MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

Traditional Point of Service Plan (POS A)

Effective January 1, 2024

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.**
• Deductible	$0	$250 Single / $500 Family
• Coinsurance	Plan pays 90% or 80%	Plan pays 80%
• Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year (1)	$1,000 Single / $2,000 Family	$2,250 Single / $4,500 Family
• Lifetime Maximum	Unlimited	Unlimited
Inpatient Services		
• Unlimited days of care in semi-private room (2)(3)	90%	80% after deductible
• Physician services	100%	80% after deductible
• Intensive care	90%	80% after deductible
• Mental health services/Substance abuse services (4)	90%	80% after deductible
• Ancillary services, lab tests, x-rays, medications	90%	80% after deductible
• Anesthesia	90%	90%
• Maternity care	90%	80% after deductible
• Newborn care	90%	80% after deductible
Outpatient Services		
• Any physician office visit, diagnosis and treatment (PCP)	No copay for the first visit and then 100% after $10 copay per visit	80% after deductible
• Any physician office visit, diagnosis and treatment (Specialist)	100% after $20 copay	80% after deductible
• Lab & X-ray – Diagnostic	100%	80% after deductible
• Lab & X-ray – Preventive	100%	100% (no deductible)
• Colonoscopies (Diagnostic)	100% *(Outpatient surgical facility fee may apply)*	Not covered
• Advanced Imaging Procedures (e.g., MRI, CT, and PET scans) (3)	100% after $100 copay (5)	80% after deductible
• Physical exams and Well-child care	100%	Not covered
• Immunizations/Flu Shots	100%	100% (no deductible)
• Covered surgical procedures	100% after $100 copay (6)	80% after deductible
• Mental health services/Substance abuse services (4)	No copay for the first visit and then 100% after $10 copay per visit	80% after deductible
• Maternity care	100% (7)	80% after deductible
• Gynecological exam - Preventive	100% (7)	100% (no deductible)
• Physical, Speech or Occupational Therapy (8)	100% after $20 copay	80% after deductible
• Outpatient facility fees	100%; $100 copay for surgical facility	80% after deductible
• Ambulance (medically necessary)	100%	100%
Emergency Room Services		
• Emergency/Acute care	100% after $150 copay	100% after $150 copay
• Non-emergency care	100% after $150 copay	100% after $150 copay
Other Services		
• Walk-In or Urgent Care Center	100% after $20 copay (9)	80% after deductible
• Home Health/Hospice care	100%	80% after deductible
• Skilled nursing facility (3)(10)	100%	80% after deductible
• Human tissue & organ transplants	90%	Not covered
• Durable Medical Equipment	80%	70% (no deductible)
• Oral surgery (limited benefits)	100%	100%
• Eye exams - Preventive	100% (7)	100% (no deductible)
• Chiropractic care	100% after $20 copay (7)(11)	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) The provider must contact Anthem Blue Cross and Blue Shield's Mental Health Administrator for review of inpatient, partial hospitalization, and intensive outpatient non-emergency services, in order to receive the In-Network level of benefits. If certification is not obtained, benefits may be denied.
(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.