Maine Automobile Dealers Association Insurance Trust
Qualified High Deductible Health Plan

HSA Compatible *Value* 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.

Plan	*Value*
Individual Deductible	$6,000
Family Deductible	$12,000

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:

Plan	*Value*
Coinsurance Percentage	80% - 60%
Coinsurance Limit - Individual	$900
Coinsurance Limit - Family	$1,800

Plan	*Value*
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)

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.

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

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	*Value 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.

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
albuterol sulfate nebulization solution
albuterol sulfate nebulization syrup
albuterol sulfate nebulization tablets
albuterol sulfate HFA
Arnuity Ellipta
Breo Ellipta
breyna
budesonide inhalation suspension
budesonide/formoterol aerosol
cromolyn nebulization solution
elixophyllin
Flovent Diskus
Flovent HFA
fluticasone HFA
fluticasone diskus (generic for Flovent Diskus) fluticasone/ salmeterol HFA (generic for Advair HFA) fluticasone/ salmeterol powder (generic for Advair Diskus)
fluticasone/ salmeterol powder (generic for Airduo RespiClick)
fluticasone/ vilanterol
formoterol nebulization solution*
levalbuterol nebulization solution*
levalbuterol HFA
montelukast
ProAir RespiClick
QVAR RediHaler
Serevent Diskus Spiriva Respimat terbutaline injection terbutaline tablets Theo- 24 theophylline elixer theophylline solution theophylline ER
Trelegy Ellipta
wixela inhub
zafirlukast

BLOOD CLOTS AND STROKE
aspirin-dipyridamole ER Brilinta
cilostazol* clopidogrel bisulfate dipyridamole*
Eliquis
heparin*
jantoven
prasugrel*
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 for OneTouch and Accu- Chek products will be covered by this benefit. Continuous Glucose Monitors (CGMs) are not included in PreventiveRx Coverage.
acarbose
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
Farxiga
glimepiride (1mg, 2 mg, 4mg)
glipizide glipizide ER/XL
glipizide/ metformin glyburide
glyburide micronized
glyburide/ metformin Glyxambi
Humalog
Humalog Junior KwikPen
Humalog KwikPen Humalog Mix 50/50 Humalog Mix 50/50 KwikPen
Humalog Mix 75/25
Humalog Mix 75/25 KwikPen
Humulin 70/30 Humulin 70/30 KwikPen Humulin N
Humulin N KwikPen
Humulin R Humulin R KwikPen
Insulin Glargine (100U/ml) Insulin Glargine Solostar (100U/ml)
Insulin Lispro Insulin Lispro Junior KwikPen
Insulin Lispro KwikPen Insulin Lispro Protamine Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus SoloStar
Lyumjev
Lyumjev KwikPen
metformin (500 mg, 850 mg, 1000 mg)
metformin ER (Generic for Glucophage XR)
miglitol
Mounjaro
nateglinide*
Ozempic
pioglitazone
pioglitazone/ glimepiride
pioglitazone/ metformin
repaglinide*
Rybelsus
Soliqua
SymlinPen
Synjardy
Synjardy XR
Toujeo Max
Toujeo SoloStar
Tresiba
Tresiba Flextouch
Trijardy XR
Trulicity
Victoza
Xigduo XR
Xultophy

HEART HEALTH AND HIGH BLOOD PRESSURE
acebutolol
acetazolamide
acetazolamide ER
amiloride*
amiloride/ hctz
amlodipine besylate
amlodipine/ benazepril
amlodipine/ olmesartan
amlodipine/ valsartan
amlodipine/ valsartan/ hctz
atenolol
atenolol/ chlorthalidone
benazepril
benazepril/ hctz
betaxolol
bisoprolol fumarate
bisoprolol fumarate/ hctz
bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia XT
carvedilol
carvedilol ER*
chlorthalidone
clonidine tablets
clonidine patches*
digitek
digox
digoxin
diltiazem
diltiazem CD
diltiazem ER
dilt-XR
doxazosin
enalapril
enalapril oral solution*
enalapril/ hctz
eplerenone*
ethacrynic acid tablets*
felodipine ER
fosinopril sodium
fosinopril/ hctz
furosemide
guanfacine
hydralazine
hydrochlorothiazide
indapamide
irbesartan
irbesartan/ hctz
isosorbide dinatrate (40 mg)*
isosorbide dinitrate (5mg, 10 mg, 20 mg, 30 mg)
isosorbide dinitrate/ hydralazine
isosorbide mononitrate
isosorbide mononitrate ER
isradipine
labetalol
lisinopril
lisinopril/ hctz
losartan
losartan/ hctz
matzim LA
methazolamide*
methyldopa
metolazone
metoprolol succinate ER
metoprolol tartrate
metoprolol tartrate/ hctz
minoxidil
moexipril
nadolol*
nebivolol
nicardipine
nifedipine*
nifedipine ER*
nimodipine
nisoldipine ER
Nitro-Dur 0.3, 0.8mg/ hr
nitroglycerin
nitroglycerin 400 mcg spray*
nitroglycerin sublingual tablets
olmesartan
olmesartan/ amlodipine/ hctz
olmesartan/ hctz
perindopril
pindolol*
prazosin
propranolol
propranolol ER
quinapril
quinapril/ hctz
ramipril
ranolazine ER*
sorine*
sotalol*
sotalol AF*
spironolactone
spironolactone/ hctz
taztia XT
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terazosin
tiadylt
timolol tablets
torsemide
trandolapril
trandolapril/ verapamil
triamterene*
triamterene/ hctz
valsartan
valsartan/ hctz
verapamil
verapamil ER
verapamil SR

