Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Maine Education Association Benefits Trust (MEABT): STANDARD $500 PLAN

Your Network: National PPO (BlueCard PPO)

Effective July 1, 2024

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,000 family	$500 person / $1,000 family
Overall Out-of-Pocket Limit	$9,450 person / $18,900 family	$9,450 person / $18,900 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. All medical and prescription drug deductibles, copayments and coinsurance apply to the 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.*		
Primary Care (PCP) *virtual and office*	$25 copay per visit deductible does not apply	45% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	20% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care *virtual and office*	$35 copay per visit deductible does not apply	45% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit deductible does not apply	45% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 40 visits per year.*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per year.*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Surgery	25% coinsurance after deductible is met	45% 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	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Preferred Reference Lab	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	45% coinsurance after deductible is met
X-Ray		
Office	25% coinsurance after deductible is met	45% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	45% 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.*	$25 copay per visit deductible does not apply	45% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$300 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	25% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	25% coinsurance deductible does not apply	45% coinsurance deductible does not apply
Doctor Services	25% coinsurance deductible does not apply	45% coinsurance deductible does not apply
Outpatient Surgery		
Facility Fees		
Hospital	25% coinsurance after deductible is met	45% 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	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Ambulatory Surgical Center	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Physician and other services *including surgeon fees*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Home Health Care	25% coinsurance after deductible is met	45% 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	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	25% coinsurance after deductible is met	45% 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.*	25% coinsurance after deductible is met	45% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Inpatient Hospice	No charge	20% coinsurance deductible does not apply
Durable Medical Equipment	25% coinsurance after deductible is met	45% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	25% coinsurance after deductible is met	45% 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.*	25% coinsurance after deductible is met	45% 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 Non-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 Pharmacy. 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)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 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 (30 day supply 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to ME Bureau of Insurance (ME BOI) approval and are subject to change.

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.

Questions: (833) 772-4121 or visit us at www.anthem.com

Your summary of benefits

Anthem

Your Plan: Maine Education Association Benefits Trust (MEABT): STANDARD $500 PLAN
Your Network: National PPO (BlueCard PPO)

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable) Jennifer Kent	Date
Underwriting signature (if applicable)	Date

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)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 772-4121.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 772-4121:

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。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 772-4121 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 772-4121.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 772-4121.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 772-4121.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 772-4121 にお電話ください。

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

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 772-4121.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 772-4121.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.