

**MAINE MUNICIPAL EMPLOYEES HEALTH TRUST**  
**Comprehensive Point of Service Plan**  
**(POS C)**

**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)**

	<b>In-Network</b>	<b>Out-of-Network</b>
Please Note: In order to receive <b>In-Network</b> level of benefits under the Point of Service plan, all services (except emergency or urgent/acute care situations, as determined by prudent layperson) must be authorized in advance by the participant's Primary Care Physician. 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>		<b>All charges subject to Max. Allow.</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>	\$0 Plan pays 90% or 80% \$1,000 Single / \$2,000 Family Unlimited Per Person <sup>(1)</sup>	\$250 Single / \$500 Family Plan pays 70% \$2,250 Single / \$4,500 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>	90% <sup>(2)</sup> 100% 90% 90% 90% 90%	70% after deductible <sup>(2)</sup> 70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after 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>Lab &amp; X-ray – Routine (Mammograms, Pap Smear, PSA including screening and lab test, Colonoscopy)</li> <li>Colonoscopies (Diagnostic)</li> <li>Advanced Imaging Procedures (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 \$15 copay 100% 100% 100% 100% (Outpatient surgical facility fee copay may apply) 100% after \$100 copay <sup>(2),(3)</sup> 100% 100% 100% after \$100 copay <sup>(4)</sup> (Anesthesia covered at 90%) 100% <sup>(5)</sup> 100% <sup>(5)</sup> 100% after \$15 copay <sup>(6)</sup> 100%; \$100 copay for surgical facility 100%	70% after deductible 70% after deductible 100% (no deductible) 100% (no deductible) Not covered 70% after deductible <sup>(2)</sup> Not covered 100% (no deductible) 70% after deductible 70% after deductible 100% (no deductible) 70% after deductible <sup>(6)</sup> 70% after deductible 100%
<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 \$100 copay 100% after \$100 copay (with PCP referral)	100% after \$100 copay 100% after \$100 copay (with PCP referral)
<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 (Limited transportation and lodging benefits available)</li> <li>Durable Medical Equipment</li> <li>Oral surgery (Limited benefits)</li> <li>Routine eye exams</li> <li>Chiropractic care</li> </ul>	90% 90% – Limited to 100 days per calendar year <sup>(2)</sup> 90% 80% 90% 100% <sup>(5)</sup> 100% after \$15 copay <sup>(5),(7)</sup>	70% after deductible 70% after deductible – Limited to 100 days per calendar year <sup>(2)</sup> Not covered 70% (no deductible) 70% after deductible 100% (no deductible) 70% after deductible
<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) <b>31-90</b> day supply copay (Tier 1-Select Generic / Tier 1-Standard / Tier 2 / Tier 3 / 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 MMEHT at 1-800-852-8300 or <a href="mailto:htservice@memun.org">htservice@memun.org</a> for information.</i>	<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
<b>Mental Health Services / Substance Abuse Services</b>		
All eligible inpatient and outpatient services <sup>(8)</sup>	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays <sup>(9),(10)</sup>	Covered as any medical condition, not subject to any separate deductibles, coinsurance, or copays <sup>(10)</sup>

- Formerly Combined In-Network and Out-of-Network Maximum of \$5,000,000 per person..
- 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 for an inpatient admission, a \$500 penalty may apply. This \$500 penalty does not apply to the Out-of-Pocket Maximum.
- Advanced Imaging copays limited to \$300 per person per calendar year.
- Copay applies only when there is a facility charge billed.
- Participants may self-refer only to a participating provider.
- Combined physical, speech, and occupational therapy benefits limited to 75 visits per person per calendar year (combined In-Network and Out-of-Network).
- Acute chiropractic care may be self-referred to a participating chiropractor for up to 36 visits per calendar year.
- 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.
- 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. 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.