

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

Traditional Point of Service Plan (POS A)

Effective January 1, 2022

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: In order to receive In-Network level of benefits under the Point of Service plan, all services (except emergency or urgent/acute care situations) must be authorized in advance by the participant's Primary Care Physician. Services received Out-of-Network cannot be used to satisfy the In-Network 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 	\$0 Plan pays 90% or 80% \$1,000 Single / \$2,000 Family Unlimited	\$250 Single / \$500 Family Plan pays 80% \$2,250 Single / \$4,500 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 	90% 100% 90% 90% 90% 90% 90% 90%	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 90% 80% after deductible 80% 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 • Colonoscopies (Diagnostic) • Advanced Imaging Procedures (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 ⁽⁸⁾ • Outpatient facility fees • Ambulance (medically necessary) 	100% after \$10 copay (PCP) or \$20 copay (Specialist) 100% 100% 100% 100% after \$100 copay ⁽⁵⁾ 100% 100% 100% after \$100 copay ⁽⁶⁾ 100% after \$10 copay 100% ⁽⁷⁾ 100% ⁽⁷⁾ 100% after \$20 copay 100%; \$100 copay for surgical facility 100%	80% after deductible 80% after deductible 100% (no deductible) Not covered 80% after deductible Not covered 100% (no deductible) 80% after deductible 80% after deductible 80% after deductible 100% (no deductible) 80% after deductible 80% after deductible 100%
Emergency Room Services		
<ul style="list-style-type: none"> • Emergency/Acute care • Non-emergency care 	100% after \$150 copay 100% after \$150 copay	100% after \$150 copay 100% after \$150 copay
Other Services		
<ul style="list-style-type: none"> • Walk-In or Urgent Care Center • Home Health/Hospice care • Skilled nursing facility ^{(3),(10)} • Human tissue & organ transplants • Durable Medical Equipment • Oral surgery (limited benefits) • Eye exams - Preventive • Chiropractic care 	100% after \$20 copay ⁽⁹⁾ 100% 100% 90% 80% 100% 100% ⁽⁷⁾ 100% after \$20 copay ^{(7),(11)}	80% after deductible 80% after deductible 80% after deductible Not covered 70% (no deductible) 100% 100% (no deductible) 80% after deductible
Prescription Drugs		
Each 30-day supply – Retail Pharmacy (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$4 / \$10 / \$30/ \$50/ \$60	Copays: \$4 / \$10 / \$30/ \$50/ \$60
90 day supply – Mail Order (Tier 1-Select Generic/ Tier 1-Standard/ Tier 2/ Tier 3/ Tier 4)	Copays: \$8 / \$20 / \$60 / \$100 / \$120	Copays: \$8 / \$20 / \$60 / \$100 / \$120
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 \$6,500 single / \$13,000 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 and 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) Advanced Imaging copays limited to \$300 per person per calendar year.
- (6) Copay applies only when there is a facility charge billed.
- (7) Participants may self-refer to a participating provider.
- (8) 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).
- (9) 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.
- (10) Skilled nursing facility services limited to 100 days per calendar year (combined In-Network and Out-of-Network).
- (11) Acute chiropractic care may be self-referred to a participating chiropractor for up to 36 visits per calendar year.