Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Maine Education Association Benefits Trust (MEABT): CHOICE PLUS

Your Network: HMO Maine

Covered Medical Benefits	Cost if you use a PCP Referred Level	Cost if you use a Self-referred Benefit Level
Overall Deductible	$200 person / $400 family	$250 person / $500 family
Overall Out-of-Pocket Limit Coinsurance maximum $1,000/$2,000. Copay maximum $7,900/$15,800	$9,100 person / $18,200 family	$10,400 person / $20,800 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are required to select a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services. When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for PCP visits, x-rays, lab services and Urgent Care when provided by the Value-Based Provider. No member cost share is required for the first primary care visit of the plan year.*		
LiveHealth Online *via www.livehealthonline.com: Office visit copayments are waived for care through LiveHealth Online.*		
Primary Care (PCP) *virtual and office*	$15 copay per visit deductible does not apply	35% coinsurance after deductible is met
Mental Health and Substance Abuse Care *virtual and office*	No charge	35% coinsurance after deductible is met (out of network)
Specialist Care *virtual and office*	$25 copay per visit deductible does not apply	35% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a PCP Referred Level	Cost if you use a Self-referred Benefit Level
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$15 copay per visit deductible does not apply	35% coinsurance after deductible is met
Manipulation Therapy *No referral required for up to 36 visits per calendar year to a network chiropractor. Subject to a 40 visit per calendar year limit.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Acupuncture	15% coinsurance after deductible is met	15% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Surgery	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services		
Lab		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Preferred Reference Lab	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
X-Ray		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Radiology Center	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a PCP Referred Level	Cost if you use a Self-referred Benefit Level
Freestanding Radiology Center	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.* *When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for Urgent Care when provided by the Value-Based Provider.*	$15 copay per visit deductible does not apply	35% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	15% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	15% coinsurance deductible does not apply	35% coinsurance after deductible is met (out of network)
Doctor Services	15% coinsurance deductible does not apply	35% coinsurance after deductible is met (out of network)
Outpatient Surgery		
Facility Fees		
Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Ambulatory Surgical Center	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and Other Services		
Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Ambulatory Surgical Center	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a PCP Referred Level	Cost if you use a Self-referred Benefit Level
Physician and other services *including surgeon fees*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Home Health Care	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.*		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per year.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Inpatient Hospice	No charge	35% coinsurance after deductible is met
Durable Medical Equipment	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prosthetic Devices	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hearing Aids *Coverage for members through age 18 is limited to 1 hearing aid per hearing-impaired ear every 36 months. Coverage for members age 19 and over is limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (2 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx became CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1a - Typically Lower Cost Generic	$10 copay per prescription (30 day supply retail) and $20 copay per prescription (90 day supply retail and home delivery)	$10 copay per prescription (30 day supply retail) $20 copay per prescription (90 day supply retail and home delivery)
Tier 1b - Typically Generic	$15 copay per prescription (30 day supply retail) and $30 copay per prescription (90 day supply retail and home delivery)	$15 copay per prescription (30 day supply retail) $30 copay per prescription (90 day supply retail and home delivery)
Tier 2 – Typically Preferred Brand	$35 copay per prescription (30 day supply retail) and $70 copay per prescription (90 day supply retail and home delivery)	$35 copay per prescription (30 day supply retail) $70 copay per prescription (90 day supply retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription (30 day supply retail) and $120	$60 copay per prescription (30 day supply retail)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	copay per prescription (90 day supply retail and home delivery)	$120 copay per prescription (90 day supply retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	$85 copay per prescription (retail and home delivery)	Not covered out of network

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 772-4121

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

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Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 772-4121。

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 772-4121.

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