

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

PPO 2500 Plan

Effective January 1, 2010

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

BENEFIT DESCRIPTION	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Deductible • Coinsurance • Maximum Out-of-Pocket Expenses Per Calendar Year (Deductible + Coinsurance) • Lifetime Maximum 	\$2,500 Single / \$5,000 Family Plan pays 80% \$3,500 Single / \$7,000 Family \$5,000,000 Per Person ⁽¹⁾	\$5,000 Single / \$10,000 Family Plan pays 60% \$7,000 Single / \$14,000 Family \$5,000,000 Per Person ⁽¹⁾
Inpatient Services <ul style="list-style-type: none"> • Unlimited days of care in semi-private room • Physician services • Intensive care • Ancillary services, lab tests, x-rays, anesthesia, medications • Maternity care • Newborn care 	80% after In-Network deductible ⁽²⁾ 80% after In-Network deductible 80% after In-Network deductible 80% after In-Network deductible 80% after In-Network deductible 80% after In-Network deductible	60% after Out-of-Network deductible ⁽²⁾ 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
Outpatient Services <ul style="list-style-type: none"> • Any physician office visit, diagnosis and treatment • Lab & X-ray – Diagnostic • Lab & X-ray – Preventive • Advanced Imaging (e.g., MRI, CT, and PET scans) • Physical exams and Well-child care • Immunizations/Flu Shots • Covered surgical procedures • Maternity care • Gynecological exam • Physical, Speech or Occupational Therapy • Outpatient facility fees • Ambulance (medically necessary) 	100% after \$25 (PCP/Non-Specialist) copay or \$35 (Specialist) copay 80% after In-Network deductible 100% (no deductible) 80% after In-Network deductible ⁽²⁾ 100% after \$25 copay 100% after \$25 copay 80% after In-Network deductible ⁽²⁾ 80% after In-Network deductible 100% after \$35 copay 80% after In-Network deductible ⁽³⁾ 80% after In-Network deductible 80% after In-Network deductible	80% after \$25 (PCP/Non-Specialist) copay or \$35 (Specialist) copay 60% after Out-of-Network deductible 80% (no deductible) 60% after Out-of-Network deductible ⁽²⁾ 80% after \$25 copay 80% after \$25 copay 60% after Out-of-Network deductible ⁽²⁾ 60% after Out-of-Network deductible 80% after \$35 copay 60% after Out-of-Network deductible ⁽³⁾ 60% after Out-of-Network deductible 80% after Out-of-Network deductible
Emergency Room Services <ul style="list-style-type: none"> • Emergency/Urgent/Acute care • Non-emergency care 	100% after \$150 copay 100% after \$150 copay	100% after \$150 copay 100% after \$150 copay
Other Services <ul style="list-style-type: none"> • Home Health/Hospice care • Skilled nursing facility • Human tissue & organ transplants • Durable Medical Equipment • Oral surgery • Routine eye exams • Chiropractic care 	80% after In-Network deductible 80% after In-Network deductible – Limit 100 days per calendar year ⁽¹⁾⁽²⁾ 80% after In-Network deductible 80% (no deductible) Not covered Not covered 100% after \$35 copay ⁽⁵⁾	60% after Out-of-Network deductible 60% after Out-of-Network deductible – Limit 100 days per calendar year ⁽¹⁾⁽²⁾ 60% after Out-of-Network deductible 60% (no deductible) ⁽⁴⁾ Not covered Not covered 80% after \$35 copay ⁽⁵⁾
Prescription Drugs <ul style="list-style-type: none"> Up to 30-day supply copay (Tier 1 / Tier 2 / Tier 3) Up to 31-90 day supply copay (Tier 1 / Tier 2 / Tier 3) 	\$10 Tier 1 / \$30 Tier 2 / \$50 Tier 3 \$20 Tier 1 / \$60 Tier 2 / \$100 Tier 3	\$10 Tier 1 / \$30 Tier 2 / \$50 Tier 3 \$20 Tier 1 / \$60 Tier 2 / \$100 Tier 3
<i>Anthem Rx may exclude coverage for certain prescription drugs when better value, clinically-equivalent medications in the same therapeutic class are available. Please contact the Health Trust at 1-800-852-8300 or htservice@memun.org for information.</i>		
Mental Health Services / Substance Abuse Services All eligible inpatient and outpatient services ⁽⁶⁾	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays ⁽⁷⁾⁽⁸⁾	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays ⁽⁷⁾⁽⁸⁾

For specific information regarding provisions, please contact Health Trust Service Representatives at 1-800-852-8300 or htservice@memun.org

- (1) Combined In-Network and Out-of-Network Maximum.
- (2) Participant must contact Anthem Blue Cross and Blue Shield seven (7) days prior to any scheduled hospital or skilled nursing facility admission, or outpatient surgical procedure or advanced imaging procedure, and obtain certification. Failure to receive certification will result in the participant incurring a \$500 penalty. This \$500 penalty does not apply to the Out-of-Pocket Maximum.
- (3) Combined physical, speech, and occupational therapy benefits limited to \$5,000 per person per calendar year.
- (4) Limited to a maximum of \$5,000 per person, per calendar year (Out-of-Network only).
- (5) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).
- (6) Covered mental health and substance abuse conditions include psychotic disorders (including schizophrenia); dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders (autism); tic disorders; eating disorders (including bulimia and anorexia); and substance abuse-related disorders.
- (7) All services must be pre-authorized by Anthem Blue Cross and Blue Shield.
- (8) Participants must contact Anthem Blue Cross and Blue Shield prior to any scheduled hospital admission to obtain certification. Failure to obtain certification will result in the participant incurring a \$500 penalty. This \$500 penalty does not apply to the Out-of-Pocket Maximum.

Please Note: Payment made Out-Of-Network cannot be applied towards meeting the In-Network Deductible or Out-of-Pocket Maximum, and vice versa.