Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Maine Education Association Benefits Trust (MEABT): STANDARD PLAN $200

Your Network: National PPO (BlueCard PPO)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$200 person / $400 family	$200 person / $400 family
Overall Out-of-Pocket Limit *Coinsurance maximum $1,000/$2,000. Copay maximum $7,900/$15,800*	$9,100 person / $18,200 family	$9,100 person / $18,200 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). The In-Network and Non-Network deductibles and out-of-pocket are combined and accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP). 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	20% coinsurance deductible does not apply
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 an In-Network Provider	Cost if you use a Non-Network Provider
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 *Coverage is limited to 40 visits per year.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per year.*	15% coinsurance after deductible is met	35% 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	20% coinsurance deductible does not apply
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance deductible does not apply
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
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
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 deductible does not apply
Doctor Services	15% coinsurance deductible does not apply	35% coinsurance deductible does not apply
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
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.* *Coverage for physical, occupational and speech therapies is limited to 60 visits combined per year.*		
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	20% coinsurance deductible does not apply
Durable Medical Equipment	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	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 medical copayment limit	Combined with medical copayment 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)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 copay per prescription (90 day supply retail and home delivery)	$60 copay per prescription (30 day supply retail) $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.

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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

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(TTY/TDD: 711)

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