

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

PPO 500 Plan

Effective January 1, 2021

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.
<ul style="list-style-type: none"> • Deductible • Coinsurance • Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year ⁽¹⁾ • Lifetime Maximum 	\$500 Single / \$1,000 Family Plan pays 80% \$2,000 Single / \$4,000 Family Unlimited	\$1,000 Single / \$2,000 Family Plan pays 60% \$3,000 Single / \$6,000 Family Unlimited
Inpatient Services		
<ul style="list-style-type: none"> • Unlimited days of care in semi-private room ⁽²⁾⁽³⁾ • Physician services • Intensive care • Mental health services/Substance abuse services ⁽⁴⁾ • Ancillary services, lab tests, x-rays, medications • Anesthesia • Maternity care • Newborn care 	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible 80% after deductible 60% after deductible 60% after 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) ⁽³⁾ • Physical exams and Well-child care • Immunizations/Flu Shots • Covered surgical procedures • Mental health services/Substance abuse services ⁽⁴⁾ • Maternity care • Gynecological exam – Preventive • Physical, Speech or Occupational Therapy ⁽⁵⁾ • Outpatient facility fees • Ambulance (medically necessary) 	100% after \$20 copay (PCP) or \$35 copay (Specialist) 80% after deductible 100% (no deductible) 80% after deductible 100% (no deductible) 100% (no deductible) 80% after deductible 100% after \$20 copay 100% after \$20 copay (PCP) or \$35 copay (Specialist) 100% no deductible 100% after \$35 copay 80% after deductible 80% after deductible	80% after \$20 copay (PCP) or \$35 copay (Specialist) 60% after deductible 80% (no deductible) 60% after deductible 80% (no deductible) 80% (no deductible) 60% after deductible 80% after \$20 copay 80% after \$20 copay (PCP) or \$35 copay (Specialist) 80% no deductible 80% after \$35 copay 60% after deductible 80% after deductible
Emergency Room Services		
<ul style="list-style-type: none"> • Emergency/Acute care • Non-emergency care 	100% after \$200 copay 100% after \$200 copay	100% after \$200 copay 100% after \$200 copay
Other Services		
<ul style="list-style-type: none"> • Walk-In or Urgent Care Center • Home Health/Hospice care • Skilled nursing facility ⁽³⁾⁽⁷⁾ • Human tissue & organ transplants • Durable Medical Equipment • Oral surgery (limited benefits) • Eye exams – Preventive • Chiropractic care ⁽⁸⁾ 	100% after \$35 copay ⁽⁶⁾ 80% after deductible 80% after deductible 80% after deductible 80% (no deductible) 80% after deductible 100% (no deductible) 100% after \$35 copay	80% after \$35 copay 60% after deductible 60% after deductible 60% after deductible 60% (no deductible) 80% after deductible 80% (no deductible) 80% after \$35 copay
Prescription Drugs		
Each 30-day supply – Retail Pharmacy (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$8 / \$15 / \$35 / \$60 / \$80	Copays: \$8 / \$15 / \$35 / \$60 / \$80
90 day supply – Mail Order (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$16 / \$30 / \$70 / \$120 / \$160	Copays: \$16 / \$30 / \$70 / \$120 / \$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 \$5,500 single / \$11,000 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 or 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).