Your Summary of Benefits

Missouri Educators' Trust
Lumenos Health Savings Accounts (Embedded)
Effective 7/1/2016

Plan 11 (Health 19)

Covered Benefits	Network	Non-Network
Deductible Embedded 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: $3,500 Family: $7,000	Single: $7,000 Family: $14,000
Out-of-Pocket Limit	Single: $3,500 Family: $7,000	Single: $9,000 Family: $18,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services 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 which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	No cost share	30%
• Immunizations through age 18	No cost share	No cost share
Emergency and Urgent Care		
• **Emergency Room Services (facility/other covered services)** (copayment waived if admitted)	0%	0%
• **Urgent Care Center Services**	0%	30%
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	0%	30%
• Injectable Medications Not Listed Elsewhere	$0	30%
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	0%	30%

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Blue 8.0		
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
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, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs	0%	30%
• Hospice Care	0%	30%
• Ambulance Services	0%	0%
• Outpatient Labe Services	0%	30%
Accidental Dental Services $3,000 limit per accident **(Network and Non-network combined)**	Copayments/Coinsurance based on setting where covered services are received	30%
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)**		
• Physician Home and Office Visits	0%	30%
• 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	0%	30%
Behavioral Health Services: **Mental Illness and Substance Abuse**[1] • Inpatient Facility Services • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	Benefits provided in accordance with Federal Mental Health Parity	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs		
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	0%	30%[2]
• **Anthem Rx Home Delivery Service:** (90-day supply) Includes diabetic test strip	0% **Tier 4-See Specialty Medications Disclaimer	Not covered
<u>**Tier 4-Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail order. Member may be responsible for additional cost when not selecting the available generic drug.</u> <u>Member may be responsible for additional cost when not selecting the available generic drug.</u>		
Medicare Rx - Wrap		

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, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies. Copayments/coinsurance accumulates to the Medical OOP max. Once the Medical OOP max is met, no additional costshare 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.
- 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 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.
- Live Health Online (LHO) is covered.
- Benefit period = calendar year
- 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.
- 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.
- Hospital stay for Maternity coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- **4th Tier per script 30 day supply.

1 We encourage you to review the Schedule of Benefits for limitations. .
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:
Members are encouraged to always obtain 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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Your Summary of Benefits

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date