MAINE MUNICIPAL EMPLOYEES HEALTH TRUST
PPO 2500 Plan
Effective January 1, 2023

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

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

	In-Network	Out-of-Network
Please Note: Services received Out-of-Network cannot be used to satisfy the In-Network Deductible or Out-of-Pocket Maximum. Similarly, services received In-Network cannot be used to satisfy the Out-of-Network Deductible or Out-of-Pocket Maximum.		
BENEFIT DESCRIPTION		**All charges subject to Max. Allow.**
• Deductible	$2,500 Single / $5,000 Family	$5,000 Single / $10,000 Family
• Coinsurance	Plan pays 80%	Plan pays 60%
• Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year (1)	$5,000 Single / $10,000 Family	$7,000 Single / $14,000 Family
• Lifetime Maximum	Unlimited	Unlimited
Inpatient Services		
• Unlimited days of care in semi-private room (2)(3)	80% after deductible	60% after deductible
• Physician services	80% after deductible	60% after deductible
• Intensive care	80% after deductible	60% after deductible
• Mental health services/Substance abuse services (4)	80% after deductible	60% after deductible
• Ancillary services, lab tests, x-rays, medications	80% after deductible	60% after deductible
• Anesthesia	80% after deductible	80% after deductible
• Maternity care	80% after deductible	60% after deductible
• Newborn care	80% after deductible	60% after deductible
Outpatient Services		
• Any physician office visit, diagnosis and treatment (PCP)	No copay for the first visit and then 100% after $25 copay per visit	80% after $25 copay
• Any physician office visit, diagnosis and treatment (Specialist)	100% after $40 copay	80% after $40 copay
• Lab & X-ray – Diagnostic	80% after deductible	60% after deductible
• Lab & X-ray – Preventive	100% (no deductible)	80% (no deductible)
• Advanced Imaging (e.g., MRI, CT, and PET scans) (3)	80% after deductible	60% after deductible
• Physical exams and Well-child care	100% (no deductible)	80% (no deductible)
• Immunizations/Flu Shots	100% (no deductible)	80% (no deductible)
• Covered surgical procedures	80% after deductible	60% after deductible
• Mental health services/Substance abuse services (4)	No copay for the first visit and then 100% after $25 copay per visit	80% after $25 copay
• Maternity care	100% after $25 copay (PCP) or $40 copay (Specialist)	80% after $25 copay (PCP) or $40 copay (Specialist)
• Gynecological exam – Preventive	100% (no deductible)	80% (no deductible)
• Physical, Speech or Occupational Therapy (5)	100% after $40 copay	80% after $40 copay
• Outpatient facility fees	80% after deductible	60% after deductible
• Ambulance (medically necessary)	80% after deductible	80% after deductible
Emergency Room Services		
• Emergency/Acute care	100% after $200 copay	100% after $200 copay
• Non-emergency care	100% after $200 copay	100% after $200 copay
Other Services		
• Walk-In or Urgent Care Center	100% after $40 copay (6)	80% after $40 copay
• Home Health/Hospice care	80% after deductible	60% after deductible
• Skilled nursing facility (3) (7)	80% after deductible	60% after deductible
• Human tissue & organ transplants	80% after deductible	60% after deductible
• Durable Medical Equipment	80% (no deductible)	60% (no deductible)
• Oral surgery (limited benefits)	80% after deductible	80% after deductible
• Eye exams – Preventive	100% (no deductible)	80% (no deductible)
• Chiropractic care (8)	100% after $40 copay	80% after $40 copay
Prescription Drugs		
Each **30-day** supply – Retail Pharmacy (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: $8 / $20 / $40 / $70 / $80	Copays: $8 / $20 / $40 / $70 / $80
90 day supply – Mail Order (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: $16 / $40 / $80 / $140 / $160	Copays: $16 / $40 / $80 / $140 / $160
Specialty medications may only be filled through specialty pharmacies and in quantities up to a 30 day supply. Some specialty medications may be subject to partial fills for new prescriptions. Please contact the Health Trust with any questions.		

(1) In-Network copays will be capped at $2,500 single / $5,000 family. This means that you will not have to pay more than $7,500 single / $15,000 family for all covered services received In-Network (including deductible, coinsurance, and copays).
(2) Private rooms covered when medically necessary.
(3) 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, benefits may be denied.
(4) 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.
(5) Combined physical, speech, and occupational therapy benefits (including those billed by a chiropractor or a D.O.) limited to 75 visits per person per calendar year (combined In-Network and Out-of-Network).
(6) For a current list of In-Network Walk-In and Urgent Care Centers, please call the Health Trust at 1-800-852-8300, or refer to the Health Trust website at www.mmeht.org.
(7) Skilled nursing facility services limited to 100 days per calendar year (combined In-Network and Out-of-Network).
(8) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).