Your Summary of Benefits

Anthem BlueCross BlueShield

Missouri Educators' Trust
High Deductible Health Plan (Embedded) – Blue Access PPO or Blue Preferred Select PPO Plan 13
Effective 7/1/2019

Covered Benefits	Network	Non-Network
Deductible The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Out-of-Pocket Limit	Single: $6,000 Family: $12,000	Single: $12,000 Family: $24,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/ Specialty Care Physician (SCP) Including Office Surgeries: • Allergy injections (PCP and SCP) • Allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non maternity related Ultrasounds and Pharmaceuticals	20% 20% 20% 20%	40%
Preventive Care Services • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings, Vision screenings and Ocular Photo screening • Immunizations through age 5	No cost share No cost share	40% No cost share
Emergency and Urgent Care **Emergency Room Services** • facility/other covered services (copayment waived if admitted) **Urgent Care Center Services** • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, • Non-Maternity related Ultrasounds and Pharmaceuticals • Allergy injections • Allergy testing	20% 20% 20% 20% 20%	20% 40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits, (1 per day) Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams Injectable Medications Not Listed Elsewhere	20%	40%

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Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 60 days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 60 visits (excludes IV Therapy) (Network/Non-network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services • Outpatient Lab Services	20% 20% 20% 20%	40% 40% 20% 40%
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	20%	40%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 40 visits • Pulmonary Rehabilitation 40 visits • Physical/Manipulation therapy excludes Chiropractic Services: 40 visits • Occupational Therapy: 40 visits • Chiropractic Services: 26 visits • Speech therapy: 40 visits	 20% 20%	 40% 40%
Behavioral Health Services: **Mental Illness and Substance Abuse**[1] • Inpatient Facility Services • Physician Home and Office Visits (PCP/SPC) • Other Outpatient Services @ Hospital/Alternative Care Facility	 20% 20% 20%	 40% 40% 40%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	20%	40%

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Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance and copayment including 0%.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/ coinsurance applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Ambulance and Emergency Room covered at the Network level. Emergency Only. **However, the member may be responsible for any balance due from a Non-Network provider after the plan payment.**
- Network and Non-Network deductible**,** copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26 .
- 0% means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. **However, when choosing a Non-Network provider, the member is responsible for any balance due after the plan payment.**
- PCP is a Network Provider who is a practitioner that specializes in Family practice, General practice, Internal medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP cost share.
- When Allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Benefit period = calendar year .
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Wigs limited to 1 per benefit period.
- Elective abortions are not covered.

[1] We encourage you to review the Schedule of Benefits for limitations.

Precertification:
Members are responsible for obtaining prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: NONE

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5735.

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(TTY/TDD: 711)

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Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով (855) 333-5735

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Language Access Services:

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(Navajo) (Din4): D77 naaltsoos bik1'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[hodoonih t'1adoo b33h 7l7n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (855) 333-5735.

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