



**State of Maine Health Plan Benefit Summary -- Effective July 1, 2021**

Benefit	Benefit Level	
	In Network Level	Out of Network Level
<p><b>IMPORTANT INFORMATION</b></p>	<p>To receive benefits at the Network level, the services must be provided by an Anthem participating PPO provider.</p> <p>Benefits are based on a maximum allowance for covered services. The maximum allowance is the most that will be paid for a particular service.</p> <p>You are responsible for any copayments, deductibles and coinsurance that may apply.</p> <p>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.</p>	<p>Coverage described in this column applies when you use an out of network provider.</p> <p>Benefits are based on a maximum allowance for covered services. The maximum allowance is the most that will be paid for a particular service.</p> <p>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.</p>
<p><b>INPATIENT ADMISSION REVIEW</b></p> <p><b>Note: Your participating provider calls 1-800-392-1016</b></p>	<p>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.</p> <p>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.</p> <p>Failure to call for inpatient admission review could result in you paying unexpected charges.</p>	

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<b>CALENDAR YEAR DEDUCTIBLE</b> <i>Cross accumulates in and out of network</i>	\$600 individual/\$1,200 family Family deductible amount must be satisfied by at least two family members.	\$3,000 individual/\$6,000 family Family deductible amount must be satisfied by at least two family members.
<b>COINSURANCE **</b>	90% unless otherwise noted	60% unless otherwise noted
<b>CALENDAR YEAR OUT-OF-POCKET LIMIT</b> <i>(Includes medical deductible, coinsurance and copayments)</i> ** out of network coinsurance does not cross accumulate. (i.e. each is separate)	\$2,000 individual/\$4,000 family	\$5,000 individual/\$10,000 family
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>HOSPITAL SERVICES</b> <i>(Services billed by a hospital)</i> <b>Inpatient</b> General medical & surgical care Maternity room & board & other  <b>Outpatient</b> <ul style="list-style-type: none"> <li>• Surgery</li> <li>• Laboratory tests and x-ray imaging services; other outpatient services.</li> <li>• High tech diagnostics (SPECT, nuclear cardiology, MRI, CT Scan, PET Scan)</li> <li>• Colonoscopies (Screening &amp; Medically Necessary)</li> </ul>	90% after deductible 90% after deductible	60% after deductible 60% after deductible
	90% after deductible	60% after deductible
	100% (Independent Labs)                      90% after deductible <i>Note: Not all providers perform the same services</i>	60% after deductible
	100% (Independent Imaging Centers) <i>Note: Not all providers perform the same services</i>	60% after deductible
	100% - no deductible	60% after deductible

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<b>BARIATRIC, CARDIAC, JOINT REPLACEMENT AND SPINE SURGERIES</b>	100% - no deductible (Coordinated through the Carrum Health Surgery benefit. Call 1-888-855-7806 or visit <a href="http://my.carrumhealth.com/StateOfMaine">my.carrumhealth.com/StateOfMaine</a> for more information.)	90% after deductible	60% after deductible
<b>AMBULANCE SERVICES</b>	90% after deductible		
<b>EMERGENCY ROOM &amp; URGENT CARE</b>	In an emergency, seek care immediately. Emergency room visit is covered at 100% after you pay a \$300 copayment. 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.		
<b>WALK-IN CENTER</b>	100% after \$25 copay for participating Walk-in Centers in Maine. Updates are provided on your Employee Health and Wellness website at <a href="http://www.maine.gov/bhr/oeht">http://www.maine.gov/bhr/oeht</a> and by calling Member Services at the number on your ID card.  <i>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).</i>		60% after deductible for non-participating walk-in centers.
<b>AMBULATORY SURGERY FACILITY</b>	95% after deductible (Designated ambulatory surgery center or facility)	90% after deductible	60% after deductible

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	Preferred Providers	In-Network Providers	Out-of-Network Providers
<b>SPECIALITY PHARMACY - SITE OF CARE REDIRECTION PROGRAM</b> <i>(Infusion/Injection Therapy)</i>	100% Benefit – no cost shares <ul style="list-style-type: none"> <li>• <i>Ambulatory Infusion Suites</i></li> <li>• <i>Home Infusion Therapy</i></li> <li>• <i>Physicians Offices</i></li> <li>• <i>Select Hospitals – Outpatient Setting</i> <ul style="list-style-type: none"> <li>○ <i>Northern Light</i></li> <li>○ <i>Mid Coast Hospital</i></li> <li>○ <i>St. Mary's Regional Medical Center</i></li> <li>○ <i>St. Joseph Hospital</i></li> <li>○ <i>Central Maine Medical Center</i></li> </ul> </li> </ul>	60% after in-network deductible Outpatient hospital settings	60% after out of network deductible
<b>TRANSPLANT SURGERY</b> <i>(Inpatient facility surgery charges)</i>	90% after deductible		60% after deductible

