Your Summary of Benefits

Missouri Educators' Trust
Anthem Alliance® EPO
Effective 7/1/2019

Plan 8

Covered Benefits	Network	Out of Network
Deductible (Single/Family)	$2,500/$5,000	Not Covered
Out-of-Pocket Limit (Single/Family)	$5,000/$10,000	Not Covered
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 pharmaceutical products	$25/$35 $5 20% 20%	Not Covered Not Covered Not Covered Not Covered
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings, Vision screenings and Ocular Photo screening. • Immunizations through age 5	No cost share No cost share	Not Covered Not Covered
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 pharmaceutical products • Allergy injections • Allergy testing	 $100 $50 20% $5 20%	 $100 $50 Not Covered Not Covered Not Covered
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	20%	Not Covered

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Inpatient Facility Services Unlimited days except for: • 60 days Network for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 60 days Network for skilled nursing facility	20%	Not Covered
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	Not Covered
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) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20% 20%	Not Covered Not Covered 20% Emergency Only
Outpatient Therapy Services (Limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical/Manipulation therapy excluding Chiropractic Services: 40 visits • Occupational therapy: 40 visits • Chiropractic Services: 26 visits • Speech therapy: 40 visits • Cardiac Rehabilitation: 40 visits • Pulmonary Rehabilitation: 40 visits	 $25/$35 20% See Notes below for cost share details	 Not Covered Not Covered Not Covered
Accidental Dental Services $3,000 per accident	Copayments/Coinsurance based on setting where covered services are received	Not Covered
Behavioral Health Services[2]: Mental Health and Substance Abuse Benefits provided in accordance with Federal Mental Health Parity • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 20% $25/$35 20%	2 Office Visits Covered as In Network. In Patient and Out Patient services are not covered

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Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No Cost Share	Not Covered

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- Additional copayments, coinsurance and limits apply and may vary by option selected. Refer to the benefit summary for detailed information.
- Allergy injection - $5 Network copayment when office visit or Urgent care design is a copayment when rendered alone.
- Ambulance 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.
- Dependent age: to end of the month which the child attains age 26.
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network).
- Deductible does not apply to Emergency Room services where a copayment and (0%) coinsurance apply.
- Deductible(s) apply to covered medical services listed when a percentage (%) coinsurance and may not apply to some Behavioral Health Services when coinsurance applies.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No Cost Share (NCS) means no 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 all charges.
- Physical Therapy and Occupational Therapy, Speech Therapy, Pulmonary Rehab and Cardiac Rehab will take the PCP cost share when performed in the office visit setting and Outpatient setting.
- Physician Home and Office Services exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injections and drugs.
- Specialist (SCP) copayment is applicable to all Specialist (excludes: General Physicians, Internists, Pediatrics, OB/Gyns, Geriatrics, Physical Therapy, Athletic Trainers, Occupational Therapy, Speech Therapy, Pulmonary Rehab and Cardiac Rehab or any other Network provided as allowed by the plan).
- Live Health Online (LHO) is covered at the PCP cost share.
- Benefit period = calendar year .
- Elective abortion are not covered.
- Diagnostic Mammograms are not subject to copayment/coinsurance in Network office and Outpatient facility settings. Routine mammogram are paid as Preventive Care services.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Behavioral Health Network and Non-network office visits covered at the network level. Non-Network office visits limited to 2 visits. However, the member may be responsible for any balance due from a Non-Network provider after the plan payment.
- Mental Health/Substance Abuse Outpatient facility services includes outpatient surgery: Hospital/Alternative Care Facility.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Emergency Room and Urgent Care services Network and Non-Network covered at the Network level. However, the member may be responsible for any balance due from a Non-Network provider after the plan payment.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-network settings not covered.
- Medical Nutritional Counseling -10 visit limit per benefit period; $15 copayment per office visit excludes Preventive Nutritional Counseling.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Wig-1 per benefit period network/non-network covered up to $600 allowed amount during active cancer treatment and for treatment of Alopecia Totalis.

[1] These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
[2] We encourage you to review the Schedule of Benefits for limitations.
[3] Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

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:

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(TTY/TDD: 711)

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