

# Your Summary of Benefits



**Missouri Educators' Trust**  
**Anthem Alliance® EPO High Deductible Health Plan**  
**Effective 07/01/2019**

**Plan 13**

Covered Benefits	Network	Non Network
<b>Deductible (Single/Family)</b> <b>Embedded:</b> 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.	\$3,000/\$6,000	Not Covered
<b>Out-of-Pocket Limit (Single/Family)</b>	\$6,000/\$12,000	Not Covered
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, and pharmaceutical products</li> </ul>	\$20/\$40 after deductible  20% 20% 20%	Not Covered  Not Covered Not Covered Not Covered
<b>Preventive Care Services</b> Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings, Vision screenings and Ocular Photo screening. <ul style="list-style-type: none"> <li>Immunizations through age 5</li> </ul>	No cost share  No cost share	Not Covered  Not Covered
<b>Emergency and Urgent Care</b> <b>Emergency Room Services</b> <ul style="list-style-type: none"> <li>facility/other covered services (copayment waived if admitted)</li> </ul> <b>Urgent Care Center Services</b> <ul style="list-style-type: none"> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, and pharmaceutical products</li> <li>Allergy injections</li> <li>Allergy testing</li> </ul>	20%  20% 20% 20%	20%  20% Not Covered Not Covered
<b>Inpatient and Outpatient Professional Services</b> May include but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	20%	Not Covered
Blue 11		

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## Notes:

- Deductible(s) applies to all covered medical services listed with a percentage (%) coinsurance, including prescription drug cost shares. All covered medical services (except network Preventive Services) are subject to deductible and coinsurance unless noted otherwise.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- 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).
- 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.
- Allergy injection billed separately is subject to the Allergy injection \$5 copayment after deductible. If billed with an office visit charge, it will be covered under the OV copayment.
- 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) cost share is PCP copayment.
- Benefit period = calendar year .
- Elective abortion are not covered.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Behavioral Health Non-network office visits covered at the network level are 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. Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings and Ocular Photo screening.
- 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.**
- Chiropractic services at 50% coinsurance up to the maximum allowable.
- Medical Nutritional Counseling -10 visit limit per benefit period; \$15 copayment applied after Deductible.
- 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.

**Pre-existing Exclusion Period: None**

## 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.

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.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

**(Arabic) (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735

**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

### Chinese

**(中文) :** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5735

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**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

### (Japanese) (日本語):

この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

## Language Access Services:

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

**(Navajo) (Din4):** D77 naaltsoos bikl'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[ hodoonih t'1ladoo b33h 717n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (855) 333-5735.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5735.

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### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.