



MISSOURI EDUCATORS' TRUST

Plan Summary & Rates

Effective July 1, 2026 - June 30, 2027

Blue Access & Blue Access Choice

	Plan 15 PPO		Embedded HDHP/HSA			Embedded HDHP/HSA		
			Plan 13			Plan 16		
PLAN DESCRIPTION	In-Network	Out-of-Network	In-Network	Out-of-Network		In-Network	Out-of-Network	
Individual Deductible	\$3,500	\$5,000	\$3,400	\$6,600		\$6,000	\$12,000	
Family Deductible	\$7,000	\$10,000	\$6,800	\$13,200		\$12,000	\$24,000	
Individual Out-of-Pocket	\$7,500	\$10,000	\$6,600	\$13,200		\$7,000	\$14,000	
Family Out-of-Pocket	\$15,000	\$20,000	\$13,200	\$26,400		\$14,000	\$28,000	
Coinsurance Level	70%/30%	50%/50%	80%/20%	60%/40%		80%/20%	60%/40%	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited	Unlimited	
Office Visits (PCP/Specialist)	\$30/\$50	50% AD	20% AD	40% AD		20% AD	40% AD	
Virtual Visit	\$10 Copay		\$10 Copay			\$10 Copay		
Preventive Care	\$0 Copay	50% AD	\$0 Copay	40% AD		\$0 Copay	40% AD	
Outpatient Lab Services	\$0 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Outpatient Radiology Services	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Inpatient Hospital Care	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Outpatient Hospital/Free Standing Facility	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Emergency Care (waived if admitted)*	\$250 Copay	\$250 Copay	20% AD	20% AD		20% AD	20% AD	
Urgent Care**	\$50 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Physical Therapy (40 visits per therapy per benefit year)	\$50 Copay	50% AD	20% AD	40% AD		20% AD	40% AD	
Occupational and Speech Therapy (40 visits per therapy per benefit year)	\$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Cardiac/Pulmonary Rehab (40 visits per therapy per benefit year)	\$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Chiropractic Services (26 visits per benefit year)	\$50 Copay***	50% AD	20% AD	40% AD		20% AD	40% AD	
Skilled Nursing Facility (60 days per benefit year)	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Home Health Care (60 visits per benefit year)	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
Rx Copay (Specialty Drugs not covered out of network)	\$15/\$45/\$70/20% to \$100	Not Covered	20% AD	Not Covered		20% AD	Not Covered	
Mail Order Prescriptions (in-network only, Specialty Drugs Excluded)	2x Retail Copay	Not Covered	20% AD	Not Covered		20% AD	Not Covered	
Injectable Medications	30% AD	50% AD	20% AD	40% AD		20% AD	40% AD	
RATES/NETWORK	Blue Access Choice - Mercy Only		Blue Access Choice - Mercy Only			Blue Access Choice - Mercy Only		
Employee	\$639.00		\$585.00			\$473.00		
Employee & Spouse	\$1,259.00		\$1,151.00			\$931.00		
Employee & Child(ren)	\$1,121.00		\$1,027.00			\$831.00		
Family	\$1,777.00		\$1,624.00			\$1,315.00		
	Board Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion
Employee	\$615.00	\$24.00	\$615.00	-\$30.00	\$0.00	\$615.00	-\$142.00	\$0.00
Employee & Spouse	\$615.00	\$644.00	\$615.00	-\$30.00	\$566.00	\$615.00	-\$142.00	\$458.00
Employee & Child(ren)	\$615.00	\$506.00	\$615.00	-\$30.00	\$442.00	\$615.00	-\$142.00	\$358.00
Family	\$615.00	\$1,162.00	\$615.00	-\$30.00	\$1,039.00	\$615.00	-\$142.00	\$842.00
RATES/NETWORK	Anthem BLUE ACCESS - Cox & Mercy		Anthem BLUE ACCESS - Cox & Mercy			Anthem BLUE ACCESS - Cox & Mercy		
Employee	\$670.00		\$613.00			\$497.00		
Employee & Spouse	\$1,320.00		\$1,207.00			\$977.00		
Employee & Child(ren)	\$1,176.00		\$1,077.00			\$872.00		
Family	\$1,861.00		\$1,702.00			\$1,379.00		
	Board Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion	Board Portion	Board Paid HSA Portion	Employee Portion
Employee	\$615.00	\$55.00	\$615.00	-\$2.00	\$0.00	\$615.00	-\$118.00	\$0.00
Employee & Spouse	\$615.00	\$705.00	\$615.00	-\$2.00	\$594.00	\$615.00	-\$118.00	\$480.00
Employee & Child(ren)	\$615.00	\$561.00	\$615.00	-\$2.00	\$464.00	\$615.00	-\$118.00	\$375.00
Family	\$615.00	\$1,246.00	\$615.00	-\$2.00	\$1,089.00	\$615.00	-\$118.00	\$882.00

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 Alera Group. 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 applicable drug program.

Out of Pocket includes Deductible and Copays.

AD = After Deductible