

# MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

## PPO 1500 Plan

**Effective January 1, 2020**

*This is a summary of plan benefits. In the case of any inadvertent discrepancies, the plan document will govern.*

**For specific information regarding plan provisions, please contact the Health Trust Service Representatives at 1-800-852-8300 or [htservice@memun.org](mailto:htservice@memun.org).**

	In-Network	Out-of-Network
Please Note: Payment made Out-Of-Network cannot be applied towards meeting the In-Network Deductible or Out-of-Pocket Maximum, and vice versa.		
<b>BENEFIT DESCRIPTION</b>		
<ul style="list-style-type: none"> <li>• Deductible</li> <li>• Coinsurance</li> <li>• Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year <sup>(1)</sup></li> <li>• Lifetime Maximum</li> </ul>	\$1,500 Single / \$3,000 Family Plan pays 80% \$3,500 Single / \$7,000 Family Unlimited	\$2,500 Single / \$5,000 Family Plan pays 60% \$4,000 Single / \$8,000 Family Unlimited
<b>Inpatient Services</b>		
<ul style="list-style-type: none"> <li>• Unlimited days of care in semi-private room <sup>(2)(3)</sup></li> <li>• Physician services</li> <li>• Intensive care</li> <li>• Mental health services/Substance abuse services <sup>(4)</sup></li> <li>• Ancillary services, lab tests, x-rays, medications</li> <li>• Anesthesia</li> <li>• Maternity care</li> <li>• Newborn care</li> </ul>	80% after In-Network deductible 80% after In-Network deductible	60% after Out-of-Network deductible 60% after Out-of-Network deductible 60% after Out-of-Network deductible 60% after Out-of-Network deductible 60% after Out-of-Network deductible 80% after Out-of-Network deductible 60% after Out-of-Network deductible
<b>Outpatient Services</b>		
<ul style="list-style-type: none"> <li>• Any physician office visit, diagnosis and treatment</li> <li>• Lab &amp; X-ray – Diagnostic</li> <li>• Lab &amp; X-ray – Preventive</li> <li>• Advanced Imaging (e.g., MRI, CT, and PET scans) <sup>(3)</sup></li> <li>• Physical exams and Well-child care</li> <li>• Immunizations/Flu Shots</li> <li>• Covered surgical procedures</li> <li>• Mental health services/Substance abuse services <sup>(4)</sup></li> <li>• Maternity care</li> <li>• Gynecological exam – Preventive</li> <li>• Physical, Speech or Occupational Therapy <sup>(5)</sup></li> <li>• Outpatient facility fees</li> <li>• Ambulance (medically necessary)</li> </ul>	100% after \$25 copay (PCP) or \$40 copay (Specialist) 80% after In-Network deductible 100% (no deductible) 80% after In-Network deductible 100% (no deductible) 100% (no deductible) 80% after In-Network deductible 100% after \$25 copay 100% after \$25 copay (PCP) or \$40 copay (Specialist) 100% (no deductible) 100% after \$40 copay 80% after In-Network deductible 80% after In-Network deductible	80% after \$25 copay (PCP) or \$40 copay (Specialist) 60% after Out-of-Network deductible 80% (no deductible) 60% after Out-of-Network deductible 80% (no deductible) 80% (no deductible) 60% after Out-of-Network deductible 80% after \$25 copay 80% after \$25 copay (PCP) or \$40 copay (Specialist) 80% (no deductible) 80% after \$40 copay 60% after Out-of-Network deductible 80% after Out-of-Network deductible
<b>Emergency Room Services</b>		
<ul style="list-style-type: none"> <li>• Emergency/Acute care</li> <li>• Non-emergency care</li> </ul>	100% after \$200 copay 100% after \$200 copay	100% after \$200 copay 100% after \$200 copay
<b>Other Services</b>		
<ul style="list-style-type: none"> <li>• Walk-In or Urgent Care Center</li> <li>• Home Health/Hospice care</li> <li>• Skilled nursing facility <sup>(3)(7)</sup></li> <li>• Human tissue &amp; organ transplants</li> <li>• Durable Medical Equipment</li> <li>• Oral surgery (limited benefits)</li> <li>• Eye exams – Preventive</li> <li>• Chiropractic care <sup>(8)</sup></li> </ul>	100% after \$40 copay <sup>(6)</sup> 80% after In-Network deductible 80% after In-Network deductible 80% after In-Network deductible 80% (no deductible) 80% after In-Network deductible 100% (no deductible) 100% after \$40 copay	80% after \$40 copay 60% after Out-of-Network deductible 60% after Out-of-Network deductible 60% after Out-of-Network deductible 60% (no deductible) 80% after Out-of-Network deductible 80% (no deductible) 80% after \$40 copay
<b>Prescription Drugs</b>		
Each <b>30-day</b> supply – Retail Pharmacy (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$8 / \$15 / \$35 / \$60 / \$80	Copays: \$8 / \$15 / \$35 / \$60 / \$80
<b>90 day</b> supply copay – Mail Order (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$16 / \$30 / \$70 / \$120 / \$160	Copays: \$16 / \$30 / \$70 / \$120 / \$160
Specialty medications may only be filled through specialty pharmacies and in quantities up to a 30 day supply. Some specialty medications may be subject to partial fills for new prescriptions. Please contact the Health Trust with any questions.		

