First – To help you stay healthy, use:

**Preventive Care**
100% coverage for nationally recommended services.
*Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*

**Preventive Care**
No deductions from the HSA or out-of-pocket costs for you as long as you receive your preventive care, or preventive medications, from an in-network provider. If you choose to go to an out-of-network provider, Traditional Health Coverage benefits will apply.

---

Plus –

**Your Bridge Responsibility**
The Bridge is an amount you pay out of your pocket until you meet your annual deductible responsibility.

Your Bridge amount will vary depending on how many of your HSA dollars, if any, you choose to spend to help you meet your annual deductible responsibility. If you contribute HSA dollars up to the amount of your deductible and use them, your Bridge will equal $0.

HSA dollars spent on covered services plus your Bridge Responsibility add up to your annual deductible responsibility.

**Health Account + Bridge = Deductible**

---

If needed –

**Traditional Health Coverage**
Your Traditional Health Coverage begins after you have met your Bridge responsibility.

Additional protection:
For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year.

**Bridge**
Your Bridge responsibility will vary.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Standard</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$4,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$8,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

**Traditional Health Coverage** - After your Bridge, the plan pays:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Standard</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance Percentage</td>
<td>80% - 60%</td>
<td>80% - 60%</td>
</tr>
<tr>
<td>Coinsurance Limit - Individual</td>
<td>$2,900</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance Limit - Family</td>
<td>$5,800</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>Standard</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket Maximum - Individual</td>
<td>$6,900</td>
<td>$6,900</td>
</tr>
<tr>
<td>Out-of-pocket Maximum - Family</td>
<td>$13,800</td>
<td>$13,800</td>
</tr>
</tbody>
</table>

Your annual out-of-pocket maximum consists of funds you spend from your HSA, your Bridge responsibility and your coinsurance amounts.

If needed – Use your HSA to pay for covered services:

**Health Savings Account**
With the Lumenos Health Savings Account (HSA), you can contribute pre-tax dollars to your HSA account. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

**Contributions to Your HSA**
For 2020 contributions can be made to your HSA up to the following:

- $3,550 individual coverage
- $7,100 family coverage

**Catch-up contributions:** for individuals (and their spouses covered under the HDHP) who have attained 55 and are also not enrolled in Medicare, the HSA contribution limit is increased by $1,000

Note: These limits apply to all combined contributions from any source and are based on IRS guidelines which may adjust annually.

---

LiveHealth Online $59 (applied to deductible) enroll at livehealthonline.com
Preventive Care

Anthem’s Lumenos HSA plan covers preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. Preventive services, (except for Preventive Medicines) received from an in-network provider are covered at 100% and are not deducted from your HSA. If you see an out-of-network provider, services are covered at 80%. Preventive care services do not apply to your deductible.

The following is a list of covered preventive care services:

Well Baby and Well Child Preventive Care

Office Visits through age 18; including preventive vision exams.

Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam, Pap test and contraceptive management for females who are age 18, or have been sexually active.

Immunizations:
- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Medical Care

Anthem’s Lumenos HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount for covered services, you will have Traditional Health Coverage available to help pay for additional covered services.

The following is a summary of covered medical services under Anthem’s Lumenos HSA plan:

- Physician Office Visits
- Inpatient Hospital Services
- Outpatient Surgery Services
- Diagnostic X-rays/Lab Tests
- Emergency Hospital Services
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Maternity Care
- Chiropractic Care
- Prescription Drugs
- Home health care and hospice care
- Physical, Speech and Occupational Therapy Services
- Skilled nursing facility and inpatient rehabilitation facility services limited to 150 days per member per calendar year.
- Home health care services limited to 100 visits per member per calendar year.
- Physical and Occupational Therapy combined limit of 20 visits per member per calendar year.
- Speech Therapy limit of 20 visits per member per calendar year.
- Physical Manipulations limited to 40 visits per member per calendar year.
- Inpatient hospitalizations require authorizations.

PRESCRIPTION DRUGS

This plan uses the Essential Drug List. Drugs not on the list are not covered.

