MISSOURI EDUCATORS' TRUST

Plan Summary & Rates

Effective January 1, 2025 - June 30, 2025

Nixa Public School District

	Plan 2 PPO		Plan 7 PPO		Plan 8 PPO		Plan 15 PPO		Embedded HDHP/HSA Plan 13			Embedded HDHP/HSA Plan 16		
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	$1,500	$3,000	$2,500	$5,000	$3,500	$5,000	$3,200	$6,400		$6,000	$12,000	
Family Deductible	$2,000	$4,000	$3,000	$6,000	$5,000	$10,000	$7,000	$10,000	$6,400	$12,800		$12,000	$24,000	
Individual Out-of-Pocket	$2,000	$4,000	$4,500	$6,000	$5,000	$10,000	$7,500	$10,000	$6,000	$12,000		$7,000	$14,000	
Family Out-of-Pocket	$4,000	$8,000	$9,000	$12,000	$10,000	$20,000	$15,000	$20,000	$12,000	$24,000		$14,000	$28,000	
Coinsurance Level	80%/20%	50%/50%	60%/40%	50%/50%	80%/20%	50%/50%	70%/30%	50%/50%	80%/20%	60%/40%		80%/20%	60%/40%	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited	Unlimited	
Office Visits (PCP/Specialist)	$25/$35	50% AD	$25/$50	50% AD	$25/$35	50% AD	$30/$50	50% AD	20% AD	40% AD		20% AD	40% AD	
Preventive Care	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	40% AD		20% AD	40% AD	
Outpatient Lab Services	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	$0 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Outpatient Radiology Services	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Inpatient Hospital Care	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Outpatient Hospital/Free Standing Facility	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Emergency Care (waived if admitted)*	$100 Copay	$100 Copay	$200 Copay + 40%	$200 Copay + 40%	$100 Copay	$100 Copay	$100 Copay	$100 Copay	20% AD	20% AD		20% AD	20% AD	
Urgent Care**	$50 Copay	50% AD	$50 Copay	50% AD	$50 Copay	50% AD	$50 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Physical Therapy (40 visits per therapy per benefit year)	$35 Copay	50% AD	$50 Copay	50% AD	$35 Copay	50% AD	$50 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Occupational and Speech Therapy (40 visits per therapy per benefit year)	$35 Copay***	50% AD	40% AD	50% AD	$35 Copay***	50% AD	$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Cardiac/Pulmonary Rehab (40 visits per therapy per benefit year)	$35 Copay***	50% AD	40% AD	50% AD	$35 Copay***	50% AD	$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Chiropractic Services (26 visits per benefit year)	$35 Copay***	50% AD	$50 Copay***	50% AD	$35 Copay***	50% AD	$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Skilled Nursing Facility (60 days per benefit year)	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Home Health Care (60 visits per benefit year)	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Rx Copay (Specialty Drugs are not covered out of network)	$10/$30/$60/ 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	$15/$45/$70/20% to $100	50% with $60 min All Tiers	20% AD	40% AD		20% AD	40% 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	20% AD	Not Covered		20% AD	Not Covered	
Injectable Medications	20% AD	50% AD	40% AD	50% AD	20% AD	50% AD	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
RATES/NETWORK	Anthem BLUE ACCESS		Anthem BLUE ACCESS		Anthem BLUE ACCESS		Anthem BLUE ACCESS		Anthem BLUE ACCESS			Anthem BLUE ACCESS		
Employee	$820.00		$672.00		$659.00		$600.00		$549.00			$445.00		
Employee & Spouse	$1,616.00		$1,322.00		$1,299.00		$1,182.00		$1,081.00			$875.00		
Employee & Child(ren)	$1,441.00		$1,179.00		$1,158.00		$1,053.00		$964.00			$781.00		
Family	$2,282.00		$1,868.00		$1,833.00		$1,667.00		$1,525.00			$1,235.00		
RATES/NETWORK	Board Portion	Employee Portion	Board Portion	Employee Portion	Board Portion	Employee Portion	Board Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion
Employee	$572.00	$248.00	$572.00	$100.00	$572.00	$87.00	$572.00	$28.00	$572.00	-$23.00	$0.00	$572.00	-$127.00	$0.00
Employee & Spouse	$572.00	$1,044.00	$572.00	$750.00	$572.00	$727.00	$572.00	$610.00	$572.00	-$23.00	$532.00	$572.00	-$127.00	$430.00
Employee & Child(ren)	$572.00	$869.00	$572.00	$607.00	$572.00	$586.00	$572.00	$481.00	$572.00	-$23.00	$415.00	$572.00	-$127.00	$336.00
Family	$572.00	$1,710.00	$572.00	$1,296.00	$572.00	$1,261.00	$572.00	$1,095.00	$572.00	-$23.00	$976.00	$572.00	-$127.00	$790.00

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.

*Emergency Care copay applicable ONLY to facility charges.

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

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

****In the interest of plan and member savings, all Specialty drug participants will be required to complete an application to determine applicalbe drug program.

Out of Pocket includes Deductible and Copays.

AD = After Deductible

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