

	Harvard Current Maine's Choice	Harvard Renewal Maine's Choice	Harvard -Alternative Maine Choice	Anthem HMO	MMHT - Anthem Pemquid
Deductible (Individual/Family)	\$2,500/\$5,000	\$2,500/\$5,000	\$4,000/\$8,000	\$2,500/\$5,000	\$2,500/\$5,000
Out-Of-Pocket Maximum	\$5,000/\$10,000	\$6,000/\$12,000	\$8,500/\$17,000	\$6,000/\$12,000	\$6,100/\$12,200
Co-insurance (member pays)	30%	30%	30%	30%	20%
Office Visits (PCP / Specialist)	\$20/\$50 Copay	\$20/\$50 Copay	\$40/\$60 Copay	\$20/\$50 Copay	\$25/\$40 Copay
Hospital (In-Patient / Out-Patient)	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Deductible then 80% coinsurance
Emergency Room	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Deductible then 70% coinsurance	Copay \$200
Urgent Care	\$50	\$40	\$40	\$40	\$40
Prescription Drugs	\$5/\$25/\$50/30% to \$300/30% to \$600	\$5/\$25/\$50/30% to \$300/30% to \$600	\$5/\$25/\$50/Deductible then \$100/\$250	\$10/\$25/\$50/30% to \$300/30% to \$600	\$10/\$30/\$50/\$75/\$150
Employee Only	\$888.95	\$1,115.76	\$983.57	\$992.91	\$1,206.50
Employee & Spouse	\$1,777.90	\$2,231.52	\$1,967.15	\$1,985.82	\$2,706.37
Employee & Child(ren)	\$1,644.56	\$2,064.15	\$1,819.61	\$1,836.88	\$1,968.67
Family	\$2,755.74	\$3,458.85	\$3,049.08	\$3,078.02	\$2,706.37
TOTAL MONTHLY PREMIUM	\$17,023.38	\$21,366.78	\$18,835.42	\$19,014.22	\$20,033.15
<i>Annual Premium</i>	\$204,280.56	\$256,401.36	\$226,025.04	\$228,170.64	\$240,397.80

1 - With MMHT - The life benefit is an included benefit, for which the Town currently pays \$3,312 per year.

This document is provided for comparison purposes only. If there is a difference between this information and the information provided by the carrier, the carrier's information will govern.



MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

Pemaquid Plan

Effective January 1, 2026

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: Services received Out-of-Network cannot be used to satisfy the In-Network Deductible or 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.
<ul style="list-style-type: none"> • Deductible • Coinsurance • Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year ⁽¹⁾ • Lifetime Maximum 	\$2,500 Single / \$5,000 Family Plan pays 80% \$6,100 Single / \$12,200 Family Unlimited	\$5,000 Single / \$10,000 Family Plan pays 60% \$9,000 Single / \$18,000 Family Unlimited
Inpatient Services		
<ul style="list-style-type: none"> • Unlimited days of care in semi-private room ⁽²⁾⁽³⁾ • Physician services • Intensive care • Behavioral health/Substance use services ⁽⁴⁾ • Ancillary services, lab tests, x-rays, medications • Anesthesia • Maternity care • Newborn care 	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible 80% after deductible 60% after deductible
Outpatient Services		
<ul style="list-style-type: none"> • Any physician office visit, diagnosis and treatment (PCP) • Any physician office visit, diagnosis and treatment (Specialist) • Lab & X-ray – Diagnostic • Lab & X-ray – Preventive • Advanced Imaging (e.g., MRI, CT, and PET scans) ⁽³⁾ • Physical exams and Well-child care • Immunizations/Flu Shots • Covered surgical procedures • Behavioral health /Substance use office visits ⁽⁴⁾ • Maternity care • Gynecological exam – Preventive • Physical, Speech or Occupational Therapy ⁽⁵⁾ • Outpatient facility fees • Ambulance (medically necessary) 	No copay for the first visit and then 100% after \$25 copay per visit 100% after \$40 copay 80% after deductible 100% (no deductible) 80% after deductible 100% (no deductible) 100% (no deductible) 80% after deductible No copay for the first visit and then 100% after \$25 copay per visit 100% after \$25 copay (PCP) or \$40 copay (Specialist) 100% (no deductible) 100% after \$25 copay (PCP) or \$40 copay (Specialist) 80% after deductible 80% after deductible	80% after \$25 copay 80% after \$40 copay 60% after deductible 80% (no deductible) 60% after deductible 80% (no deductible) 80% (no deductible) 60% after deductible 80% after \$25 copay 80% after \$25 copay (PCP) or \$40 copay (Specialist) 80% (no deductible) 80% after \$25 copay (PCP) or \$40 copay (Specialist) 60% after deductible 80% after deductible
Emergency Room Services		
<ul style="list-style-type: none"> • Emergency/Acute care • Non-emergency care 	100% after \$200 copay 100% after \$200 copay	100% after \$200 copay 100% after \$200 copay
Other Services		
<ul style="list-style-type: none"> • Walk-In or Urgent Care Center ⁽⁶⁾ • Home Health/Hospice care • Skilled nursing facility ⁽³⁾⁽⁷⁾ • Human tissue & organ transplants • Durable Medical Equipment • Oral surgery (limited benefits) • Eye exams – Preventive • Chiropractic care ⁽⁸⁾ 	100% after \$40 copay 80% after deductible 80% after deductible 80% after deductible 80% (no deductible) 80% after deductible 100% (no deductible) 100% after \$40 copay	80% after \$40 copay 60% after deductible 60% after deductible 60% after deductible 60% (no deductible) 80% after deductible 80% (no deductible) 80% after \$40 copay
Prescription Drugs		
Each 30-day supply – Retail Pharmacy (Tier 1-Select Preventative / Tier 1-Standard /Tier 2 /Tier 3 /Tier 4)	Copays: \$10 / \$30 / \$50 / \$75 / \$150	Copays: \$10 / \$30 / \$50 / \$75 / \$150
90 day supply – Mail Order (Tier 1-Select Preventative / Tier 1-Standard /Tier 2 /Tier 3 /Tier 4)	Copays: \$20 / \$60 / \$100 / \$150 / N/A*	Copays: \$20 / \$60 / \$100 / \$150 / N/A*
*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 \$2,500 single / \$5,000 family. This means that you will not have to pay more than \$8,600 single / \$17,200 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 to 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) 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).
- (6) For a current list of In-Network Walk-In and Urgent Care Centers, please call the Health Trust at 1-800-852-8300, or refer to the Health Trust website at www.mmeht.org.
- (7) Skilled nursing facility services limited to 100 days per calendar year (combined In-Network and Out-of-Network).
- (8) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.harvardpilgrim.org/public/eoc?pdid=PD0000202586. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 1-888-333-4742 to request a copy.**