Note: Your prescription drug costs will be lower at Tier 1 pharmacies (CVS, Hannaford, Sam’s, Shaw’s, Target & Walmart) and higher when filled at Tier 2 pharmacies (includes Rite Aid & Walgreens).

On most medications, Member must first satisfy the calendar year deductible and then pay any applicable coinsurance.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Standard Plan</th>
<th>Value Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Medicines</td>
<td>Deductible Waived, covered at 80%</td>
<td>Deductible Waived, covered at 80%</td>
</tr>
<tr>
<td>All other Medicines</td>
<td>Deductible applies, then covered at 80%</td>
<td>Deductible applies, then covered at 80%</td>
</tr>
</tbody>
</table>

After the maximum out-of-pocket limit is reached, all prescriptions will be covered at 100% for the remainder of the calendar year.
Your Preventive Medicine Drug List (subject to change)

Preventive Medicine covers drugs that help keep you healthy because they prevent illness and other health conditions. You can get the products on this list after a 20% coinsurance payment (deductible does not apply). This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

**Note:** Most brand-name drugs that have a generic equivalent available are not covered under this Preventive Rx benefit.

**ASTHMA**
- Advair HFA
- albuterol sulfate hfa
- albuterol sulfate nebulization soln, syrup, tabs
- Arnuity
- Ellipta
- Breo Ellipta
- budesonide inhalation suspension
cromolynsodium nebulization soln
- Duleran
- Flovent Diskus
- Flovent HFA
- fluticasone salmeterol b idiul powder for inhalation
levosalbuterol nebulization soln
metaproterenol sulfate
- syrup, tabs
- montelukast
- Perforomist
- ProAir HFA
- ProAir RespiClick
- QVAR Serevent Diskus
- Spiriva Respimat
- Symbicort
terbutiline sulfate injection, tabs
- Theo-24
- theochron
theophylline, ER, CR
- wixela inh tab
- zafrulast

**BLOOD CLOTS**
- Brillinta
- Eliquis
- Heparin
- Warfarin
- Xarelto

**DIABETES**
- Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips by Lifescan & Roche will be covered by this benefit.
- acarbose
- Bydureon
- Bydureon

**HEART HEALTH AND HIGH BLOOD PRESSURE**
- acetabutol hcl
- acetazolamide afedtab or amiodine hcl
- amiloride/ hctz
- amlodipine besylate
- amlodipine/ benazepril amlodipine/ olmesartan amlodipine/ valsartan/ hctz
- atenolol
- atenolol/ chlorthalidone benazepril hcl
- benazepril hcl/ hctz
- betaxolol hctz
- Bidil
- bisoprolol fumarate
- bisoprolol fumarate/ hctz
- bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia xtc
carvedilol
carvedilol er
- chlorothalidone
- clonidine hcl
digoxin
digoxin
- Dilatrate SR
diltiazem cd
diltiazem hcl
diltiazem hcl er
doxazosin mesylate
- enalapril maleate
- enalapril/ hctz
- eplerenone
- eprosartan
- ethacrynic acid tabs
- ezetimibe
- ezetimibe/ simvastatin
- felodipine er
- fosinopril sodium
- fosinopril/ hctz
- furosemide
- guanfacine hcl
- hydrochlorothiazide
- indapamide
- irbesartan irbesartan/ hctz
- losartan
- losartan/ hctz
- metoprolol/ hctz
- metoprolol succinate er
- metoprolol tartrate
- metoprolol/ hctz
- minitran
- minoxidil
- moexipril hcl
- moexipril/ hctz
- nadolol
- nadolol/
- bendroflumethiazide
cardipidine hcl
- nifedipine
- nifedipine er
- nimodipine
- nigoldipine er
- Nitro-Dur 0.3, 0.8mg/ hr
- nitroglycerin
- nitroglycerin 400 mcg spray
- nitroglycerin er
- nitroglycerin lingual
- nitroglycerin spray
- nitroglycerin sl tabs
- olmesartan
- olmesartan/ hctz
- olmesartan/ amlodipine/ hctz
- perindopril
- pindolol
- prazosin hcl
- propranolol hcl
- propranolol hcl er
- propranolol/ hctz
- quinapril hcl
- quinapril/ hctz
- ramipril
- ranolazine er
- sorine
- sotalol hcl
- sotalol hcl af
- spironolactone
- spironolactone/ hctz
tazlta xt
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terasosin hcl
timoklimateetablet
torsemide
- trandolapril
- trandolapril/ verapamil
triamterene/ hctz
- valsartan
- valsartan/ hctz
- verapamil hcl
- verapamil hcl er