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<b>PROFESSIONAL / PHYSICIAN SERVICES -</b>		
<b><u>Preventive Care</u></b>		
Routine Physical Exam	100% -- no deductible	60% after deductible
Immunizations	100% -- no deductible	60% after deductible
Lab/Pathology	100% -- no deductible	60% after deductible
Digital Rectal Exam	100% -- no deductible	60% after deductible
Colonoscopy ( <i>screening &amp; medically necessary</i> )	100% -- no deductible	60% after deductible
<b><u>Screening &amp; Counseling Services</u></b>		
Lung Cancer Screening ( <i>age 55+</i> )	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
<b><u>Men's Preventative Care</u></b>		
PSA Tests	100% -- no deductible	60% after deductible
<b><u>Women's Preventive Care</u></b>		
Well Woman Gynecological Exam	100% -- no deductible	60% after deductible
Mammogram ( <i>screening &amp; medically necessary</i> )	100% -- no deductible	100% -- no deductible
Pap Tests	100% -- no deductible	60% after deductible
Contraceptive counseling – <i>sterilization procedures and patient education/counseling for women.</i>	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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<b>PROFESSIONAL / PHYSICIAN SERVICES (Continued) -</b>  <u>Office Visits *</u>  <u>LiveHealth Online</u>  <u>Maternity</u> Pre/Postnatal Care /Delivery  <u>Inpatient Visits, Surgeries, and Other Professional Services</u>  <u>Diagnostic Lab &amp; X-rays</u>	100% after \$20 PCP copay or 100% after \$40 specialist copay No member cost share is required for the first primary care office visit during the calendar year. A copay is applied to the second and third primary care office visits during the calendar year and accumulate toward the calendar year deductible.  100% - no deductible  90% after deductible  90% after deductible  90% after deductible	60% after deductible  NA  60% after deductible  60% after deductible  60% after deductible
<b>ANESTHESIA SERVICES</b>	90% after deductible	60% after deductible
<b>ALLERGY TESTING &amp; TREATMENT</b>	90% after deductible	60% after deductible
<b>ALLERGY INJECTIONS</b>	90% after deductible	60% after deductible
<b>SPINAL MANIPULATION</b> <i>(Limited to 25 visits per member per calendar year)</i>	100% after \$20 PCP copay or 100% after \$40 specialist copay	60% after deductible

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<b>PHYSICAL, SPEECH &amp; OCCUPATIONAL THERAPY</b>	100% after \$40 specialist copay	60% after deductible
<b>ROUTINE EYE EXAM</b> <i>(One routine eye exam per calendar year)</i>	100% -- no deductible	60% after deductible
<b>HEARING EXAM</b>	100% after \$40 specialist copay	60% after deductible
<b>HEARING AIDS - Children</b> <i>(Limited to one hearing aid for each hearing-impaired ear every 36 months through age 18.)</i>	100% after deductible	60% after deductible
<b>HEARING AIDS - Adults</b> <i>(Limited to \$3,000 per hearing aid for each hearing-impaired ear every 36 months.)</i>	90% after deductible	60% after deductible
<b>ACUPUNCTURE</b>	100% after \$40 specialist copay	
<b>CARDIAC REHABILITATION</b> <i>(Limited to 36 visits per episode)</i>		
Office	100% after \$20 PCP copay or 100% after \$40 specialist copay	60% after deductible
Outpatient Hospital	90% after deductible	60% after deductible
<b>CHEMOTHERAPY/RADIATION THERAPY</b>	90% after deductible	60% after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	90% after deductible	60% after deductible

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<b>PROSTHETICS DEVICES</b>	90% after deductible	60% after deductible
Prosthetics for Limb Replacement	90% -- no deductible	80% -- no deductible
<b>INFERTILITY TREATMENT SERVICES</b> <i>(Up to \$10,000 lifetime limit)</i>	80% after deductible	Not Covered
<b>TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) SERVICES *</b>	90% after deductible	60% after deductible
<b>SKILLED NURSING FACILITY</b> <i>(Limit: 150 days including inpatient rehabilitation in a calendar year)</i>	90% after deductible	60% after deductible
<b>HOME HEALTH CARE</b>	90% after deductible	60% after deductible
<b>HOSPICE</b>	90% after deductible	60% after deductible

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Important Information on Receiving Mental Health and Substance Abuse Benefits	<p>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.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours of admission.</p> <p>Failure to call may result in expected charges.</p>	
<b>MENTAL HEALTH and SUBSTANCE ABUSE SERVICES</b>		
Inpatient	90% after deductible	60% after deductible
Outpatient	90% after deductible	60% after deductible
Office Visits	100% after \$20 copay	60% after deductible
	No member cost share is required for the first behavioral health office visit during the calendar year. A copay is applied to the second and third behavioral health office visits during the calendar year and accumulate toward the calendar year deductible.	
LiveHealth Online	100% - no deductible	NA

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**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**