



**Maine Automobile Dealers Association Insurance Trust
Qualified High Deductible Health Plan**



HSA Compatible *Standard* Plan - Benefit Overview

Effective March 1, 2025

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

Bridge

Your Bridge responsibility will vary.

<i>Plan</i>	<i>Standard</i>
Individual Deductible	\$4,000
Family Deductible	\$8,000

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.

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

<i>Plan</i>	<i>Standard</i>
Coinsurance Percentage	80% - 60%
Coinsurance Limit - Individual	\$2,900
Coinsurance Limit - Family	\$5,800

<i>Plan</i>	<i>Standard</i>
Out-of-pocket Maximum - Individual	\$6,900
Out-of-pocket Maximum - Family	\$13,800

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 2025 contributions can be made to your HSA up to the following:

\$4,300 individual coverage

\$8,550 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.

Virtual Care, LiveHealth Online \$55 (applied to deductible) then \$10 copayment once deductible has been satisfied. Download the free Sydney Health app for your device.

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:

- Virtual Care - PCP, Urgent Care, MH & SA \$10 copay (After Deductible)
- In Person Care – PCP \$30 copay, Specialist \$50 copay (After Deductible)
- In Person Mental Health & Substance Abuse \$10 copay (After Deductible)
- Urgent Care 20% Coinsurance (After Deductible)
- Inpatient Hospital Services
- Emergency Hospital Services
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Outpatient Surgery Services
- Diagnostic X-rays/Lab Tests
- Maternity Care
- Chiropractic Care
- Prescription Drugs
- Home health care and hospice care
- Physical, Speech and Occupational Therapy Services

Some covered services may have limitations or other restrictions. With Anthem's Lumenos HSA plan, the following services are limited:

- 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, 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.

Plan	Standard Plan
Preventive Medicines	Deductible Waived, covered at 80%
All other Medicines	Deductible applies, then covered at 80%

After the maximum out-of-pocket limit is reached, all prescriptions will be covered at 100% for the remainder of the calendar year.

Adult Preventive Care

Office Visits after age 18; including preventive vision exams.

Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams, Pap test and contraceptive management.

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

Preventive Medicines – This benefit applies only to a limited number of medicines considered to be “preventive”, all other covered medicines are subject to the calendar year deductible. Prescription drugs or medication are preventive care when taken by a person who has risk factors for a disease but is asymptomatic or to prevent the reoccurrence of a disease from which a person has recovered.

