary brand ▪ Non-formulary brand	*Greater of: ▪ $15 copay/20% coinsurance ▪ $30 copay/25% coinsurance ▪ $60 copay/50% coinsurance*		*Greater of: $30 copay or 50% network costs after annual deductible*** **	Greater of: ▪ $15 copay/20% coinsurance ▪ $30 copay/25% coinsurance ▪ $60 copay/50% coinsurance		Greater of: $30 copay or 50% network costs after annual deductible****
OUT-OF-POCKET**	**Medical limit**	*$3,500/self $7,000/family**		*$10,500 or more/self $21,000 or more/family**	$3,500/self; $7,000/family*		$10,500 or more/self; $21,000 or more/family*
	Rx limit	*$4,650/self $9,300family**			$5,050/self; $10,100/family*		

^**2020 in-network coinsurance-** *0% after deductible: Tier 1 providers; all durable medical equipment; services obtained at free-standing facilities, ambulatory surgical centers and physician offices; 10% after deductible: Tier 2: providers; services obtained at outpatient hospital facilities*; **2021 in-network coinsurance-** 10% after deductible: Tier 1 providers; services obtained at free-standing facilities, ambulatory surgical centers and physician offices; 20% after deductible: Tier 2 providers; services obtained at outpatient hospital facilities

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