# State of Maine Health Plan Benefit Summary -- Effective July 1, 2018

| Benefit | Benefit Level | |
|---|---|---|
| | **In Network Level** | **Out of Network Level** |
| **IMPORTANT INFORMATION** | To receive benefits at the Network level, the services must be provided by an Anthem participating PPO provider.<br><br>Benefits are based on a maximum allowance for covered services. The maximum allowance is the most that will be paid for a particular service.<br><br>You are responsible for any copayments, deductibles and coinsurance that may apply.<br><br>Services (for example, diagnostic and surgical services) received during or associated with an office visit or services ordered or rendered by a professional or provider may be subject to the applicable coinsurance and deductible (in addition to the copayment). Ask your professional or provider whether the services you have received are included in the copayment amount. | Benefits are based on a maximum allowance for covered services. The maximum allowance is the most that will be paid for a particular service.<br><br>Coverage described in this column applies when you use an out of network provider.<br><br>You may be responsible for filing claims and paying balance bills in addition to the copayments, deductible, and coinsurance. You may also need to pay the provider or professional up front. |
| **INPATIENT ADMISSION REVIEW**<br><br>**Note: Your participating provider calls 1-800-392-1016** | All inpatient admissions, with the exception of emergency and maternity admissions, require pre-admission review. You, your physician or the provider must call the telephone number on your ID card for review before you are admitted.<br><br>All Inpatient admissions for emergency and maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your physician, or the provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your physician, or the provider should call if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. | |

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| **CALENDAR YEAR DEDUCTIBLE**<br>*Cross accumulates in and out of network* | $600 individual/$1,200 family<br>The family deductible amount must be satisfied by at least two family members. | | $3,000 individual/$6,000 family<br>The family deductible amount must be satisfied by at least two family members. |
| **COINSURANCE **** | 90% unless otherwise noted | | 60% unless otherwise noted |
| **CALENDAR YEAR OUT-OF-POCKET LIMIT**<br>*(Includes medical deductible, coinsurance and copayments)*<br><br>****** out of network *coinsurance does not cross accumulate.* | $2,000 individual/$4,000 family | | $5,000 individual/$10,000 family |
| **LIFETIME MAXIMUM** | Unlimited | | Unlimited |
| **HOSPITAL SERVICES**<br>*(Services billed by a hospital)*<br>**Inpatient**<br>General medical & surgical care<br>Maternity room & board & other | 90% after deductible<br>90% after deductible | | 60% after deductible<br>60% after deductible |
| **Outpatient**<br>• Surgery | 90% after deductible | | 60% after deductible |
| • Laboratory tests and x-ray imaging services; other outpatient services | 100% (Freestanding Labs) | 90% after deductible | 60% after deductible |
| • High tech diagnostics (SPECT, nuclear cardiology, MRI, CT Scan, PET Scan) | 100% (Freestanding Imaging Centers) | 90% after deductible | 60% after deductible |
| • Colonoscopies (Screening & Medically Necessary) | 100% - no deductible | | 60% after deductible |

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| **BARIATRIC SURGERY**<br><br>**SPINE SURGERY**<br><br>**KNEE & HIP REPLACEMENT SURGERY**<br><br>**Hospital Inpatient/Outpatient Services (billed by the facility)** | 90% after deductible | | 60% after deductible |
| **AMBULANCE SERVICES** | 90% after deductible | | |
| **EMERGENCY ROOM & URGENT CARE** | In an emergency, seek care immediately. Emergency room visit is covered at 100% after you pay a $300 copayment.<br><br>If you are admitted to the hospital as inpatient status from the emergency room, the emergency room copayment is waived and the applicable cost shares will be applied. | | |
| **WALK-IN CENTER** | 100% after $25 copay for participating Walk-in Centers in Maine. Updates are provided on your Employee Health and Benefits website at http://www.maine.gov/deh/ and by calling Member Services at the number on your ID card.<br><br>*Services (for example, diagnostic and surgical services) received during or associated with an office visit or services ordered or rendered by a professional or provider may be subject to the applicable coinsurance and deductible (in addition to the copayment).* | | 60% after deductible for non-participating walk-in centers. |
| **AMBULATORY SURGERY FACILITY** | 95% after deductible<br>*(Designated ambulatory surgery center or facility)* | 90% after deductible | 60% after deductible |
| **TRANSPLANT SURGERY**<br>*(Inpatient facility surgery charges)* | 90% after deductible | | 60% after deductible |