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Preferred <u>Deductible</u> : \$2,500 member/ \$5,000 family Standard <u>Deductible</u> : \$5,500 member/ \$11,000 family Benefits are administered on a Calendar Year basis	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs</u> , <u>Preventive care</u> , <u>provider office visits</u> , <u>Non-hospital based laboratory</u> , <u>Non-hospital based imaging</u> , <u>Non-hospital affiliated facility day surgery</u> , <u>Rehabilitation services</u> and <u>Habilitation services</u> , routine eye exams are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Preferred Network: \$6,000 member/ \$12,000 family Standard Network: \$6,000 member/ \$12,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.harvardpilgrim.org/public/find-	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u>

MD0000201706, RX0000201391, DN0000201309, VS0000201242

Important Questions	Answers	Why This Matters:
	a-provider or call 1-888-333-4742 for a list of network providers.	charge and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Preferred Provider	Standard Provider		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: \$20 copay/visit; deductible does not apply	Level 1: \$50 copay/visit; deductible does not apply	Not covered	No copay for the first office visit/member
	Specialist visit	Level 1: \$20 copay/visit; deductible does not apply Level 2: \$50 copay/visit; deductible does not apply	Level 1: \$50 copay/visit; deductible does not apply Level 2: \$100 copay/visit; deductible does not apply	Not covered	None
	Preventive care/screening/immunization	No charge; deductible does not apply	deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: 30% coinsurance Laboratory Non-Hospital based: \$15 copay/visit; deductible does not apply Hospital based: 30% coinsurance	X-rays: 50% coinsurance Laboratory: 50% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Standard Provider		
		Preferred Provider			
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.harvardpilgrim.org/2026CoreME5T.</p>	Imaging (CT/PET scans, MRIs)	<p>Non-Hospital Based: \$250 <u>copay</u>/visit; <u>deductible</u> does not apply</p> <p>Hospital Based: 30% <u>coinsurance</u></p>	50% <u>coinsurance</u>	Not covered	None
	Generic drugs	<p>30-day Retail Tier 1: \$10 <u>copay</u>/prescription; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 1: \$20 <u>copay</u>/prescription; <u>deductible</u> does not apply</p> <p>30-day Retail Tier 2: \$25 <u>copay</u>/prescription; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 2: \$50 <u>copay</u>/prescription; <u>deductible</u> does not apply</p>		Not covered	Core ME formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable <u>cost sharing</u> . Covered only outside of service area.
	Preferred brand drugs	<p>30-day Retail Tier 3: \$50 <u>copay</u>/prescription; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 3: \$100 <u>copay</u>/prescription; <u>deductible</u> does not apply</p>		Not covered	
	Non-preferred brand drugs	<p>30-day Retail Tier 4: 30% <u>coinsurance</u> up to \$300; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 4: 30% <u>coinsurance</u> up to \$600; <u>deductible</u> does not apply</p>		Not covered	
	<u>Specialty drugs</u>	<p>30-day Retail Tier 4: 30% <u>coinsurance</u> up to \$300; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 4: 30% <u>coinsurance</u> up to \$600; <u>deductible</u> does not apply</p> <p>30-day Retail Tier 5: 50% <u>coinsurance</u> up to \$600; <u>deductible</u> does not apply</p> <p>90-day Mail Tier 5: 50% <u>coinsurance</u> up to \$1,200; <u>deductible</u> does not apply</p>		Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-hospital affiliated facility: \$300 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Preferred Provider	Standard Provider		
		Hospital affiliated facility: 30% coinsurance			
	Physician/surgeon fees	Non-hospital affiliated facility: No charge; deductible does not apply Hospital affiliated facility: 30% coinsurance	50% coinsurance	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	30% coinsurance			None
	<u>Emergency medical transportation</u>	30% coinsurance			None
	<u>Urgent care</u>	Urgent care center: \$40 copay/visit; deductible does not apply	Urgent care center: 50% coinsurance	Urgent care center: Not covered	Non-participating provider's only covered outside the service area. Cost sharing may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay/visit; deductible does not apply		Not covered	No copay for first mental health/substance abuse visit/member
	Inpatient services	30% coinsurance		Not covered	
If you are pregnant	Office visits	\$20 copay/visit; deductible does not apply	\$50 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Preferred Provider	Standard Provider		
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance		Not covered	None
	Rehabilitation services	Physical Therapy: \$30 copay/visit; deductible does not apply	Physical Therapy: \$60 copay/visit; deductible does not apply	Not covered	Physical, occupational & speech therapies - 60 combined visits/Calendar Year.
	Habilitation services	Occupational Therapy: \$30 copay/visit; deductible does not apply	Occupational Therapy: \$60 copay/visit; deductible does not apply		
		Speech Therapy: \$30 copay/visit; deductible does not apply	Speech Therapy: \$60 copay/visit; deductible does not apply		
	Skilled nursing care	30% coinsurance	50% coinsurance	Not covered	150 days/Calendar Year combined with Inpatient Rehabilitation services.
	Durable medical equipment	30% coinsurance		Not covered	None
	Hospice services	30% coinsurance		Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	\$20 copay/visit; deductible does not apply	\$100 copay/visit; deductible does not apply	Not covered	1 exam/Calendar Year
	Children's glasses	Reimbursed first \$50, then 50% of covered charges; apply			Frames & lenses every 12 months OR 1st order of contacts up to end of month child turns 19
	Children's dental check-up	No charge; deductible does not apply			1 exam every 6 months up to end of month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Cosmetic Surgery	• Non-emergency care when traveling outside the U.S.
• Dental Care (Adult)	• Private-duty nursing
• Long-Term Care	• Routine foot care (except for diabetes or systemic circulatory diseases)
	• Weight Loss Programs
	• Services that are not Medically Necessary

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Abortion	• Chiropractic care
• Acupuncture	• Hearing Aids - 1 per impaired ear every 36 months/to age 19; \$3,000/impaired ear every 36 months for all other members
• Bariatric surgery	• Infertility treatment
	• Routine eye care (Adult) - 1 exam/Calendar Year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000, or contact Harvard Pilgrim at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the [CoverME.gov](http://www.CoverME.gov). For more information, about the [CoverME.gov](http://www.CoverME.gov), visit www.CoverME.gov or call 1-866-636-0355.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals- Member Services Department Harvard Pilgrim Health Care, Inc. 1 Wellness Way Canton, MA 02021- 1166 Telephone: 1-888-333-4742 Fax: 1-617-509-3085	Department of Labor's Employee Benefits Security Administration Benefits Security Administration 1-866-444-3272 www.dol.gov/ebsa/healthreform	Consumer for Affordable Health Care 12 Church Street, PO Box 2409 Augusta, Maine 04338-2490 1-800-965-7476 www.maineahc.org consumerhealth@mainecahc.org	Maine Bureau of Insurance 34 State House Station Augusta, ME 04333 1-207-624-8475 1-800-300-5000
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Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,500
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other copayment \$15

This EXAMPLE event includes services like:
 Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic Test (ultrasounds and blood work)
 Specialist visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$2,700
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$5,500

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,500
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other copayment \$15

This EXAMPLE event includes services like:
 Primary care physician office visits (including disease education)
 Diagnostic Tests (blood work)
 Prescription drugs
 Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,500
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

This EXAMPLE event includes services like:
 Emergency room care (including medical supplies)
 Diagnostic test (x-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,200
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

The plan would be responsible for the other costs of these EXAMPLE covered services.

