# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

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

Your Network: National PPO (BlueCard PPO)

Effective July 1, 2025

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge |
| **Mental Health & Substance Use Disorder Services** | No charge |
| **Specialist care** | No charge |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Overall Deductible** | $300 person / $600 family | $300 person / $600 family |
| **Overall Out-of-Pocket Limit** *Coinsurance maximum $1,500/$3,000. Copay maximum $7,400/$14,800.* | $9,200 person / $18,400 family | $9,200 person / $18,400 family |
| 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.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>The In-Network and Out-of-Network deductibles and out-of-pocket are combined and accumulate toward each other. | | |
| **Doctor Visits (virtual and office)** *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.* | | |
| **Primary Care (PCP)** *virtual and office* | $20 copay per visit deductible does not apply | 40% coinsurance after deductible is met |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | No charge | 20% coinsurance deductible does not apply |
| **Specialist Care** *virtual and office* | $30 copay per visit deductible does not apply | 40% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postnatal care and delivery) | 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 an Out-of-Network Provider |
|---|---|---|
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit deductible does not apply | 40% coinsurance after deductible is met |
| **Manipulation Therapy**<br>*Coverage is limited to 40 visits per member per benefit period.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Acupuncture**<br>*Coverage is limited to 20 visits per year.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Other Services in an Office** | | |
| **Allergy Testing** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Surgery** | 20% 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** *per IRS guidelines* | No charge | 20% coinsurance deductible does not apply |
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Reference Lab | 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 |
| **X-Ray** | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 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 |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 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 |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.*<br>*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.* | $20 copay per visit deductible does not apply | 40% coinsurance after deductible is met |
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | $300 copay per visit deductible does not apply | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | No charge | Covered as In-Network |
| **Ambulance** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | 20% coinsurance deductible does not apply | 40% coinsurance deductible does not apply |
| Doctor Services | 20% coinsurance deductible does not apply | 40% coinsurance deductible does not apply |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | 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 |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical, occupational and speech therapies is limited to 60 visits combined per member per benefit period.* | | |
| 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** *office and outpatient hospital* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per year.* | 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 |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hearing Aids**<br>*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.* | 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 an Out-of-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** | Not applicable | Not applicable |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with Out-of-Network medical out-of-pocket limit |

| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***National*** | | |
|---|---|---|
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (2 times the 30 day supply cost share(s) at Retail pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**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)<br>$20 copay per prescription (90 day supply retail and home delivery) |
| **Tier 1b - Typically Generic** | $20 copay per prescription (30 day supply retail) and $40 copay per prescription (90 day supply retail and home delivery) | $20 copay per prescription (30 day supply retail)<br>$40 copay per prescription (90 day supply retail and home delivery) |
| **Tier 2 - Typically Preferred Brand** | $45 copay per prescription (30 day supply retail) and $90 copay per prescription (90 day supply retail and home delivery) | $45 copay per prescription (30 day supply retail)<br>$90 copay per prescription (90 day supply retail and home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | $70 copay per prescription (30 day supply retail) and $140 copay per prescription (90 day supply retail and home delivery) | $70 copay per prescription (30 day supply retail)<br>$140 copay per prescription (90 day supply retail and home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 20% coinsurance up to $150 per prescription (30 day supply retail and home delivery) | Not covered |

**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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

*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.*



Questions: (833) 772-4121 or visit us at www.anthem.com

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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

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**(TTY/TDD: 711)**

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