**HIGH CHOLESTEROL**
- atorvastatin
- atorvastatin/ amlodipine
- cholestyramine
- cholestyramine light
colesevelam
colestipol hcl
ezetimibe
ezetimibe- simvastatin
- fenofibrate (43, 50, 67, 130, 134, 150, 200mg capsules & 40, 48, 54, 120, 145, 160mg tablets)
- fenofibric acid
- fluvastatin
- gemfibrozil
- lovastatin
- niacin ER
- pravastatin
- pravastatin
- rosvastatin
- simvastatin
- Welchol 3.75 Gram Oral Powder Packet

**OSTEOPOROSIS**
- alendronate sodium
- amabzel
calcitonin- salmon
Climara Pro
- Combipatch
dotti
- estradioltab.patch
estradiol/ norethindrone acetate
- estropipate
- Fosamax Plus
- ibandronate sodium tablets
- Jevantique
- jinteli
- medroxprogesterone acetate
- Menest
- norethindrone- ethin estradiol
- Premarin tablets
- Premphase
- Prempro
- raloxifene
- risedronate

**STROKE**
- aspirin- diprydamole ER
- clopidogrel bisulfate
diprydamole
- prasugrel
"This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits."

**Important Information About Allowance Used To Pay Claims**

Network professionals and providers have agreed to accept the maximum allowance as the basis of payment in full. If you use a non-network professional or provider whose services are paid based on a maximum allowance, you will be responsible for all charges billed in excess of the maximum allowance. *The amount you may owe could be substantial.*

**KEY TERMS**

**Individual Deductible:** The amount an individual plan participant pays toward the cost of most covered services before benefits begin.

**Family Deductible:** The amount a family pays toward the cost of most covered services before benefits begin. The family deductible amount is twice the individual deductible amount. All family plan participants combine their deductible payments until they meet the family deductible limit. Any family plan participant who meets the individual deductible before the family deductible is met will begin to receive benefits. One family member may not meet more than the individual amount: the family deductible amount must be satisfied by at least two family members.

**Coinsurance Percent:** After you meet your deductible requirements, the Plan shares the cost of most covered services until you meet your coinsurance limit. For example, if the Plan pays 80%, then you pay 20%.

**Copayment:** A fixed dollar amount that you pay for some covered services.

**Maximum Allowance:** The highest dollar amount that the Plan pays providers and professionals for a covered service.

**Network Professional/Network Provider:** A professional or provider who has a written agreement with Anthem Blue Cross and Blue Shield to accept the maximum allowance as payment in full for covered services.

**Non-network Professional/Non-network Provider:** A professional or provider who does not have a written agreement with Anthem Blue Cross and Blue Shield to accept the maximum allowance as payment in full.

**Total Out-of-pocket Limit:** This is the annual dollar limit for your costs for most covered services.

**THIS IS NOT A CONTRACT.** It is an overview of your benefits. If there are discrepancies between this Benefit Overview and the Summary Plan Description (SPD), the SPD will govern.

If you have *eligibility* questions, (i.e., enrollments, changes or terminations) please contact:

**Maine Automobile Dealers Association Insurance Trust**
(207) 623-3882

If you have *benefit* questions, or need assistance, you are encouraged to contact:

**Cross Employee Benefits**
(207) 404-5326 - (800) 999-7345

or

**Anthem Blue Cross and Blue Shield of Maine**
(800) 527-7706

If you have questions regarding your *HSA, HRA, Medical Care or Dependent Care Accounts*, please contact:

**Group Dynamic, Inc.** (800) 626-3539

3772ME Rev. (1.9.20)