

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Maine Education Association Benefits Trust (MEABT): STANDARD \$500 PLAN

Your Network: National PPO (BlueCard PPO)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,000 family	\$500 person / \$1,000 family
Overall Out-of-Pocket Limit Coinsurance maximum \$2,000/\$4,000. Copay maximum \$6,600/\$13,200	\$9,100 person / \$18,200 family	\$9,100 person / \$18,200 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>The In-Network and Non-Network deductibles and out-of-pocket are combined and accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP). When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for PCP visits, x-rays, lab services and Urgent Care when provided by the Value-Based Provider. No member cost share is required for the first primary care visit of the plan year.</i></p>		
<p>LiveHealth Online via www.livehealthonline.com: Office visit copayments are waived for care through LiveHealth Online.</p>		
Primary Care (PCP) <i>virtual and office</i>	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Mental Health and Substance Abuse Care <i>virtual and office</i>	No charge	20% coinsurance deductible does not apply
Specialist Care <i>virtual and office</i>	\$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 40 visits per year.</i> Acupuncture <i>Coverage is limited to 20 visits per year.</i>	\$20 copay per visit deductible does not apply 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance deductible does not apply
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	20% coinsurance deductible does not apply
<u>Diagnostic Services</u> Lab Office Preferred Reference Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> <i>When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for Urgent Care when provided by the Value-Based Provider.</i> Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$20 copay per visit deductible does not apply \$200 copay per visit deductible does not apply No charge 20% coinsurance after deductible is met	40% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	20% coinsurance deductible does not apply 20% coinsurance deductible does not apply	40% coinsurance deductible does not apply 40% coinsurance deductible does not apply
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies is limited to 60 visits combined per year.</i>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per year.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	No charge	20% coinsurance deductible does not apply
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids <i>Coverage for members through age 18 is limited to 1 hearing aid per hearing-impaired ear every 36 months. Coverage for members age 19 and over is limited to \$3,000 per hearing aid for each hearing-impaired ear every 36 months.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with medical copayment limit	Combined with medical copayment limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (2 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx became CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1a - Typically Lower Cost Generic	\$10 copay per prescription (30 day supply retail) and \$20 copay per prescription (90 day supply retail and home delivery)	\$10 copay per prescription (30 day supply retail) \$20 copay per prescription (90 day supply retail and home delivery)
Tier 1b - Typically Generic	\$15 copay per prescription (30 day supply retail) and \$30 copay per prescription	\$15 copay per prescription (30 day supply retail) \$30 copay per prescription (90 day

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	(90 day supply retail and home delivery)	supply retail and home delivery)
Tier 2 – Typically Preferred Brand	\$35 copay per prescription (30 day supply retail) and \$70 copay per prescription (90 day supply retail and home delivery)	\$35 copay per prescription (30 day supply retail) \$70 copay per prescription (90 day supply retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription (30 day supply retail) and \$120 copay per prescription (90 day supply retail and home delivery)	\$60 copay per prescription (30 day supply retail) \$120 copay per prescription (90 day supply retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	\$85 copay per prescription (30 day supply retail and home delivery)	Not covered out of network

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 772-4121

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 772-4121.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 772-4121:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 772-4121。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 772-4121 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 772-4121.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 772-4121.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 772-4121.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 772-4121 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 772-4121로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (833) 772-4121.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 772-4121.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 772-4121 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 772-4121.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 772-4121.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.