

**MAINE MUNICIPAL EMPLOYEES HEALTH TRUST**  
**PPO 2500 Plan**  
**Effective January 1, 2012**

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

**For specific information regarding provisions, please contact 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>• Maximum Out-of-Pocket Expenses Per Calendar Year (Deductible + Coinsurance)</li> <li>• Lifetime Maximum</li> </ul>	\$2,500 Single / \$5,000 Family Plan pays 80% \$3,500 Single / \$7,000 Family  Unlimited Per Person <sup>(1)</sup>	\$5,000 Single / \$10,000 Family Plan pays 60% \$7,000 Single / \$14,000 Family  Unlimited Per Person <sup>(1)</sup>
<b>Inpatient Services</b>		
<ul style="list-style-type: none"> <li>• Unlimited days of care in semi-private room</li> <li>• Physician services</li> <li>• Intensive care</li> <li>• Ancillary services, lab tests, x-rays, anesthesia, medications</li> <li>• Maternity care</li> <li>• Newborn care</li> </ul>	80% after In-Network deductible <sup>(2)</sup> 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 <sup>(2)</sup> 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
<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)</li> <li>• Physical exams and Well-child care</li> <li>• Immunizations/Flu Shots</li> <li>• Covered surgical procedures</li> <li>• Maternity care</li> <li>• Gynecological exam (Routine)</li> <li>• Physical, Speech or Occupational Therapy</li> <li>• Outpatient facility fees</li> <li>• Ambulance (Medically necessary)</li> </ul>	100% after \$25 copay (PCP/Non-Specialist) or \$35 copay (Specialist) 80% after In-Network deductible 100% (no deductible) 80% after In-Network deductible <sup>(2)</sup> 100% (no deductible) 100% (no deductible) 80% after In-Network deductible 80% after In-Network deductible 100% (no deductible) 80% after In-Network deductible <sup>(3)</sup> 80% after In-Network deductible 80% after In-Network deductible	80% after \$25 copay (PCP/Non-Specialist) or \$35 copay (Specialist) 60% after Out-of-Network deductible 80% (no deductible) 60% after Out-of-Network deductible <sup>(2)</sup> 80% (no deductible) 80% (no deductible) 60% after Out-of-Network deductible 60% after Out-of-Network deductible 80% (no deductible) 60% after Out-of-Network deductible <sup>(3)</sup> 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 / Urgent / Acute care</li> <li>• Non-emergency care</li> </ul>	100% after \$150 copay 100% after \$150 copay	100% after \$150 copay 100% after \$150 copay
<b>Other Services</b>		
<ul style="list-style-type: none"> <li>• Home Health / Hospice care</li> <li>• Skilled nursing facility</li> <li>• Human tissue &amp; organ transplants</li> <li>• Durable Medical Equipment</li> <li>• Oral surgery</li> <li>• Routine eye exams (adults and children over age 5)</li> <li>• Routine eye exams (children under age 5)</li> <li>• Chiropractic care</li> </ul>	80% after In-Network deductible 80% after In-Network deductible – Limit 100 days per calendar year <sup>(2)</sup> 80% after In-Network deductible 80% (no deductible) Not covered Not covered 100% (no deductible) 100% after \$35 copay <sup>(4)</sup>	60% after Out-of-Network deductible 60% after Out-of-Network deductible – Limit 100 days per calendar year <sup>(2)</sup> 60% after Out-of-Network deductible 60% (no deductible) Not covered Not covered 80% (no deductible) 80% after \$35 copay <sup>(4)</sup>
<b>Prescription Drugs</b>		
Up to <b>30-day</b> supply copay (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4) Up to <b>31-90 day</b> supply copay (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	<b>\$4</b> Tier 1-Select Generic / <b>\$10</b> Tier 1-Standard / <b>\$30</b> Tier 2/ <b>\$50</b> Tier 3/ <b>\$60</b> Tier 4 <b>\$8</b> Tier 1-Select Generic / <b>\$20</b> Tier 1-Standard / <b>\$60</b> Tier 2 / <b>\$100</b> Tier 3 / <b>\$120</b> Tier 4	<b>\$4</b> Tier 1-Select Generic / <b>\$10</b> Tier 1-Standard / <b>\$30</b> Tier 2/ <b>\$50</b> Tier 3/ <b>\$60</b> Tier 4 <b>\$8</b> Tier 1-Select Generic / <b>\$20</b> Tier 1-Standard / <b>\$60</b> Tier 2/ <b>\$100</b> Tier 3/ <b>\$120</b> Tier 4
<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 <a href="mailto:htservice@memun.org">htservice@memun.org</a> for information.</i>		
<b>Mental Health Services / Substance Abuse Services</b>		
All eligible inpatient and outpatient services <sup>(5)</sup>	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays <sup>(6)(7)</sup>	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays <sup>(7)</sup>

- (1) Formerly Combined In-Network and Out-of-Network Maximum of \$5,000,000 per person.
- (2) The Provider or Participant must contact Anthem Blue Cross and Blue Shield before any scheduled hospital or skilled nursing facility admission outpatient advanced imaging procedure to obtain certification. If certification is not obtained, a \$500 penalty may apply. This \$500 penalty does not apply to the Out-of-Pocket Maximum.
- (3) Combined physical, speech, and occupational therapy benefits limited to 75 visits per person per calendar year (combined In-Network and Out-of-Network).
- (4) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).
- (5) 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.
- (6) All services must be pre-authorized by Anthem Blue Cross and Blue Shield.
- (7) 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. If certification is not obtained for an inpatient admission, benefits will be paid at the Out-of-Network level and a \$500 penalty may apply. This \$500 penalty does not apply to the Out-of-Pocket Maximum.