HEART RATE AND RHYTHM
amiodarone
disopyramide*
flecainide*
mexiletine*
Norpace CR
pacerone
propafenone*
propafenone ER*
quinidine
quinidine CR
quinidine ER

HIGH CHOLESTEROL
atorvastatin
atorvastatin/ amlodipine
cholestyramine*
cholestyramine lite
colesevelam tablets*
colestipol
ezetimibe*
ezetimibe/ simvastatin*
fenofibrate (43, 50, 67, 130, 134, 150, 200 mg capsules & 48, 54, 145, 160 mg tablets)
fenofibric acid
fluvastatin
gemfibrozil
lovastatin
niacin ER
pravastatin
prevalite*
rosuvastatin*
simvastatin

MALARIA
atovaquone/proguanil
chloroquine
hydroxychloroquine
mefloquine
primaquine

MENTAL HEALTH
amitriptyline
amoxapine
aripiprazole*
aripiprazole ODT*
bupropion
bupropion SR
bupropion XL
carbamazepine
carbamazepine ER
chlorpromazine
citalopram solution
citalopram tablets
clomipramine
clozapine*
clozapine ODT*
desipramine*
desvenlafaxine ER
Dilantin
divalproex sodium DR, ER
doxepin
duloxetine*
Epitol
escitalopram
ethosuximide
felbamate*
fluoxetine capsules
fluoxetine solution
fluoxetine tablets
fluoxetine DR
fluphenazine
fluvoxamine
fluvoxamine ER
gabapentin*
haloperidol solution
haloperidol tablets
imipramine capsules
imipramine tablets
lamotrigine chewable
lamotrigine ER
lamotrigine ODT
lamotrigine tablets
levetiracetam*
levetiracetam ER*
lithium
lithium ER
loxapine
mirtazapine
mirtazapine ODT
molindone*
nefazodone
nortriptyline
olanzapine*
olanzapine ODT*
olanzapine/ fluoxetine
oxcarbazepine
paliperidone ER*
paroxetine
paroxetine ER
perphenazine
phenelzine
phenytek
phenytoin
phenytoin chewable
phenytoin ER
phenytoin infatabs
pregabalin*
primidone
prochlorperazine
protriptyline*
quetiapine
quetiapine ER*
risperidone ODT*
risperidone solution
risperidone tablets
roweepra*
sertraline
subvenite
thioridazine
thiothixene
tiagabine*
topiramate
topiramate ER
tranylcypromine
trazodone
trifluoperazine
trimipramine
valproic acid
venlafaxine
venlafaxine ER 225 mg tablets
venlafaxine ER capsules
ziprasidone*
zonisamide*

OSTEOPOROSIS
alendronate
amabelz
calcitonin- salmon*
Climara Pro
Combipatch
dotti
estradiol gel
estradiol patch
estradiol tablets
estradiol/ norethindrone
Fosamax Plus D
Fyavolv
ibandronate tablets
jinteli
lyllana
medroxyprogesterone
Menest
mimvey
norethindrone-ethinyl estradiol
Premarin tablets
Premphase
Prempro
raloxifene
risedronate
risedronate DR

Anthem Lumenos

Lumenos HSA Plan Summary

"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:

Flores, formerly Group Dynamic, Inc. (800) 532-3327