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

## HSA Compatible Plan Benefit Overview

## *Effective March 1, 2017*

**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

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

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**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.

**Annual Deductible Responsibility***
**$3,600** individual coverage
**$7,200** family coverage ($3,600 individual level)

**** Note: This Plan does not provide 4th quarter carry-over of calendar year deductibles.***

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**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:
**80% for in-network providers** **60% for out-of-network providers**

Your coinsurance is limited, each calendar year, to a maximum of $2,850 individually or $5,700 per family

**Annual Out-of-Pocket Maximum**

| In-Network Providers | Out-of-Network Providers |
|---|---|
| $6,450 individual coverage | $6,450 individual coverage |
| $12,900 family coverage | $12,900 family coverage |

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

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**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 2017 contributions can be made to your HSA up to the following:
**$3,400** individual coverage
**$6,750** 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 $49 (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)

**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:

- 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

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**<br>(Including Contraceptives – deductible and/or copayments may apply)<br><br>**Drug Card Copayment**<br>***This plan uses the Essential Drug List. Drugs not on the list are not covered.***<br>***Tier 1 drugs have the lowest copay while tier 4 drugs have the highest copay. Prior authorization, Step therapy, quantity limits, dose optimization, generic select, half tablet, clinically equivalent medications, specialty split fill, etc… may apply to some medications.***<br>***https://www.anthem.com/pharmacyinformation/*** | On **most** medications, Member must first satisfy the calendar year deductible and then pay a copayment (per 30 day supply) of:<br><br>**$20 tier 1 - $45 tier 2 - $100 tier 3**<br>**25% to $250 maximum per Rx tier 4** (per 30 day supply)<br><br>**All copayments are per 30 day supply except Home Delivery of Tier 1 prescriptions which are (2) copays per 90 day supply**<br><br>***On Preventive Medicines only, calendar year deductible is waived, only copayments are assessed.*** |

## 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 copayment or at low or no cost to you. 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
Advair HFA
albuterol sulfate nebulization soln, syrup, tabs
aminophylline
Arnuity Ellipta
Breo Ellipta
budesonide inhalation suspension
cromolyn sodium nebulization soln
Dulera
dyphylline
dyphylline/ guaifenesin
elixophylline
Flovent Diskus
Flovent HFA
Foradil
levalbuterol nebulization soln
metaproterenol sulfate syrup, tabs
montelukast
Perforomist
ProAir HFA
ProAir RespiClick
QVAR
Serevent Diskus
Spiriva Respimat
terbutaline sulfate injection, tabs
Theo- 24
Theochron
theophylline
zarfirlukast

### Blood clots
Brilinta
Eliquis
heparin
Pradaxa
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
ActoPlusMet XR
Bydureon
Byetta
chlorpropamide
glimepiride
glipizide
glipizide er/xl
glipizide with metformin hcl
glyburide
glyburide with metformin hcl
glyburide, micronized
Glyset
Humalog
Humulin
Janumet
Janumet XR
Januvia
Jardiance
Jentadueto
Juvisync
Lantus
Lantus Solostar
Levemir
Levemir Flexpen
Levemir FlexTouch
metformin hcl
metformin hcl er
nateglinide
pioglitazone
pioglitazone- glimepiride
pioglitazone- metformin
repaglinide
repaglinide- metformin
Symlin
Synjardy
tolazamide
tolbutamide
Tradjenta

### Heart health and high blood pressure
acebutolol hcl
acetazolamide
afeditab cr
amiloride hcl
amiloride/ hctz
amlodipine besylate
amlodipine/ benazepril
amlodipine/ valsartan
amlodipine/ valsartan/ hctz
atenolol
atenolol/ chlorthalidone
benazepril hcl
benazepril hcl/ hctz
betaxolol hcl
Bidil
bisoprolol fumarate
bisoprolol fumarate/ hctz
bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia xt
carvedilol
chlorthiazide
chlorthalidone
clonidine hcl
Clorpres 0.1, 0.2mg
Coreg CR
digitek
digoxin
Dilatrate SR
dilt-cd
diltia XT
diltiazem hcl
diltiazem hcl er
doxazosin mesylate
enalapril maleate
enalapril/ hctz
eplerenone
eprosartan
felodipine er
fosinopril sodium
fosinopril/ hctz
furosemide
guanfacine hcl
hydralazine
hydrochlorothiazide
indapamide
irbesartan
irbesartan/ hctz
Isordil 40mg
isosorbide dinitrate
isosorbide dinitrate er
isosorbide mononitrate
isosorbide mononitrate er
isradipine
labetolol hcl
Lanxoin
lisinopril
lisinopril/ hctz
losartan
losartan/ hctz
Matzim LA
methazolamide
methyclothiazide
methyldopa
methyldopa/ hctz
metolazone
metoprolol succinate er
metoprolol tartrate
metoprolol/ hctz
minoxidil
moexipril hcl
moexipril/ hctz
nadolol
nadolol/ bendroflumethiazide
nicardipine hcl
nifedipine
nifedipine er
nimopidine
nisoldipine
Nitro-Bid
Nitro-Dur 0.3, 0.8mg/ hr
nitroglycerin
nitroglycerin 400 mcg spray
nitroglycerin er
nitroglycerin lingual
nitroglycerin spray
Nitrostat
perindopril
pindolol
prazosin hcl
propranolol hcl
propranolol hcl er
propranolol/ hctz
quinapril hcl
quinapril/ hctz
ramipril
Ranexa
reserpine
sotalol hcl
sotalol hcl af
spironolactone
spironolactone/ hctz
Taztia XT
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terazosin hcl
thalitone
timolol maleate
torsemide
trandolapril
trandolapril/ verapamil
triamterene/ hctz
valsartan
valsartan/ hctz
Valturna
verapamil hcl
verapamil hcl er

### High cholesterol
Advicor
atorvastatin
atorvastatin/ amlodipine
cholestyramine
cholestyramine light
colestipol hcl
fenofibrate (43, 67, 130, 134, 200 mg capsules & 48, 54, 145, 160mg tablets)
fenofibric acid
fluvastatin
gemfibrozil
lovastatin
niacin ER
omega- 3 ethyl ester 1 gm capsule
pravastatin
Prevalite
rosuvastatin
simvastatin
Welchol

### Osteoporosis
alendronate sodium
calcitonin- salmon
Climara Pro
Combipatch
covaryx
covaryx HS
est. estrogens with methyltestosterone
estradiol tab, patch
estradiol/ norethindrone acetate
estropipate
Femtrace
fortical
Fosamax Plus D
ibandronate sodium tablets
Jevantique
Jinteli
medroxyprogesterone acetate
Menest
norethindrone- ethin estradiol
Premarin tablets
Premphase
Prempro
raloxifene
risedronate

### Stroke
aspirin- dipyridamole ER
cilostazol
clopidogrel bisulfate
dipyridamole
Effient
ticlopidine

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.

**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**