- (1) In-Network copays will be capped at \$4,000 single / \$8,000 family. This means that you will not have to pay more than \$7,500 single / \$15,000 family for all covered services received In-Network (including deductible, coinsurance, and copays).
- (2) Private rooms covered when medically necessary.
- (3) The Provider or Participant must contact Anthem Blue Cross and Blue Shield before any scheduled hospital or skilled nursing facility admission or outpatient advanced imaging procedure to obtain certification. If certification is not obtained, benefits may be denied.
- (4) All services must be pre-authorized by Anthem Blue Cross and Blue Shield. The Provider or Participant must contact Anthem Blue Cross and Blue Shield's Mental Health Administrator for review of inpatient non-emergency services in order to receive the In-Network level of benefits.
- (5) Combined physical, speech, and occupational therapy benefits (including those billed by a chiropractor or a D.O.) limited to 75 visits per person per calendar year (combined In-Network and Out-of-Network).
- (6) For a current list of In-Network Walk-In and Urgent Care Centers, please call the Health Trust at 1-800-852-8300, or refer to the Health Trust website at [www.mmeht.org](http://www.mmeht.org).
- (7) Skilled nursing facility services limited to 100 days per calendar year (combined In-Network and Out-of-Network).
- (8) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call us at 1-800-852-8300 or visit [www.mmeht.org](http://www.mmeht.org). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-852-8300 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$1,500/individual or \$3,000/family for <u>in network providers</u> ; \$2,500/individual or \$5,000/family for <u>out of network providers</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$3,500 individual / \$7,000 family for <u>in network providers</u> ; \$4,000 individual / \$8,000 family for <u>out of network providers</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . However, <u>in network copays</u> will be capped at \$4,000 individual / \$8,000 family. This means that you will not have to pay more than \$7,500 individual / \$15,000 family for all covered services received <u>in network</u> (including <u>copays</u> ).
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.mmeht.org">www.mmeht.org</a> or call 1-800-852-8300 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out of network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out of network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	<u>Primary care</u> visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$25 <u>copay</u> /visit then 20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit then 20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	The <u>provider</u> must contact Anthem Blue Cross and Blue Shield/AIM and obtain <u>preauthorization</u> .
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.mmeht.org">www.mmeht.org</a>	Generic drugs (Tier 1 Select & Tier 1 Standard)	Select: \$8 <u>copay</u> /prescription for each 30 day supply (retail) \$16 <u>copay</u> /prescription for a 90-day supply (mail order) Standard: \$15 <u>copay</u> /prescription for each 30-day supply (retail) \$30 <u>copay</u> /prescription for a 90-day supply (mail order)		<u>Prescription drugs</u> are not subject to the overall <u>deductible</u> .  Step Therapy and <u>Prior Authorization</u> may apply to some drugs.
	Preferred brand drugs (Tier 2)	\$35 <u>copay</u> /prescription for each 30-day supply (retail) \$70 <u>copay</u> /prescription for a 90-day supply (mail order)		<u>Specialty drugs</u> may have separate cost structures and means of delivery. <u>Specialty medications</u> may only be filled at a specialty pharmacy in quantities up to a 30 day supply, regardless of the tier in which they fall. Certain exceptions may apply. For specific information, contact <a href="http://www.mmeht.org">www.mmeht.org</a> .
	Non-preferred brand drugs (Tier 3)	\$60 <u>copay</u> /prescription for each 30-day supply (retail) \$120 <u>copay</u> /prescription for a 90-day supply (mail order)		
	Lifestyle & <u>Specialty drugs</u> (Tier 4)	\$80 <u>copay</u> /prescription for each 30-day supply (retail pharmacy for lifestyle medications; specialty pharmacy for specialty medications) \$160 <u>copay</u> /prescription for a 90-day supply (mail order for lifestyle medications only; 90-day supply not available for <u>specialty medications</u> )		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Must be medically necessary
	<u>Urgent care</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit then 20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Precertification</u> is required. If you don't get <u>precertification</u> , benefits may be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$25 <u>copay</u> /visit then 20% <u>coinsurance</u>	The <u>Provider</u> or Participant must contact Anthem Blue Cross and Blue Shield's Mental Health Administrator for review of non-emergency services, in order to receive the <u>in network</u> level of benefits. If <u>precertification</u> is not obtained for an inpatient admission, benefits may be denied.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	\$25 PCP/\$40 <u>Specialist copay</u> /visit; <u>deductible</u> does not apply	\$25 PCP/\$40 <u>Specialist copay</u> /visit then 20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If <u>precertification</u> is not obtained, benefits may be denied.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Plan</u> covers paramedical supportive services; does not cover daily living assistance.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit then 20% <u>coinsurance</u>	Coverage is limited to 75 visits for <u>in network</u> and <u>out of network</u> Physical, Occupational and Speech therapy combined per Calendar Year.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit then 20% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 100 days per calendar year combined <u>in</u> and <u>out of network</u> . If <u>precertification</u> is not obtained, benefits may be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not subject to the overall <u>deductible</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not subject to the overall <u>deductible</u> .
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (with prior authorization)
- Chiropractic Care (up to 36 visits per calendar year)
- Hearing Aids
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Municipal Employees Health Trust at 1-800-852-8300 or [www.mmeht.org](http://www.mmeht.org), your state insurance department, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Anthem BCBS ME; Attn: Appeals; PO Box 218 North Haven, CT 06473-0218. You may also wish to contact Member Services at the Maine Municipal Employees Health Trust, at 1-800-852-8300.

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$70
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,130</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay\*:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,860</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$400
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,240</b>

\*Note: These numbers assume the patient does not participate in the plan's diabetes wellness program. If you have diabetes and participate in the plan's wellness program, you may be able to reduce your costs. For more information about the diabetes wellness program, please contact Maine Municipal Employees Health Trust at 1-800-852-8300 for information about the diabetes wellness program.