




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, visit www.tarohealth.com or call us at 1-833-928-0569. 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/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$9,450/Individual or \$18,900/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Primary Care, Specialist visits, Urgent Care, Mental Health visit, Hab/Rehab, Chiro, Labs, Diagnostic tests, Preventive Care , Advanced Imaging, Tier 1 and Tier 2 Drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$9,450/Individual or \$18,900/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.tarohealth.com or call 1-833-928-0569 for a list of network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral ?	No.	You can see the specialist you choose without a referral .

Important Questions	Answers	Why This Matters:
to see a specialist ?		

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge; Deductible does not apply	Not covered	All primary care services must be provided by a Network Direct Primary Care physician
	Specialist visit	Up to \$200 copay /visit; Deductible does not apply	Not covered	None
	Preventive care/screening/immunization	No Charge; 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)	\$15 copay labs/\$300 copay x-ray; Deductible does not apply	Not covered	Cost sharing driven by provider/setting
	Imaging (CT/PET scans, MRIs)	\$450 copay ; Deductible does not apply	Not covered	Preauthorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.tarohealth.com/	Generic drugs	\$35 copay ; Deductible does not apply	Not covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail cost sharing amount. Narcotics are limited to a 30-day supply.
	Preferred brand drugs	\$215 copay ; Deductible does not apply	Not covered	
	Non-preferred brand drugs	No charge after deductible	Not covered	Your cost for covered insulin drugs will not exceed \$35 per 30-day supply or \$105 per 90-day supply. Preauthorization/step therapy may be required. If you don't get preauthorization payment may be denied
	Specialty drugs	No charge after deductible	Not covered	Limited to a 30-day supply. Preauthorization/step therapy may be required. If you don't get preauthorization payment may be denied

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.tarohealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required
	Physician/surgeon fees	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required
If you need immediate medical attention	Emergency room care	No charge after <u>deductible</u>	No charge after <u>deductible</u>	<u>Out-of-Network</u> Emergency Room services are covered if the services are for an emergency condition
	Emergency medical transportation	No charge after <u>deductible</u>	No charge after <u>deductible</u>	Emergency Transportation services by an <u>Out-of-Network provider</u> are covered if the services are for an emergency condition
	Urgent care	\$100 <u>copay</u> /visit; <u>Deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>Deductible</u> does not apply	When temporarily out of the service area, <u>Out-of-Network Urgent Care</u> services are covered. <u>Cost sharing</u> is driven by provider/setting
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
	Physician/surgeon fees	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> may be required for outpatient non-office services.
	Inpatient services	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
If you are pregnant	Office visits	Up to \$200 <u>copay</u> /visit; <u>Deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	No charge after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	No charge after <u>deductible</u>	Not covered	
If you need help recovering or have other special health	Home health care	No charge after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
	Rehabilitation services	\$200 <u>copay</u> /visit; <u>Deductible</u> does not	Not covered	Hab and Rehab PT and OT is limited to 20 visits per Member per Year, combined. Hab

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
needs		apply		and Rehab ST is limited to a total of 60 total combined visits per Member per Year, combined.	
	Habilitation services	\$200 <u>copay</u> /visit; <u>Deductible</u> does not apply	Not covered		
	Skilled nursing care	No charge after <u>deductible</u>	Not covered		150 Days per Benefit Period. <u>Preauthorization</u> is required
	Durable medical equipment	No charge after <u>deductible</u>	Not covered		<u>Preauthorization</u> may be required
	Hospice services	No charge after <u>deductible</u>	Not covered		Respite care covered for up to a 48-hour period. <u>Preauthorization</u> is required
If your child needs dental or eye care	Children's eye exam	No charge; <u>Deductible</u> does not apply	Not covered	Limited to one exam per Year	
	Children's glasses	No charge; <u>Deductible</u> does not apply	Not covered	Child frames and lenses or contact lenses covered once every 24 months.	
	Children's dental check-up	Not Covered	Not covered	Pediatric dental coverage can be purchased separately as a stand-alone policy	

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"> Acupuncture Long-Term Care Routine Eye Care (Adult) 	<ul style="list-style-type: none"> Cosmetic Surgery Non-emergency care when traveling outside the U.S. Routine Foot Care 	<ul style="list-style-type: none"> Dental Care (Adult) Private Duty Nursing 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 Hearing Aids (1 hearing aid per ear every 3 years; up to \$3,000 per ear for members to age 19) 	<ul style="list-style-type: none"> Bariatric Surgery (limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty) Infertility Treatment 	<ul style="list-style-type: none"> Chiropractic Care (40 visits per 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 Anthem 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 CoverMe.gov. For more information about the 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: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000 Consumers for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490, (800) 965-7476, www.maine cahc.org, consumerhealth@maine cahc.org.

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 Standards? Not Applicable

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-928-0569.

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

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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	\$9,450
■ Specialist copayment	\$200
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*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	\$8,800
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$9,450

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$9,450
■ Specialist copayment	\$200
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$800
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The plan's overall deductible	\$9,450
■ Specialist copayment	\$200
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$2,000
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.