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
 - Provides free language services to people whose primary language is not English, such as qualified interpreters.
- If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).
- If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

Point52Health Civil Rights Legal Coordinator

1 Wellness Way

Canton, MA 02021-1166

866-750-2074, TTY service: 711

Fax: 617-668-2754

Email: OCRCoordinator@point52health.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)


Complaint forms are available at www.hhs.gov/ocr/office/file/index.html



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.harvardpilgrim.org/public/eoc?pdid=PD0000202592. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 1-888-333-4742 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p>Medical & Prescription Drug Deductible: Preferred Deductible: \$4,000 member/ \$8,000 family Standard Deductible: \$7,500 member/ \$15,000 family Benefits are administered on a Calendar Year basis</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
Are there services covered before you meet your deductible?	<p>Yes. Tier 1, Tier 2 and Tier 3 <u>prescription drugs</u>, <u>Preventive care</u>, <u>provider</u> office visits, Non-hospital based laboratory, Non-hospital based imaging, Non-hospital affiliated facility day surgery, <u>Rehabilitation services</u> and <u>Habilitation</u> services, routine eye exams are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
Are there other deductibles for specific services?	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
What is the out-of-pocket limit for this plan?	<p>Preferred Network: \$8,500 member/ \$17,000 family Standard Network: \$8,500 member/ \$17,000 family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
What is not included in the out-of-pocket limit?	<p><u>Premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.harvardpilgrim.org/public/find-a-provider or call 1-888-333-4742 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Standard Provider	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or <u>clinic</u>	Primary care visit to treat an injury or illness	Level 1: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Level 1: \$80 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	No <u>copay</u> for the first office visit/member
	<u>Specialist</u> visit	Level 1: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply Level 2: \$60 <u>copay</u> /visit; <u>deductible</u> does not apply	Level 1: \$80 <u>copay</u> /visit; <u>deductible</u> does not apply Level 2: \$120 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-rays: 30% <u>coinsurance</u> Laboratory Non-Hospital based: \$15 <u>copay</u> /visit; <u>deductible</u> does not apply	X-rays: 50% <u>coinsurance</u> Laboratory: 50% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Preferred Provider	Standard Provider		
		Hospital based: 30% coinsurance			
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: \$250 copay/visit; deductible does not apply Hospital Based: 30% coinsurance	50% coinsurance	Not covered	None
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harvardpilgrim.org/2026CoreME5T.</p>	Generic drugs	30-day Retail Tier 1: \$5 copay/prescription; deductible does not apply 90-day Mail Tier 1: \$10 copay/prescription; deductible does not apply 30-day Retail Tier 2: \$25 copay/prescription; deductible does not apply 90-day Mail Tier 2: \$50 copay/prescription; deductible does not apply		Not covered	Core ME formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area.
	Preferred brand drugs	30-day Retail Tier 3: \$50 copay/prescription; deductible does not apply 90-day Mail Tier 3: \$100 copay/prescription; deductible does not apply		Not covered	
	Non-preferred brand drugs	30-day Retail Tier 4: \$100 copay/prescription 90-day Mail Tier 4: \$200 copay/prescription		Not covered	
	Specialty drugs	30-day Retail Tier 4: \$100 copay/prescription 90-day Mail Tier 4: \$200 copay/prescription 30-day Retail Tier 5: \$250 copay/prescription 90-day Mail Tier 5: \$500 copay/prescription		Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-hospital affiliated facility: \$300 copay/visit; deductible does not apply Hospital affiliated facility: 30% coinsurance	50% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Preferred Provider	Standard Provider		
If you need immediate medical attention	Physician/surgeon fees	Non-hospital affiliated facility: No charge; deductible does not apply Hospital affiliated facility: 30% coinsurance	50% coinsurance	Not covered	
	Emergency room care	30% coinsurance			None
	Emergency medical transportation	30% coinsurance			None
If you have a hospital stay	Urgent care	Urgent care center: \$40 copay/visit; deductible does not apply	Urgent care center: 50% coinsurance	Urgent care center: Not covered	Non-participating provider's only covered outside the service area. Cost sharing may vary based on location.
	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/visit; deductible does not apply	deductible does not apply	Not covered	No copay for first mental health/substance abuse visit/member
	Inpatient services	30% coinsurance		Not covered	
	Office visits	\$40 copay/visit; deductible does not apply	\$80 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
If you are pregnant	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Not covered	
	Home health care	30% coinsurance		Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Standard Provider		
		Preferred Provider				
special health needs	<u>Rehabilitation services</u> <u>Habilitation services</u>	Physical Therapy: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Physical Therapy: \$70 <u>copay</u> /visit; <u>deductible</u> does not apply	Occupational Therapy: \$70 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Physical, occupational & speech therapies - 60 combined visits/Calendar Year.
		Speech Therapy: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Speech Therapy: \$70 <u>copay</u> /visit; <u>deductible</u> does not apply	Speech Therapy: \$70 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	150 days/Calendar Year combined with Inpatient Rehabilitation services.	
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>		Not covered	None	
	<u>Hospice services</u>	30% <u>coinsurance</u>		Not covered	For inpatient see "If you have a hospital stay"	
	If your child needs dental or eye care	Children's eye exam	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$120 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	1 exam/Calendar Year
		Children's glasses	Reimbursed first \$50, then 50% of covered charges; <u>deductible</u> does not apply			Frames & lenses every 12 months OR 1st order of contacts up to end of month child turns 19
		Children's dental check-up	No charge; <u>deductible</u> does not apply			1 exam every 6 months up to end of month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Long-Term Care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care (except for diabetes or systemic circulatory diseases) • Services that are not Medically Necessary • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Abortion • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing Aids - 1 per impaired ear every 36 months/to age 19; \$3,000/impaired ear every 36 months for all other members • Infertility treatment • Routine eye care (Adult) - 1 exam/Calendar Year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000, or contact Harvard Pilgrim at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the CoverME.gov. For more information, about the CoverME.gov, visit www.CoverME.gov or call [1-866-636-0355](tel:1-866-636-0355).

