Your Summary of Benefits

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

Plan 14
(Health 23 Employee Only)
(Health 24 Employee + Dependents)

Covered Benefits	Network	Non-Network
Deductible Non-Embedded Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit	Single: $3,000 Family: $6,000	Single: $6,000 Family:$12,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • 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 and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Childhood Immunizations through age 18	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%	20% 40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits, Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams • Injectable Medications Not Listed Elsewhere	20% 20%	40% 40%
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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, Orthotics and Prosthetics • 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 • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardio Rehabilitation: 40 visits • Pulmonary Rehabilitation: 40 visits • Physical therapy: 40 visits • Physical/Manipulation therapy excludes Chiropractic Services: 40 visits • Chiropractic Services: 26 visits • Occupational therapy: 40 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%

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Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage.	20%	40%
Prescription Drugs [4] Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap **Tier 4-Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to 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.	Deductible applies prior to copay $10/$30/$50 $20/$60/$100 **Tier 4-See Specialty Medications Disclaimer	50% Not covered

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.
- 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.
- 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.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- 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.
- 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

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.
*4th Tier per script 30 day supply

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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.

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