### Important Questions | Answers | Why this Matters:
--- | --- | ---
**What is the overall deductible?** | $500 Member/ $1,000 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. $2,500 Member/ $5,000 Family for Network and Non Network providers. (deductible + coinsurance) | 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.

| Copayment Maximum $4,350 Member / $8,700 Family | 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](http://www.anthem.com/meabt).

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Anthem BCBS ME
MEA Standard Plan $500 Deductible

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

| 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.

<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>Your Cost If You Use an Network Provider</th>
<th>Your Cost If You Use an Out of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 Copay/Visit</td>
<td>$20 Copay/Visit then 20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 Copay/Visit</td>
<td>$20 Copay/Visit then 20% Coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% Coinsurance for Chiropractic Care</td>
<td>40% Coinsurance for Chiropractic Care</td>
<td>Coverage is limited to 40 visits per member per calendar year for Chiropractic Care (Physical Manipulations). Acupuncture is Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charges</td>
<td>20% Coinsurance, no Deductible</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 Copay/Prescription for 30-day supply</td>
<td>$20 Copay/Prescription for up to a 90-day supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$35 Copay/Prescription for 30-day supply</td>
<td>$70 Copay/Prescription for up to a 90-day supply</td>
<td>Step Therapy and Prior Authorization may apply to some drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 Copay/Prescription for 30-day supply</td>
<td>$120 Copay/Prescription for up to a 90-day supply</td>
<td>Specialty drugs may have separate cost structures and means of delivery. For specific information, contact <a href="http://www.anthem.com/meabt">www.anthem.com/meabt</a></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$85 Copay/Prescription for 30-day supply</td>
<td>Specialty drugs cannot be filled for 90 day supplies</td>
<td></td>
</tr>
</tbody>
</table>

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## Summary of Benefits and Coverage:

**What this Plan Covers & What it Costs**

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</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$200 Copay/Visit</td>
<td>$200 Copay/Visit</td>
<td>If admitted, the ER copay is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$200 Copay/Visit</td>
<td>$200 Copay/Visit</td>
<td>If admitted, the ER copay is waived.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Failure to obtain pre-authorization may result in non coverage or reduced benefits.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 Copay/Visit for office visits</td>
<td>$20 Copay then 20%/Visit for office visits</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>$300 Penalty applies if failed to obtain pre-authorization.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 Copay/Visit for office visits</td>
<td>$20 Copay then 20%/Visit for office visits</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>$300 Penalty applies if failed to obtain pre-authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Failure to obtain pre-authorization may result in non coverage or reduced benefits.</td>
</tr>
</tbody>
</table>

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### Common Medical Event

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Coverage is limited to combined 60 visits per member per calendar year for Occupational, Speech and Physical therapy.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Hospice service</td>
<td>No Charges</td>
<td>20% Coinsurance, No Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### If you need help recovering or have other special health needs

- **Skilled nursing care**: 20% Coinsurance
- **Durable medical equipment**: 20% Coinsurance
- **Hospice service**: No Charges

### If your child needs dental or eye care

- **Eye exam**: Not Covered
- **Glasses**: Not Covered
- **Dental check-up**: Not Covered

**Questions:** Call 1-800-527-7706 or visit us at [www.anthem.com/meabt](http://www.anthem.com/meabt).

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Anthem BCBS ME
MEA Standard Plan $500 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

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Hearing aids (Adult)</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Long-term care</td>
</tr>
<tr>
<td></td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td></td>
<td>Routine eye exams</td>
</tr>
<tr>
<td></td>
<td>Routine foot care</td>
</tr>
<tr>
<td></td>
<td>Weight loss programs</td>
</tr>
<tr>
<td></td>
<td>Bariatric surgery</td>
</tr>
<tr>
<td></td>
<td>Chiropractic care</td>
</tr>
<tr>
<td></td>
<td>Most coverage provided outside the United States. See <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a></td>
</tr>
<tr>
<td></td>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td></td>
<td>Routine eye care(Adult)</td>
</tr>
</tbody>
</table>

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](http://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](http://www.cciio.cms.gov).

Questions: Call 1-800-527-7706 or visit us at [www.anthem.com/meabt](http://www.anthem.com/meabt).

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Anthem BCBS ME
MEA Standard Plan $500 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

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’ta ni nu’liigoo ci dooda’i, shikáa adoolwoł ūnižinigo t’áá diné k’čújgo, t’áá shoodi ba na’ałníhí ya sidáhí bich’į naabídúlkiid. Ei doo búigha daago ni ba’nija’go ho’aaláwi bich’į hodiiłní. Hai’dáa iini’taago ci’ya, t’áá shoödí diné ya åtah halne’įgíí ni béésh bee hane’i wólta’ bi’ki s’niílígí bi’kéhgo bich’į hodiilní.

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

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.
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.

Questions: Call 1-800-527-7706 or visit us at www.anthem.com/meabt.

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Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,520
- Patient pays $2,020

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 $500
- Copays $20
- Coinsurance $1,350
- Limits or exclusions $150

Total $2,020

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

- Amount owed to providers: $5,400
- Plan pays $4,000
- Patient pays $1,400

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 $500
- Copays $580
- Coinsurance $240
- Limits or exclusions $80

Total $1,400

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.

Questions: Call 1-800-527-7706 or visit us at www.anthem.com/meabt.

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