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals- Member Services Department Harvard Pilgrim Health Care, Inc. 1 Wellness Way Canton, MA 02021- 1166 Telephone: 1-888-333-4742 Fax: 1-617-509-3085	Department of Labor's Employee Benefits Security Administration Benefits Security Administration 1-866-444-3272 www.dol.gov/ebsa/healthreform	Consumer for Affordable Health Care 12 Church Street, PO Box 2409 Augusta, Maine 04338-2490 1-800-965-7476 www.mainecahc.org consumerhealth@mainecahc.org	Maine Bureau of Insurance 34 State House Station Augusta, ME 04333 1-207-624-8475 1-800-300-5000
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Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

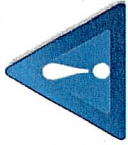
Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other copayment \$15

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic Test (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$6,500

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other copayment \$15

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic Tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,200
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
 - Provides free language services to people whose primary language is not English, such as qualified interpreters.
- If you need these services, contact our Civil Rights Compliance Officer (see below for contact information). If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with:

Point32Health Civil Rights Legal Coordinator

1 Wellness Way
Canton, MA 02021-1166
866-750-2074, TTY service: 711
Fax: 617-668-2754

Email: OCRCordinator@point32health.org


You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

RE: Overview

From Adam Sturtevant <adam@nbinsurance.net>
Date Tue 1/6/2026 8:30 AM
To Nicole Briand <nbriand@bowdoinham.com>

 2 attachments (1 MB)
HMO2500SBC.pdf; HMO4000SBC.pdf;

Good morning Nicole.

Please see the plan summary for the HMO 2500 Gold and the HMO 4000 Silver plans. The plan benefits are the same between the HP and Anthem HMO's, and they both use a tiered network. The preferred tier in Southern and Central/Midcoast is the Maine Health provider system with Northern Light being in the lower (standard tier.) In Maine the HP and Anthem networks match up very well.

The one network advantage I see with Harvard is their standard lower tiered network does include Boston Hospitals, Anthem would typically require an approval for medical necessity for non-emergency care in Boston.

Thank you,

Adam

Adam Sturtevant, VP
Northern Benefits
Direct: 207-208-8969
Mobile: 207-232-9288

www.nbinsurance.net



From: Nicole Briand <nbriand@bowdoinham.com>
Sent: Monday, January 5, 2026 12:23 PM
To: Adam Sturtevant <adam@nbinsurance.net>
Subject: Re: Overview

Thank you very much!

Can you send me the plan details for the harvard 2500 & 4000 and Anthem 2500? I'd like to give staff the opportunity to review them. Could you also tell me the coverage region for these plans?

Nicole Briand

Town Manager

Please note that email sent from or coming to this address may be considered a public document and be subject to the State of Maine Freedom of Access Law.

From: Adam Sturtevant <adam@nbinsurance.net>

Sent: Monday, January 5, 2026 10:08 AM

To: Nicole Briand <nbriand@bowdoinham.com>

Subject: Overview

Hi Nicole,

I have updated the review with the next deductible up from you renewal with Harvard, it is the 4000 HMO. There is also a 5000 but thought this made more sense.

Best,

Adam

Adam Sturtevant, VP
Northern Benefits
Direct: 207-208-8969
Mobile: 207-232-9288

www.nbinsurance.net



Proposed medical plans

Town of Bowdoinham

Quote ID: 01522298

Effective Date: March 01, 2026



Contract code	Anthem Clear Choice SG Silver Maine HMO Tiered Options 4000/30%/8500 Maine HMO Tiered Options	Anthem Clear Choice SG Gold Maine HMO Tiered Options 2500/30%/6000 Maine HMO Tiered Options	Anthem Maine HMO Tiered Options Gold 2900/30%/6000 Maine HMO Tiered Options	Anthem Clear Choice SG Gold Maine HMO Tiered Options 1500/30%/5000 Maine HMO Tiered Options
	8VRC	8VSO	8VSY	8VRJ
Deductible (individual, family)	Preferred: \$4,000 per Individual or \$8,000 per Family.	Preferred: \$2,500 per Individual or \$5,000 per Family.	Preferred: \$2,900 per Individual or \$5,800 per Family.	Preferred: \$1,500 per Individual or \$3,000 per Family.
Coinsurance	Participating: \$6,000 per Individual or \$12,000 per Family.	Participating: \$4,000 per Individual or \$8,000 per Family.	Participating: \$4,000 per Individual or \$8,000 per Family.	Participating: \$3,500 per Individual or \$7,000 per Family.
Out-of-pocket maximum (individual, family)	Calendar Year / Embedded 30%/50%	Calendar Year / Embedded 30%/50%	Calendar Year / Embedded 30%/50%	Calendar Year / Embedded 30%/50%
Office visit primary care physician copay	Preferred: \$8,500 per Individual or \$17,000 per Family.	Preferred: \$6,000 per Individual or \$12,000 per Family.	Preferred: \$6,000 per Individual or \$12,000 per Family.	Preferred: \$5,000 per Individual or \$10,000 per Family.
Office visit specialist copay	Participating: \$10,150 per Individual or \$20,300 per Family.	Participating: \$8,000 per Individual or \$16,000 per Family.	Participating: \$8,000 per Individual or \$16,000 per Family.	Participating: \$5,500 per Individual or \$11,000 per Family.
Inpatient hospital copay	Preferred: \$0(1st visit);\$40 Participating: \$0(1st visit);\$70	Preferred: \$0(1st visit);\$20 Participating: \$0(1st visit);\$50	Preferred: \$0(1st visit);\$25 Participating: \$0(1st visit);\$50	Preferred: \$0(1st visit);\$25 Participating: \$0(1st visit);\$50
Emergency room copay	Preferred: \$60 Participating: Ded:\$110	Preferred: \$80 Participating: Ded:\$30%	Preferred: \$110 Participating: Ded:\$30%	Preferred: \$50 Participating: \$100
Urgent care copay	Preferred: Ded:30%	Preferred: Ded:50%	Preferred: Ded:50%	Preferred: Ded:30%
Prescription drugs – network/drug list	Preferred: Ded:30%	Preferred: Ded:30%	Preferred: Ded:30%	Preferred: Ded:30%
Prescription deductible	Participating: Ded:30%	Participating: Ded:30%	Participating: Ded:30%	Participating: Ded:30%
Deductible applies to tiers	Participating: \$40	Participating: \$40	Participating: \$75	Participating: \$40
Prescription drugs – retail	Medical \$4,000 per Individual or \$8,000 per Family.	n/a per Individual or n/a per Family.	n/a per Individual or n/a per Family.	Medical \$1,500 per Individual or \$3,000 per Family.
Proposed total premium	3-4** \$5/\$25/\$50/\$100/\$250	n/a \$10/\$25/\$50/30%-\$300/50%-\$600	n/a \$5/\$25/\$50/\$100/\$250	3-4** \$20/\$25/\$50/\$80/\$250
Employee	\$16,397.77	\$19,014.22	\$19,019.59	\$19,561.35
Employee + spouse	\$856.28	\$992.91	\$993.19	\$1,021.48
Employee + child(ren)	\$1,712.56	\$1,985.82	\$1,986.38	\$2,042.96
Employee + family	\$1,584.12	\$1,836.88	\$1,837.40	\$1,889.74
	\$2,654.47	\$3,078.02	\$3,078.89	\$3,166.59

Riders that are applicable: N/A
** Deductible must be satisfied before copay/coinsurance is applied.

