MISSOURI EDUCATORS' TRUST

Plan Summary & Rates

Effective July 1, 2021 - June 30, 2022

Houston R-I School District

									Embedded HDHP/HSA			
	Plan 3 PPO		Plan 4 PPO		Plan 7 PPO		Plan 8 PPO		Plan 10		Plan 12	
PLAN DESCRIPTION	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Individual Deductible	$1,000	$2,000	$1,000	$2,000	$1,500	$3,000	$2,500	$5,000	$2,800	$5,000	$5,000	$8,000
Family Deductible	$2,000	$4,000	$2,000	$4,000	$3,000	$6,000	$5,000	$10,000	$5,000	$10,000	$10,000	$16,000
Individual Out-of-Pocket	$3,000	$4,000	$3,500	$4,000	$4,500	$6,000	$5,000	$10,000	$4,500	$10,000	$6,350	$12,000
Family Out-of-Pocket	$6,000	$8,000	$7,000	$8,000	$9,000	$12,000	$10,000	$20,000	$9,000	$20,000	$12,700	$24,000
Coinsurance Level	80%/20%	50%/50%	60%/40%	50%/50%	60%/40%	50%/50%	80%/20%	50%/50%	100%/0%	60%/40%	100%/0%	70%/30%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits (PCP/Specialist)	$25/$50	50% AD	$25/$40	50% AD	$25/$50	50% AD	$25/$35	50% AD	$20/$40 AD	40% AD	$20/$40 AD	30% AD
Preventive Care	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	40% AD	$0 Copay	30% AD
Outpatient Lab Services	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	0% AD	40% AD	0% AD	30% AD
Outpatient Radiology Services	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
Inpatient Hospital Care	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
Outpatient Hospital/Free Standing Facility	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
Emergency Care (waived if admitted)*	$200 Copay	$200 Copay	$200 Copay + 40%	$200 Copay + 40%	$200 Copay + 40%	$200 Copay + 40%	$100 Copay	$100 Copay	$150 Copay AD	$150 Copay AD	$150 Copay AD	$150 Copay AD
Urgent Care* **	$50 Copay	50% AD	$50 Copay	50% AD	$50 Copay	50% AD	$50 Copay	50% AD	$50 Copay AD	40% AD	$50 Copay AD	30% AD
Physical, Occupational, Speech Therapy (40 visits per therapy per benefit year)	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	$35 Copay**	50% AD	0% AD	40% AD	0% AD	30% AD
Cardiac/Pulmonary Rehab (40 visits per therapy per benefit year)	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	$35 Copay**	50% AD	0% AD	40% AD	0% AD	30% AD
Chiropractic Services (26 visits per benefit year)	$50 Copay**	50% AD	$40 Copay**	50% AD	$50 Copay**	50% AD	$35 Copay**	50% AD	$40 Copay AD**	40% AD	$40 Copay AD**	30% AD
Skilled Nursing Facility (60 days per benefit year)	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
Home Health Care (60 visits per benefit year)	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
Rx Copay - (Specialty Drugs not covered out of network)	$15/$35/$75/ 20% to $100	50% with $75 min All Tiers	$15/$35/$75/ 20% to $100	50% All Tiers	$15/$35/$75/ 20% to $100	50% All Tiers	$10/$35/$60/ 20% to $100	50% with $60 min All Tiers	$10/$30/$60/20% to $100 All AD	$20/$60/$120 All AD	$10/$30/$60/20% to $100 All AD	$20/$60/$120 All AD
Mail Order Prescriptions (in-network only, Specialty Drugs Excluded)	2x Retail Copay	Not Covered	2x Retail Copay	Not Covered	2x Retail Copay	Not Covered	2x Retail Copay	Not Covered	2x Retail Copay AD	Not Covered	2x Retail Copay AD	Not Covered
Injectable Medications	20% AD	50% AD	40% AD	50% AD	40% AD	50% AD	20% AD	50% AD	0% AD	40% AD	0% AD	30% AD
RATES/NETWORK	**Aetna OPEN ACCESS CHOICE POS II**		**Aetna OPEN ACCESS CHOICE POS II**		**Aetna OPEN ACCESS CHOICE POS II**		**Aetna OPEN ACCESS CHOICE POS II**		**Aetna OPEN ACCESS CHOICE POS II**		**Aetna OPEN ACCESS CHOICE POS II**	
Employee	$682.17		$653.59		$601.13		$589.89		$592.91		$492.76	
Employee & Spouse	$1,344.37		$1,288.05		$1,184.66		$1,162.53		$1,168.47		$971.10	
Employee & Child(ren)	$1,198.53		$1,148.34		$1,056.18		$1,036.45		$1,041.72		$865.79	
Family	$1,898.59		$1,819.07		$1,673.06		$1,641.78		$1,650.18		$1,371.47	

***Emergency Care copay applicable ONLY to facility charges.**

****Therapy copay applicable ONLY when place of service is Physician Office. Deductible &/or Coinsurance applies at any other place of service.**

*****Urgent Care charges apply to deductible &/or coinsurance if billed as a hospital or outpatient charge.**

This is a partial description of benefits offered. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This illustration is only to assist in determining what Plan(s) your district will offer. The Summary of Benefits & Coverage (SBC) and Plan Document will supersede this illustration. This illustration is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Out of Pocket includes Deductible and Copays.

AD = After Deductible

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