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	acarbose	amiloride*	moexipril	134, 150, 200 mg capsules &	olanzapine ODT*
albuterol sulfate	alogliptin	amiloride/ hctz	nadolol*	48, 54, 145, 160 mg tablets)	olanzapine/ fluoxetine
nebulization solution	alogliptin/metformin	amlodipine besylate	nebivolol	fenofibric acid	oxcarbazepine
albuterol sulfate	alogliptin/pioglitazone	amlodipine/ benazepril	nicardipine	fluvastatin	paliperidone ER*
nebulization syrup	Farxiga	amlodipine/ olmesartan	nifedipine*	gemfibrozil	paroxetine
albuterol sulfate	glimepiride (1mg, 2 mg, 4mg)	amlodipine/ valsartan	nifedipine ER*	lovastatin	paroxetine ER
nebulization tablets	glipizide glipizide	amlodipine/ valsartan/ hctz	nimodipine	niacin ER	perphenazine
albuterol sulfate HFA	ER/XL	atenolol	nisoldipine ER	pravastatin	phenelzine
Arnuity Ellipta	glipizide/ metformin glyburide	atenolol/ chlorthalidone	Nitro-Dur 0.3, 0.8mg/ hr	prevalite*	phenylephrine
Breo	glyburide micronized	benazepril	nitroglycerin	rosuvastatin*	phenytoin
Ellipta	glyburide/ metformin	benazepril/ hctz	nitroglycerin 400 mcg spray*	simvastatin	phenytoin chewable
breynga	Glyxambi	betaxolol	nitroglycerin sublingual tablets	MALARIA	phenytoin ER
budesonide inhalation	Humalog	bisoprolol fumarate	olmesartan	atovaquone/proguanil	phenytoin infatabs
suspension	Humalog Junior KwikPen	bisoprolol fumarate/ hctz	olmesartan/ amlodipine/ hctz	chloroquine	pregabalin*
budesonide/formoterol aerosol	Humalog KwikPen Humalog	bumetanide	olmesartan/ hctz	hydroxychloroquine	primidone
cromolyn nebulization solution	Mix 50/50 Humalog Mix 50/50	candesartan	perindopril	mefloquine	prochlorperazine
elixophyllin	KwikPen	candesartan/ hctz	pindolol*	primaquine	protriptyline*
Flovent	Humalog Mix 75/25	captopril	prazosin	MENTAL HEALTH	quetiapine
Diskus	Humalog Mix 75/25	carvedilol	propranolol	amitriptyline	quetiapine ER*
Flovent HFA	KwikPen	carvedilol ER*	propranolol ER	amoxapine	risperidone ODT*
fluticasone	Humulin 70/30 Humulin	chlorthalidone	quinapril	aripiprazole*	risperidone solution
HFA	70/30 KwikPen Humulin N	clonidine tablets	quinapril/ hctz	aripiprazole ODT*	risperidone tablets
fluticasone diskus (generic for	Humulin N KwikPen	clonidine patches*	ramipril	bupropion	roweepra*
Flovent Diskus) fluticasone/	Humulin R Humulin	digitek	ranolazine ER*	bupropion SR	sertraline
salmeterol HFA (generic for	R KwikPen	digox	sorine*	bupropion XL	subvenite
Advair HFA) fluticasone/	Insulin Glargine (100U/ml) Insulin	digoxin	sotalol*	carbamazepine	thioridazine
salmeterol powder (generic for	Glargine Solostar (100U/ml)	diltiazem	sotalol AF*	carbamazepine ER	thiothixene
Advair Diskus)	Insulin Lispro Insulin	diltiazem CD	spironolactone	chlorpromazine	tiagabine*
fluticasone/ salmeterol powder	Lispro Junior KwikPen	diltiazem ER	spironolactone/ hctz	citalopram solution	topiramate
(generic for Airduo RespiClick)	Insulin Lispro KwikPen Insulin	diit-XR	taztia XT	citalopram tablets	topiramate ER
fluticasone/ vilanterol	Lispro Protamine Janumet	doxazosin	telmisartan	clomipramine	tranylcypromine
formoterol nebulization solution*	Janumet XR	enalapril	telmisartan/ amlodipine	clozapine*	trazodone
levalbuterol nebulization solution*	Januvia	enalapril oral solution*	telmisartan/ hctz	clozapine ODT*	trifluoperazine
levalbuterol HFA	Jardiance	enalapril/ hctz	terazosin	desipramine*	trimipramine
montelukast	Lantus	eplerenone*	tiadylt	desvenlafaxine ER	valproic acid
ProAir RespiClick	Lantus SoloStar	ethacrynic acid tablets*	timolol tablets	Dilantin	venlafaxine
QVAR ReditHaler	Lyumjev	fenpropion acid tablets*	torsemide	divalproex sodium DR, ER	venlafaxine ER 225 mg tablets
Serevent Diskus Spiriva	Lyumjev KwikPen	felodipine ER	trandolapril	doxepin	venlafaxine ER capsules
RespiMat terbutaline injection	metformin (500 mg, 850 mg,	fosinopril sodium	trandolapril/ verapamil	duloxetine*	ziprasidone*
terbutaline tablets Theo- 24	1000 mg)	fosinopril/ hctz	triamterene*	Epitol	zonisamide*
theophylline elixer theophylline	metformin ER (Generic for	furosemide	triamterene/ hctz	escitalopram	OSTEOPOROSIS
solution theophylline ER	Glucophage XR)	guanfacine	valsartan	ethosuximide	alendronate
Trelegy Ellipta	miglitol	hydrochlorothiazide	valsartan/ hctz	felbamate*	amabel
wixela inhub	Mounjaro	indapamide	verapamil	fluoxetine capsules	calcitonin- salmon*
zafirlukast	nateglinide*	irbesartan	verapamil ER	fluoxetine solution	Climara Pro
BLOOD CLOTS AND	Ozempic	irbesartan/ hctz	verapamil SR	fluoxetine tablets	Combipatch
STROKE	pioglitazone	isosorbide dinatrate (40 mg)*	HEART RATE AND	fluoxetine DR	dotti
aspirin-dipyridamole ER Brilinta	pioglitazone/ glimepiride	isosorbide dinitrate	RHYTHM	fluphenazine	estradiol gel
cilostazol* clopidogrel	pioglitazone/ metformin	(5mg, 10 mg, 20	amiodarone	fluvoxamine	estradiol patch
bisulfate dipyridamole*	repaglinide*	mg, 30 mg)	disopyramide*	fluvoxamine ER	estradiol tablets
Eliquis	Rybelsus	isosorbide dinitrate/	flecainide*	gabapentin*	estradiol/ norethindrone
heparin*	Soliqua	hydralazine	mexiletine*	haloperidol solution	Fosamax Plus D
jantoven	SymlinPen	isosorbide mononitrate	Norpace CR	haloperidol tablets	Fyavolv
prasugrel*	Synjardy	isosorbide mononitrate ER	pacerone	imipramine capsules	ibandronate tablets
warfarin	Synjardy XR	isradipine	propafenone*	imipramine tablets	jinteli
Xarelto	Toujeo Max	labetalol	propafenone ER*	imipramine chewable	lyllana
DIABETES	Toujeo SoloStar	lisinopril	quinidine	lamotrigine ER	medroxyprogesterone
<i>Diabetic supplies including blood</i>	Tresiba	lisinopril/ hctz	quinidine CR	lamotrigine ODT	Menest
<i>glucose meters, test strips and</i>	Tresiba Flextouch	losartan	quinidine ER	lamotrigine tablets	mimvey
<i>lancets require a prescription to</i>	Trijardy XR	losartan/ hctz	HIGH CHOLESTEROL	levetiracetam*	norethindrone-ethinyl estradiol
<i>be covered by this plan. Only</i>	Trulicity	matzim LA	atorvastatin	levetiracetam ER*	Premarin tablets
<i>blood glucose meters & blood</i>	Victoza	methazolamide*	atorvastatin/ amlodipine	lithium	Premphase
<i>glucose test strips for</i>	Xigduo XR	methylodopa	cholestyramine*	lithium ER	Prempro
<i>OneTouch and Accu- Chek</i>	Xultophy	metolazone	cholestyramine lite	loxapine	raloxifene
<i>products will be covered by</i>	HEART HEALTH AND	metoprolol succinate ER	colesevelam tablets*	mirtazapine	risedronate
<i>this benefit. Continuous</i>	HIGH BLOOD PRESSURE	metoprolol tartrate	colestipol	mirtazapine ODT	risedronate DR
<i>Glucose Monitors (CGMs) are</i>	acebutolol	metoprolol tartrate/ hctz	ezetimibe*	molindone*	
<i>not included in PreventiveRx</i>	acetazolamide	minoxidil	ezetimibe/ simvastatin*	nefazodone	
<i>Coverage.</i>	acetazolamide ER		fenofibrate (43, 50, 67, 130,	nortriptyline	
				olanzapine*	



"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) 532-3327