Anthem rates and benefits are subject to regulatory review or approval. Your total premium may change for various reasons, including but not limited to changes in your employee census and changes to the ACA requirements. This proposal by the group is subject to underwriting approval by Health Underwriting; please do not cancel your coverage until the application has been approved in writing in certain states, underwriting will not approve some application allowed on this proposal tool such as retroactive quoting, retroactive effective dates, and issuance of more than one product. The information is intended to present only a general overview of the benefits. The entire provisions of benefits and exclusions are contained in the Certificate of Coverage. In the event of a conflict between the Certificate of Coverage and this description, the terms of the Certificate of Coverage will prevail.

Group signature: _____ Date: _____
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Medical rates - Schedule B

Town of Bowdoinham

Quote ID: 01522298

Effective Date: March 01, 2026

Effective date of this Addendum is 12:01 a.m. on March 01, 2026

This Addenda applies to the Employer and its affiliated companies as agreed to in writing by Anthem Blue Cross and Blue Shield.

The Employer will pay a per Subscriber per month fee calculated by adding the sum of the rates for each of the Member categories

(Subscriber, Spouse, up to three oldest Dependents 20 years and younger, and Dependents 21 years and over) set forth in the tables below:

	Anthem Clear Choice SG Silver/ Maine HMO Tiered Maine HMO Tiered Options 8VRC	Anthem Clear Choice SG Gold Maine HMO Tiered Options Maine HMO Tiered Options 8V50	Anthem Maine HMO Tiered Options Gold 2900/30%/6000 Maine HMO Tiered Options 8V52	Anthem Clear Choice SG Gold Maine HMO Tiered Options Maine HMO Tiered Options 8VRJ
Employee	\$856.28	\$992.91	\$993.19	\$1,021.48
Employee + spouse	\$1,712.56	\$1,985.82	\$1,986.38	\$2,042.96
Employee + child(ren)	\$1,584.12	\$1,836.88	\$1,837.40	\$1,889.74
Employee + family	\$2,654.47	\$3,078.02	\$3,078.89	\$3,166.59

Anthem Blue Cross and Blue Shield

Denise F. McDonough

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President



MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

60 Community Drive | Augusta, ME 04330-9486

MAINE NON-PROFIT ORGANIZATION DEVELOPED FOR LOCAL GOVERNMENT EMPLOYEES

- Governed by a dedicated Board of Trustees, all who are members of a Health Trust plan
- 480 employer groups, over 10,000 covered employees & retirees and approximately 20,000 members including dependents
- Sound fiscal management and self-insured, pooled funding
- Serving Maine people and providing Maine jobs

EFFECTIVE TRUST MANAGEMENT FOR OVER 40 YEARS

- Experienced and knowledgeable trustees, advisors, staff, and business partners
- Stable premium rates with single digit average annual increases over the past 10 years
- History of returning premium contributions through rate reductions using available reserves

QUALITY BENEFIT OPTIONS FOR ACTIVE EMPLOYEES AND EMPLOYERS

- Medical plans, life insurance options, dental insurance, and vision insurance
- Plans by subgroups/collective bargaining units, domestic partner, surviving spouse
- Expertise in plan design, COBRA, HIPAA, administration, problem resolution
- Early retiree medical plan and Medicare Advantage retiree plan
- Robust prescription coverage including home delivery option

ADMINISTRATIVE SUPPORT

- Administration of COBRA for all eligible benefits at no additional cost to the employer
- Direct billing to COBRA members by MMEHT
- Direct retiree billing option, or deductions from MainePERS pension payments
- GASB 75 actuarial valuation assistance and reporting
- Claims analysis reporting and education

HEALTH PROMOTION - Wellness Works

- Wellness Incentive Grant and App-based wellness engagement tool for employers
- Incentive programs with rewards, on-site classes, webinar options and an employee newsletter
- Employee Assistance Program at no additional cost with Health Trust health plans

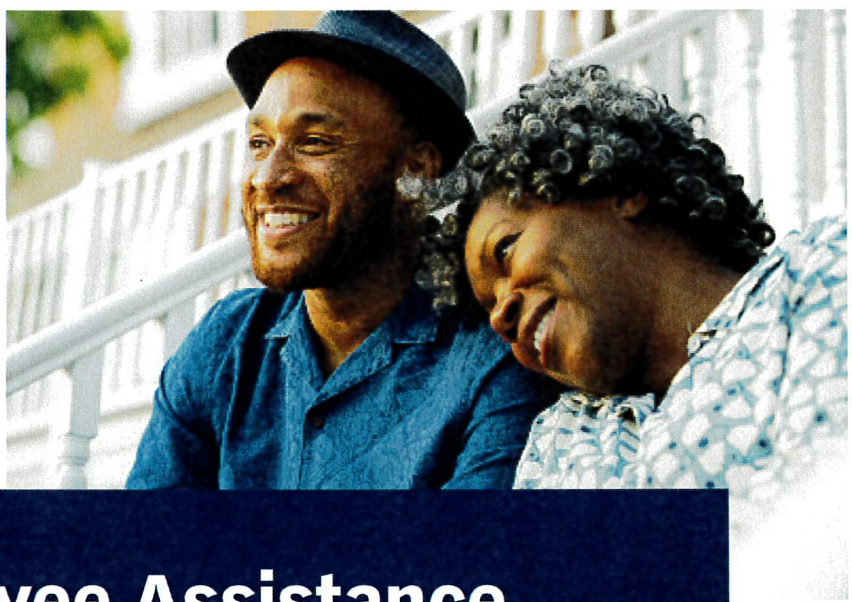
HEALTH MANAGEMENT

- Anthem programs providing support for chronic disease management and virtual care
- Nurse Hotline with 24 hour/7 day per week assistance via toll-free telephone number
- Virtual and telehealth options
- Generous preventive care benefits

EXCEPTIONAL LOCAL SERVICE

- Experienced and dedicated staff members located in Augusta, Maine
- Effective claims resolution processes and personal customer service assistance
- On-site employer visits from experienced representatives that know you and your employees
- Dedicated support with in-house member services phone line

For Over 40 Years, the Difference is Trust



Your Employee Assistance Program can help with life's demands

When you or those in your household face personal or work-related challenges, the **Anthem Employee Assistance Program (EAP)** is available to help you anytime, anywhere.



Counseling with up to three visits for each issue, each year, including in-person or online visits through LiveHealth Online and Talkspace text or video¹



Dependent care for information on childcare, adoption, summer camps, college placement, elder care, and assisted living



Legal consultation with a 30-minute phone or in-person meeting, discounted fees to retain a lawyer, and online resources



Additional anthemEAP.com resources, including well-being articles, podcasts, webinars, and tools for depression, anxiety, relationships, alcohol use, and eating habits



Financial consultation, including a phone meeting with financial professionals during business hours



Crisis consultation for around-the-clock support for emergencies



ID recovery for help reporting to consumer credit agencies, filling out paperwork, and negotiating with creditors if your ID is stolen



Emotional Well-being Resources, administered by Learn to Live, with digital tools and online programs to help you develop resilience, reduce stress, and practice mindfulness — at no added cost

**Confidential help 24/7,
365 days a year**

To reach your EAP, call 800-647-9151, scan this QR code with the camera on your mobile device, or visit **anthemEAP.com** and enter **MMEHT** to log in.