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| | In Network Level | Out of Network Level |
| **PROFESSIONAL / PHYSICIAN SERVICES -** | | |
| **Preventive Care** | | |
| Routine Physical Exam | 100% -- no deductible | 60% after deductible |
| Well Woman Gynecological Exam | 100% -- no deductible | 60% after deductible |
| Mammogram *(screening & medically necessary)* | 100% -- no deductible | 100% -- no deductible |
| Immunizations | 100% -- no deductible | 60% after deductible |
| Lab/Pathology | 100% -- no deductible | 60% after deductible |
| Screening x-rays/tests | 100% -- no deductible | 60% after deductible |
| PSA Tests | 100% -- no deductible | 60% after deductible |
| Pap Tests | 100% -- no deductible | 60% after deductible |
| Digital Rectal Exam | 100% -- no deductible | 60% after deductible |
| Colonoscopy *(screening & medically necessary)* | 100% -- no deductible | 60% after deductible |
| **Screening & Counseling Services** | | |
| Lung Cancer Screening *(age 55+)* | 100% -- no deductible | 60% after deductible |
| Obesity: Screening & Counseling | 100% -- no deductible | 60% after deductible |
| Tobacco Use | 100% -- no deductible | 60% after deductible |
| Alcohol Misuse | 100% -- no deductible | 60% after deductible |
| Sexually Transmitted Infections | 100% -- no deductible | 60% after deductible |
| Nutritional Counseling | 100% -- no deductible | 60% after deductible |
| **Women's Preventive Care** | | |
| Contraceptive counseling – sterilization procedures and patient education/counseling for women. | 100% -- no deductible | 60% after deductible |
| Breastfeeding support and counseling | 100% -- no deductible | 60% after deductible |
| Breastfeeding supplies (breast pumps must be obtained in-network for 100% coverage) | 100% -- no deductible | 60% after deductible |

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| **PROFESSIONAL / PHYSICIAN SERVICES (Continued) -** | | |
| **Office Visits *** | 100% after $20 PCP copay or 100% after $40 specialist copay | 60% after deductible |
| **Maternity** | | |
| Pre/Postnatal Care /Delivery | 90% after deductible | 60% after deductible |
| **Inpatient Visits, Surgeries, and Other Professional Services** | 90% after deductible | 60% after deductible |
| **Diagnostic Lab & X-rays** | 90% after deductible | 60% after deductible |
| **ANESTHESIA SERVICES** | 90% after deductible | 60% after deductible |
| **ALLERGY TESTING & TREATMENT** | 90% after deductible | 60% after deductible |
| **ALLERGY INJECTIONS** | 90% after deductible | 60% after deductible |
| **SPINAL MANIPULATION** *(Limited to 25 visits per member per calendar year)* | 100% after $20 PCP copay or 100% after $40 specialist copay | 60% after deductible |
| **PHYSICAL, SPEECH & OCCUPATIONAL THERAPY** | 100% after $40 specialist copay | 60% after deductible |

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| **ROUTINE EYE EXAM**<br>*(One routine eye exam per calendar year)* | 100% -- no deductible | 60% after deductible |
| **HEARING EXAM** | 100% after $40 specialist copay | 60% after deductible |
| **HEARING AIDS**<br>*(Limited to one hearing aid for each hearing-impaired ear every 36 months through age 18.)* | 100% after deductible | 60% after deductible |
| **ACUPUNCTURE** | 100% after $40 specialist copay | |
| **CARDIAC REHABILITATION**<br>*(Limited to 36 visits per episode)*<br>Office | 100% after $20 PCP copay or 100% after $40 specialist copay | 60% after deductible |
| Outpatient Hospital | 90% after deductible | 60% after deductible |
| **CHEMOTHERAPY/RADIATION THERAPY** | 90% after deductible | 60% after deductible |
| **DURABLE MEDICAL EQUIPMENT** | 90% after deductible | 60% after deductible |
| **PROSTHETICS DEVICES** | 90% after deductible | 60% after deductible |
| Prosthetics for Limb Replacement | 90% -- no deductible | 80% -- no deductible |

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| **INFERTILITY TREATMENT SERVICES** *(Up to $10,000 lifetime limit)* | 80% after deductible | Not Covered |
| **TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) SERVICES *** | 90% after deductible | 60% after deductible |
| **SKILLED NURSING FACILITY** *(Limit: 150 days in a calendar year)* | 90% after deductible | 60% after deductible |
| **HOME HEALTH CARE** | 90% after deductible | 60% after deductible |
| **HOSPICE** | 90% after deductible | 60% after deductible |

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| | In Network Level | Out of Network Level |
| Important Information on Receiving Mental Health and Substance Abuse Benefits | Certain Mental health and substance abuse services require prior authorization. All Inpatient services as well as partial hospitalization and intensive outpatient services require prior authorization. You or someone you designate must call Anthem Behavioral Health at 1-800-755-0851 for preauthorization.<br><br>For emergency admissions, you or someone you designate should call within 48 hours of admission. | |
| **MENTAL HEALTH and SUBSTANCE ABUSE SERVICES** | | |
| Inpatient | 90% after deductible | 60% after deductible |
| Outpatient | 90% after deductible | 60% after deductible |
| Office Visits | 100% after $20 copay | 60% after deductible |

Office visit copayments apply to the office visit charge only. All other covered services rendered during the office visit are subject to the applicable deductible and coinsurance percentage.

**This Benefit Summary 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 Benefit Book. If there is a difference between this summary and the Benefit Book, the Benefit Book will prevail.**