The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at 1-800-852-8300 or visit www.mmeht.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-852-8300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/individual or $400/family for in network providers; $300/individual or $600/family for out of network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary care, preventive care, specialist visits and certain prescription drugs. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,350 individual / $4,700 family for in network providers; $3,600 individual / $7,200 family for out-of-network providers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit. However, in network copayments will be capped at $4,150 individual / $8,300 family. This means that you will not have to pay more than $6,500 individual / $13,000 family for all covered services received in network (including copayments).
Will you pay less if you use a network provider?	Yes. See www.mmeht.org or call 1-800-852-8300 for a list of network providers. Costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No copayment for the first visit then $20 copayment/visit; deductible does not apply	$20 copayment/visit then 20% coinsurance	Virtual visits (telehealth) benefits available.
	Specialist visit	$30 copayment/visit; deductible does not apply	$30 copayment/visit then 20% coinsurance	Virtual visits (telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	20% coinsurance; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	The provider must contact Anthem Blue Cross and Blue Shield and obtain preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mmeht.org	Typically Lower Cost Generic drugs (Tier 1 Select Preventative)	$10 copayment/prescription each 30-day supply (retail) $20 copayment/prescription 90-day supply (mail order)		Prescription drugs are not subject to the overall deductible. Step therapy and preauthorization may apply to some drugs. Specialty drugs may have separate cost structures and means of delivery. Specialty drugs may only be filled at a specialty pharmacy in quantities up to a 30-day supply, regardless of the tier in which they fall. Certain exceptions may apply*. For specific information, contact www.mmeht.org.
	Typically Generic drugs (Tier 1 Standard)	$30 copayment/prescription each 30-day supply (retail) $60 copayment/prescription 90-day supply (mail order)		
	Typically Preferred Brand drugs & Non-Preferred Generic Drugs (Tier 2)	$50 copayment/prescription each 30-day supply (retail) $100 copayment/prescription 90-day supply (mail order)		
	Typically Non-Preferred Brand drugs (Tier 3)	$75 copayment/prescription each 30-day supply (retail) $150 copayment/prescription 90-day supply (mail order)		
	Specialty drugs (Tier 4)	$150 copayment/prescription each 30-day supply (specialty pharmacy) 90-day supply not available for specialty drugs)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

*For more information about limitations and exceptions, see the Health Trust Plan Document

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment/visit; deductible does not apply	$150 copayment/visit; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary
	Urgent care	$30 copayment/visit; deductible does not apply	$30 copayment/visit then 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be denied.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit - No copayment for the first office visit then $20 copayment/visit; deductible does not apply Other Outpatient – No charge	Office Visit - $20 copayment/visit then 20% coinsurance Other Outpatient – 20% coinsurance	Office Visit – Copayment waived for virtual visits (telehealth) with in network provider. Other Outpatient - The provider or participant must contact Anthem Blue Cross and Blue Shield's Mental Health Administrator for review of inpatient, partial hospitalization, and intensive outpatient non-emergency services, in order to receive the in network level of benefits. If preauthorization is not obtained, benefits may be denied.
	Inpatient services	20% coinsurance	40% coinsurance	The provider or participant must contact Anthem Blue Cross and Blue Shield's Mental Health Administrator for review of inpatient, partial hospitalization and intensive outpatient non-emergency services, in order to receive the in network level of benefits. If preauthorization is not obtained, benefits may be denied.
If you are pregnant	Office visits	$20 PCP/$30 Specialist copayment/visit; deductible does not apply	$20 PCP/$30 Specialist copayment/visit then 20% coinsurance	Cost sharing does not apply to preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

*For more information about limitations and exceptions, see the Health Trust Plan Document

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	If preauthorization is not obtained for an inpatient admission, benefits may be denied.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Plan covers paramedical supportive services; does not cover daily living assistance.
	Rehabilitation services	$30 copayment/visit; deductible does not apply	$30 copayment/visit then 20% coinsurance	Coverage is limited to 75 visits for in network and out of network physical, occupational and speech therapy combined per calendar year.
	Habilitation services	$30 copayment/visit; deductible does not apply	$30 copayment/visit then 20% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 100 days per calendar year combined in and out of network. If preauthorization is not obtained, benefits may be denied.
	Durable medical equipment	20% coinsurance; deductible does not apply	40% coinsurance; deductible does not apply	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance; deductible does not apply	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the Health Trust Plan Document

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)*

- Cosmetic Surgery
- Dental Care (Adult & Pediatric)
- Glasses for a child
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care (unless you have diabetes, vascular or systemic disease)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (with prior authorization)
- Chiropractic Care (up to 36 visits per calendar year)
- Hearing Aids (frequency and dollar limits apply)
- Routine eye care (Adult & Pediatric)
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Municipal Employees Health Trust, 1-800-852-8300 or www.mmeht.org, Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333, (800) 300-5000, the U.S. Department of Labor, Employee Benefits Security Administration, 1-866-444-3272 or www.dol/gov/ebsa/healthreform, or the U.S. Department of Health and Human Services,1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.coverME.gov or call 1-866-636-0355.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Maine Municipal Employees Health Trust, 60 Community Drive, Augusta, ME 04330-9486, www.mmeht.org
- Anthem BCBS ME; ATTN: Grievances and Appeals, P.O. Box 218, North Haven, CT 06473-0218
- Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform
- Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333, (800) 300-5000 www.maine.gov/pfr/insurance/
- Additionally, a consumer assistance program can help you file your appeal. Contact Consumers for Affordable Health Care, P.O. Box 2490,108 Sewall St. Suite 200, Augusta, ME 04330-2490, (800) 965-7476, www.mainecahc.org

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the Health Trust Plan Document

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$200**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$40
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$200**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$200**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.