Everything you share is confidential.²

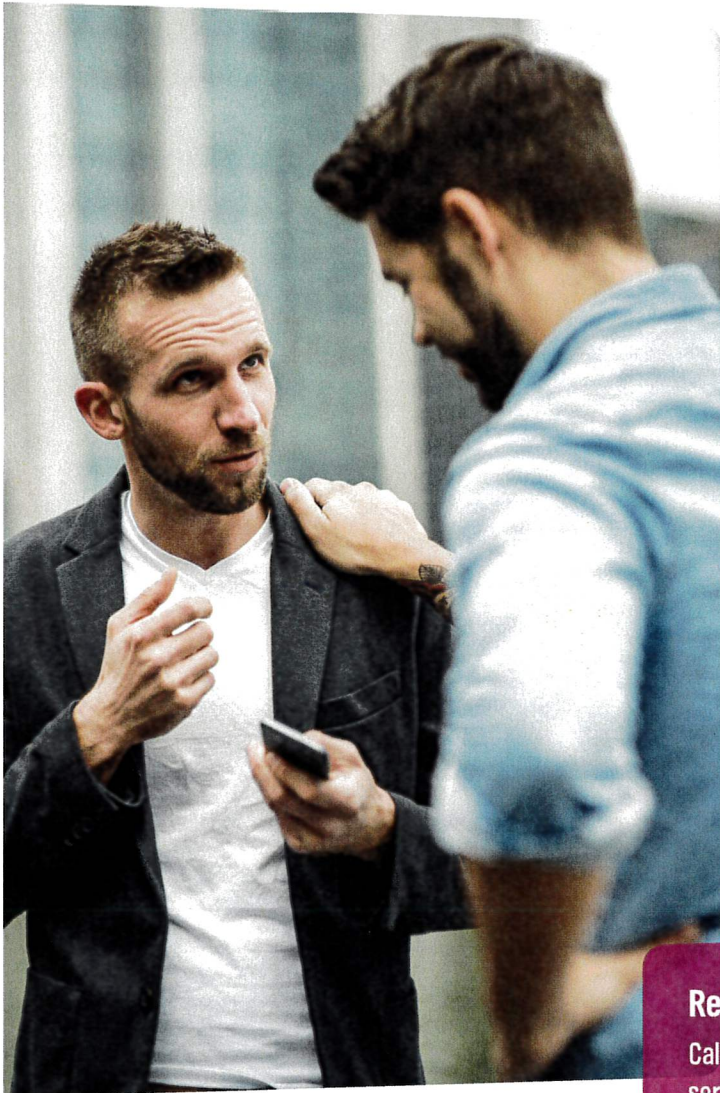
¹ Appointments subject to the availability of a therapist. Online counseling is not appropriate for all kinds of problems. If you are in crisis or having suicidal thoughts, it's important that you seek help immediately. Please text, chat, or call 388 (Suicide and Crisis Lifeline) or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online crisis not offer emergency services.

² In accordance with federal and state law and professional ethical standards. This document is for general informational purposes. Check with your employer for specific information about benefits, limitations, and exclusions. Learn to Live, Inc. is an independent company offering online tools and programs for behavioral health support. Learn to Live is an education program and should not be considered medical treatment.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Recovering from trauma

EAP is here to help



You can't really prepare for trauma. What you can do is try your best to heal. Your Employee Assistance Program (EAP) is here for you every step of that journey.

It's normal to feel afraid, angry or numb after a trauma.

You may experience:

- Anxiety, depression and stress.
- Difficulty sleeping and eating.
- Trouble concentrating, remembering things and making decisions.
- Panic attacks or heightened nervousness.
- Flashbacks of the event.
- Physical symptoms, like headaches, stomach issues and exhaustion.

It's also normal to feel overwhelmed and stuck — and need a little help moving forward. Your EAP offers free counseling, legal and financial services to you and members of your household. It's available 24/7, 365 days a year.

Know that your greatest coping tools are within you already.

The way you've survived every problem, conflict and emergency in your life so far — and somehow gotten stronger and smarter in the process. That's how you'll survive and thrive now.

Remember that you're not alone.

Call EAP at 800-647-9151 today or visit anthemEAP.com and enter MMEHT. All services are confidential. No one will know you've contacted EAP unless you give permission in writing.*



* In accordance with federal and state law, and professional ethical standards.

Source: National Institute of Mental Health: *Coping with Traumatic Events* (February 2017); nimh.nih.gov/health/topics/coping-with-traumatic-events/Index.shtml.

Language Access Services - (TTY) 700-7111

(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
(Chinese) - 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

Anthem complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thomson Health Plan, Inc. In Ohio: Community Insurance Company, Inc. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in PDS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or PDS policies; WCIC underwrites or administers Well Priority HMO or PDS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Recovering from a critical incident

EAP is here to help



A critical incident can be a medical issue, natural disaster or other unexpected trauma. It may turn your life upside down, but healing is possible. Your Employee Assistance Program (EAP) is here for you every step of that journey.

Because these events can take many forms, it's normal to respond in many ways. You may experience:

- Shock and disbelief.
- Anger and irritability.
- Anxiety, depression and stress.
- Difficulty eating and sleeping.
- Trouble concentrating, remembering things and making decisions.
- Physical symptoms, like headaches, tense muscles, stomach problems and exhaustion.

It's also normal to feel overwhelmed and stuck – and need a little help moving forward. Your EAP offers free counseling, legal and financial services to you and members of your household. It's available 24/7, 365 days a year.

Remember that you're not alone.

Call EAP at 800-647-9151 today or visit anthemEAP.com and enter MMEHT. All services are confidential. No one will know you've contacted EAP unless you give permission in writing.*



* In accordance with federal and state law, and professional ethical standards.

Source: Geographic Area Coordination Centers, Interagency Critical Incident Stress Management Program: *Reactions after a Critical Incident* (accessed December 2018): <https://gacc.nlfc.gov/clsm/documents/reactions.pdf>.

Language Access Services- (TTY/700: 711)

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How to reach us

Confidential help 24 hours a day,
7 days a week, 365 days a year –
at no extra cost



Employee Assistance
Program (EAP)

800-647-9151



Website

anthemeap.com

Enter "MMEHT" to log in.



Change your mind.
Change your Life.™

Your EAP includes access to
Emotional Well-being Resources,
administered by **Learn to Live**,
offering digital tools and online
programs to help develop resilience,
reduce stress, and practice
mindfulness — at no extra cost
to you.

Visit anthemeap.com and enter
"MMEHT," or scan the QR code on
the back of this brochure using the
camera on your mobile device.

Everything you share
is confidential.²

Help 24/7, 365 days a year

3 ways to get started:



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and enter "MMEHT."



Scan the QR code using
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Your privacy matters.

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Your Employee Assistance Program

Here to support you

If you or your household members are facing
personal or work-related challenges, the Anthem
Blue Cross and Blue Shield Employee Assistance
Program (EAP) can help you. Call 800-647-9151,
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log in.

