Anthem BCBS ME
MEA Standard Plan $200 Deductible

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 – 06/30/2017
Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/meabt or by calling 1-800-527-7706.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** Member/**$400** Family for Network and Non Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$800** Member/**$1,600** Family for Network and Non Network providers. (**deductible** + **coinsurance**) **Copayment** Maximum **$6,050 Member / $12,100 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. (**deductible** + **coinsurance** = **out-of-pocket limit**) **Copayments** do not accumulate toward your **out-of-pocket limit**; they accumulate separately to a calendar year **copayment** maximum described below. The **copayment** maximum applies to office visit **copayments,** emergency room **copayments,** and pharmacy **copayments**. This maximum is separate from the **out-of-pocket limit** described above.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-800-527-7706 or visit us at www.anthem.com/meabt.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com/meabt or call 1-800-527-7706 to request a copy.

Does this plan use a network of providers?	Yes. See www.anthem.com/meabt or call **1-800-527-7706** for a list of Network providers.	If you use an In-Network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**$15** Copay/Visit then **20%** Coinsurance	None
	Specialist visit	**$15** Copay/Visit	**$15** Copay/Visit then **20%** Coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Other practitioner office visit	**15%** Coinsurance for Chiropractic Care	**35%** Coinsurance for Chiropractic Care	Coverage is limited to 40 visits per member per calendar year for Chiropractic Care (Physical Manipulations). Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**20%** Coinsurance, no Deductible	_____None_____
If you have a test	Diagnostic test (x-ray, blood work)	**15%** Coinsurance	**35%** Coinsurance	_____None_____
	Imaging (CT/PET scans, MRIs)	**15%** Coinsurance	**35%** Coinsurance	_____None_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com.	Generic drugs	**$10** Copay/Prescription for 30-day supply **$20** Copay/Prescription for up to a 90-day supply		Step Therapy and Prior Authorization may apply to some drugs. Specialty drugs may have separate cost structures and means of delivery. For specific information, contact www.anthem.com/meabt
	Preferred brand drugs	**$35** Copay/Prescription for 30-day supply **$70** Copay/Prescription for up to a 90-day supply		
	Non-preferred brand drugs	**$60** Copay/Prescription for 30-day supply **$120** Copay/Prescription for up to a 90-day supply		
	Specialty drugs	**$85** Copay/Prescription for 30-day supply Specialty drugs cannot be filled for 90 day supplies		

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**15%** Coinsurance	**35%** Coinsurance	None
	Physician/surgeon fees	**15%** Coinsurance	**35%** Coinsurance	None
If you need immediate medical attention	Emergency room services	**$200** Copay/Visit	**$200** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	**15%** Coinsurance	**15%** Coinsurance	None
	Urgent care	**$200** Copay/Visit	**$200** Copay/Visit	If admitted, the ER copay is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	**15%** Coinsurance	**35%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Physician/surgeon fee	**15%** Coinsurance	**35%** Coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$15** Copay/Visit for office visits **15%** Coinsurance for other outpatient services	**$15** Copay then 20%/Visit for office visits **35%** Coinsurance for other outpatient services	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Mental/Behavioral health inpatient services	**15%** Coinsurance	**35%** Coinsurance	$300 Penalty applies if failed to obtain pre-authorization.
	Substance use disorder outpatient services	**$15** Copay/Visit for office visits **15%** Coinsurance for other outpatient services	**$15** Copay then 20%/Visit for office visits **35%** Coinsurance for other outpatient services	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Substance use disorder inpatient services	**15%** Coinsurance	**35%** Coinsurance	$300 Penalty applies if failed to obtain pre-authorization.
If you are pregnant	Prenatal and postnatal care	**15%** Coinsurance	**35%** Coinsurance	_____None_____
	Delivery and all inpatient services	**15%** Coinsurance	**35%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**15%** Coinsurance	**35%** Coinsurance	None
	Rehabilitation services	**15%** Coinsurance	**35%** Coinsurance	Coverage is limited to combined 60 visits per member per calendar year for Occupational, Speech and Physical therapy.
	Habilitation services	**15%** Coinsurance	**35%** Coinsurance	Coverage is limited to combined 60 visits per member per calendar year for Occupational, Speech and Physical therapy.
	Skilled nursing care	**15%** Coinsurance	**35%** Coinsurance	None
	Durable medical equipment	**15%** Coinsurance	**35%** Coinsurance	None
	Hospice service	No Charges	**20%** Coinsurance, no Deductible	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye exams
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care(Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-7706. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BCBS ME
Attn: Appeals
PO Box 218
North Haven, CT 06473-0218

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilnί. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilnί.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,570
- **Patient pays** $970

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$20
Coinsurance	$600
Limits or exclusions	$150
Total	**$970**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,455
- **Patient pays** $945

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$440
Coinsurance	$225
Limits or exclusions	$80
Total	**$945**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-527-7706.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.