Anthem.



**MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST**

¹ Appointments subject to the availability of a therapist. Online counseling is not appropriate for all kinds of problems. If you are in crisis or having suicidal thoughts, it's important that you seek help immediately. Please text, chat, or call 988 (Suicide and Crisis Helpline), or 911, for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

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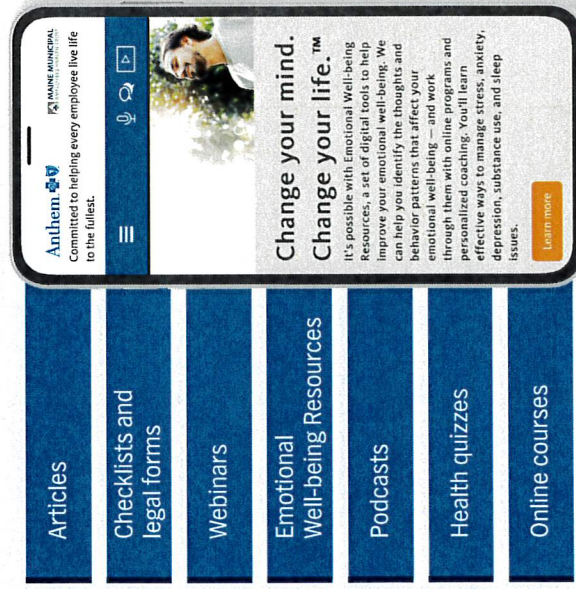
**MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST**

Your EAP is here to help

For issues, questions, and challenges both big and small, your EAP has resources to help with:

- Finding care for an elderly loved one.
- Parenting a child with special needs.
- Dealing with addiction and recovery.
- Setting retirement goals.
- Seeking work-life balance.
- Accessing mental health resources and information.

Learn more about your EAP
at anthemeap.com



These EAP services are available at no extra cost to you:



Counseling with up to three visits for each issue, including face-to-face or online visits through LiveHealth Online, and Talkspace text or video.¹



Legal consultation with a 30-minute phone or in-person meeting, discounted fees to retain a lawyer, and online resources.



Financial consultation including a phone meeting with financial professionals during business hours.



ID recovery for help with reporting to consumer credit agencies, filling out paperwork, and negotiating with creditors.



Emotional Well-being Resources

for emotional health and well-being, including personal coaching, webinars, virtual support teams, and positivity messaging.



Dependent care and daily living resources

for information on child care, adoption, summer camps, college placement, elder care, and assisted living.



Crisis consultation with a toll-free number for emergencies and round-the-clock help.



Additional anthemeap.com resources

including well-being articles, podcasts, webinars, and tools for depression, anxiety, relationships, alcohol use, and eating habits.



Contact us 24/7

Call 800-647-9151 or
visit anthemeap.com
at no extra cost to you.



RATE DEVELOPMENT

Maine Municipal Employees Health Trust rates are established by the MMEHT Board of Trustees each year in the fall, for the upcoming calendar year. Premium rates are guaranteed from January 1 through December 31 of each calendar year.

Annual Rate Setting Process: At its fall meeting each year, the Health Trust Board of Trustees determines the Average Rate Adjustment required to fund Health Trust programs in the coming year, taking into consideration claims and non-claims expenses, revenues other than premium, and available reserves.

Throughout the Trust's history, the Trustees have maintained a fiscally conservative approach with regard to funding the programs offered by the Trust. This approach has allowed the Trust to maintain its financial stability, even throughout the past several years of increasing health insurance costs. The Trustees are committed to maintaining this financial stability in the future while still striving to offer the plan flexibility that many participating employers appreciate.

Maine Municipal Employees Health Trust Ten Year History Health Plan Average Rate Adjustments Pooled Groups

Year	Rate Adjustment	Rate Adjustment	Rate Adjustment	Rate Adjustment	Rate Adjustment
	ACADIA POS C	BAXTER POS 200	KATAHDIN PPO 500	MOOSEHEAD PPO 1500	PEMAQUID PPO 2500
2026	9.00%	9.00%	9.00%	9.00%	9.00%
2025	9.00%	9.00%	9.00%	9.00%	9.00%
2024	4.25%	4.25%	4.25%	5.50%	7.50%
2023	4.50%	4.50%	4.50%	4.50%	7.00%
2022	2.00%	2.00%	2.00%	4.00%	5.00%
2021	0.00%	0.00%	0.00%	0.00%	0.00%
2020	3.00%	7.00%	7.00%	7.00%	7.00%
2019	4.00%	4.00%	4.00%	7.00%	7.00%
2018	2.00%	6.00%	6.00%	6.00%	6.00%
2017	9.25%	11.25%	11.25%	11.25%	11.25%
Ten Year Average	4.70%	5.70%	5.70%	6.33%	6.88%

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

MEDICAL PROGRAM SUMMARY - January 1, 2026 to December 31, 2026

All benefits shown are In-Network. Services received Out-of-Network, if covered, may be paid at a lower level of benefits. Please consult your Plan Document or Summary Plan Description booklet for more information. All figures shown (deductibles, copays, and coinsurance) reflect what the Member pays towards the cost of services.

	ACADIA	BAXTER	KATAHDIN	MOOSEHEAD	PEMAQUID
DEDUCTIBLE Individual / Family	\$0 (No deductible)	\$200 / \$400	\$500 / \$1,000	\$1,500 / \$3,000	\$2,500 / \$5,000
CO-INSURANCE (Member pays)	10%	20%	20%	20%	20%
OUT OF POCKET MAXIMUM Deductible plus Coinsurance Individual / Family	\$1,750 / \$3,500	\$2,350 / \$4,700	\$2,800 / \$5,600	\$5,000 / \$10,000	\$6,100 / \$12,200
COPAYS:					
Office Visit Copay (First PCP visit per calendar year paid at 100%)	\$15 PCP / \$25 Specialist	\$20 PCP / \$30 Specialist	\$20 PCP / \$35 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist
Mental Health Outpatient Copay (First visit per calendar year paid at 100%, no copay for visits via telehealth)	\$15	\$20	\$20	\$25	\$25
Emergency Room Copay	\$150	\$150	\$200	\$200	\$200
Walk-In or Urgent Care Center Copay	\$25	\$30	\$35	\$40	\$40
PREVENTIVE CARE:					
Preventive Care, including Pap tests, mammograms, women's preventive health services, colonoscopies, PSA tests, and routine physicals	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Preventive Lab and X-Ray	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Preventive Eye Exams (Limited benefits)	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
OTHER SERVICES:					
In Patient Hospital Services	10%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Out Patient Surgical Facility	10%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Diagnostic Lab & X-Ray	0%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Advanced Imaging (MRI/CT/PET)	\$100 copay Copays limited to \$300 per Cal Yr	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Chiropractic Care	\$25 copay Limited to 36 visits per Cal Yr	\$30 copay Limited to 36 visits per Cal Yr	\$35 copay Limited to 36 visits per Cal Yr	\$40 copay Limited to 36 visits per Cal Yr	\$40 copay Limited to 36 visits per Cal Yr
Physical, Speech and Occupational Therapy	\$25 copay Limited to 75 Visits per Cal Yr (Combined Limit)	\$30 copay Limited to 75 Visits per Cal Yr (Combined Limit)	\$35 copay Limited to 75 Visits per Cal Yr (Combined Limit)	\$40 copay Limited to 75 Visits per Cal Yr (Combined Limit)	\$40 copay Limited to 75 Visits per Cal Yr (Combined Limit)
PRESCRIPTION DRUGS (5 TIER): Tier 1-Select Preventive / Tier 1-Standard / Tier 2 / Tier 3 / Tier 4-Specialty	5-Tier Rx	5-Tier Rx	5-Tier Rx	5-Tier Rx	5-Tier Rx
RX COPAY (Each 1-30 day supply at retail pharmacy)	\$10 / \$20 / \$40 / \$60 / \$150	\$10 / \$30 / \$50 / \$75 / \$150	\$10 / \$30 / \$50 / \$75 / \$150	\$10 / \$30 / \$50 / \$75 / \$150	\$10 / \$30 / \$50 / \$75 / \$150
RX COPAY (31-90 day supply via mail order)	\$20 / \$40 / \$80 / \$120 / NA	\$20 / \$60 / \$100 / \$150 / NA	\$20 / \$60 / \$100 / \$150 / NA	\$20 / \$60 / \$100 / \$150 / NA	\$20 / \$60 / \$100 / \$150 / NA
OTHER:					
Cap on In-Network Copays (includes medical and Rx copays) Individual / Family	\$4,750 / \$9,500	\$4,150 / \$8,300	\$4,700 / \$9,400	\$2,500 / \$5,000	\$2,500 / \$5,000
Employee	\$1,476.73	\$1,405.91	\$1,359.40	\$1,254.12	\$1,206.50
Employee & Spouse	\$3,312.52	\$3,153.62	\$3,049.32	\$2,813.17	\$2,706.37
Employee & Child(ren)	\$2,409.60	\$2,294.00	\$2,218.16	\$2,046.38	\$1,968.67
Employee & Family	\$3,312.52	\$3,153.62	\$3,049.32	\$2,813.17	\$2,706.37
	-5.0%	-8.6%	-17.7%	-22.4%	-22.4%

MMHEHT - This is a summary for comparative purposes only. In the case of any discrepancies, the official contract or plan document will govern.



MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

Moosehead Plan (formerly PPO 1500 Plan)

Effective January 1, 2025

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: Services received Out-of-Network cannot be used to satisfy the In-Network Deductible or 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.
<ul style="list-style-type: none"> • Deductible • Coinsurance • Deductible + Coinsurance Out-of-Pocket Max. Per Calendar Year ⁽¹⁾ • Lifetime Maximum 	\$1,500 Single / \$3,000 Family Plan pays 80% \$4,000 Single / \$8,000 Family Unlimited	\$2,500 Single / \$5,000 Family Plan pays 60% \$4,000 Single / \$8,000 Family Unlimited
Inpatient Services		
<ul style="list-style-type: none"> • Unlimited days of care in semi-private room ⁽²⁾⁽³⁾ • Physician services • Intensive care • Behavioral health/Substance use services ⁽⁴⁾ • Ancillary services, lab tests, x-rays, medications • Anesthesia • Maternity care • Newborn care 	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible 80% after deductible 60% after deductible 60% after deductible
Outpatient Services		
<ul style="list-style-type: none"> • Any physician office visit, diagnosis and treatment (PCP) • Any physician office visit, diagnosis and treatment (Specialist) • Lab & X-ray – Diagnostic • Lab & X-ray – Preventive • Advanced Imaging (e.g., MRI, CT, and PET scans) ⁽³⁾ • Physical exams and Well-child care • Immunizations/Flu Shots • Covered surgical procedures • Behavioral health/Substance use office visits ⁽⁴⁾ • Maternity care • Gynecological exam – Preventive • Physical, Speech or Occupational Therapy ⁽⁵⁾ • Outpatient facility fees • Ambulance (medically necessary) 	No copay for the first visit and then 100% after \$25 copay per visit 100% after \$40 copay 80% after deductible 100% (no deductible) 80% after deductible 100% (no deductible) 100% (no deductible) 80% after deductible No copay for the first visit and then 100% after \$25 copay per visit 100% after \$25 copay (PCP) or \$40 copay (Specialist) 100% (no deductible) 100% after \$25 copay (PCP) or \$40 copay (Specialist) 80% after deductible 80% after deductible	80% after \$25 copay 80% after \$40 copay 60% after deductible 80% (no deductible) 60% after deductible 80% (no deductible) 80% (no deductible) 60% after deductible 80% after \$25 copay 80% after \$25 copay (PCP) or \$40 copay (Specialist) 80% (no deductible) 80% after \$25 copay (PCP) or \$40 copay (Specialist) 60% after deductible 80% after deductible
Emergency Room Services		
<ul style="list-style-type: none"> • Emergency/Acute care • Non-emergency care 	100% after \$200 copay 100% after \$200 copay	100% after \$200 copay 100% after \$200 copay
Other Services		
<ul style="list-style-type: none"> • Walk-In or Urgent Care Center ⁽⁶⁾ • Home Health/Hospice care • Skilled nursing facility ⁽³⁾⁽⁷⁾ • Human tissue & organ transplants • Durable Medical Equipment • Oral surgery (limited benefits) • Eye exams – Preventive • Chiropractic care ⁽⁸⁾ 	100% after \$40 copay 80% after deductible 80% after deductible 80% after deductible 80% (no deductible) 80% after deductible 100% (no deductible) 100% after \$40 copay	80% after \$40 copay 60% after deductible 60% after deductible 60% after deductible 60% (no deductible) 80% after deductible 80% (no deductible) 80% after \$40 copay
Prescription Drugs		
Each 30-day supply – Retail Pharmacy (Tier 1-Select Preventative / Tier 1-Standard / Tier 2 / Tier 3 / Tier 4)	Copays: \$10 / \$30 / \$50 / \$75 / \$150	Copays: \$10 / \$30 / \$50 / \$75 / \$150
90 day supply copay – Mail Order (Tier 1-Select Preventative / Tier 1-Standard / Tier 2 / Tier 3 / Tier 4)	Copays: \$20 / \$60 / \$100 / \$150 / N/A*	Copays: \$20 / \$60 / \$100 / \$150 / N/A*
*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 \$3,500 single / \$7,000 family. This means that you will not have to pay more than \$7,500 single / \$15,000 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 to 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) 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).
- (6) For a current list of In-Network Walk-In and Urgent Care Centers, please call the Health Trust at 1-800-852-8300, or refer to the Health Trust website at www.mmeht.org.
- (7) Skilled nursing facility services limited to 100 days per calendar year (combined In-Network and Out-of-Network).
- (8) Acute chiropractic care will be covered for up to 36 visits per calendar year (combined In-Network and Out-of-Network).