



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, <https://eoc.anthem.com/eocdps/9VALIND01012024>. 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 (855) 738-6674 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$8,500/person or \$17,000/family for Non-IHCP In- Network Providers . | 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. All services for Indian Health Care Providers (IHCP). Primary Care Specialist Visit Preventive Care for Non-IHCP Providers . Certain Prescription Drugs for Non-IHCP Providers . Vision for Non-IHCP Providers . For more information see below. | 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/person or \$18,900/family for Non-IHCP In- Network Providers . | 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 charges, 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 | Yes, Maine HMO Tiered | This plan uses a provider network . You will pay less if you use a provider in the plan's |

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| you use a network provider ? | Options. See www.anthem.com or call (855) 738-6674 for a list of network providers . Lower cost shares may apply when using a Value Based Provider*. Costs may vary by site of service and how the provider bills. | 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 for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the 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 |
|--|---|--|---|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No charge for the first visit, then \$50/visit deductible does not apply | Not covered | Preferred Network No charge for the first visit, then \$20/visit deductible does not apply. Virtual visits (Telehealth) benefits available. |
| | Specialist visit | No charge | \$110/visit deductible does not apply | Not covered | Preferred Network \$60/visit deductible does not apply. Virtual visits (Telehealth) benefits available. |
| | Preventive care / screening /immunization | No charge | No charge | 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) | Lab – Office No charge X-Ray – Office No charge | Lab – Office Same as In- Network Tier 1 X-Ray – Office 50% coinsurance | Lab – Office Not covered X-Ray – Office Not covered | Preferred Network \$15/service deductible does not apply for Lab. Preferred Network 35% coinsurance for X-Ray. |
| | Imaging (CT/PET scans, MRIs) | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . |

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9VALIND01012024>.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ | Typically Generic (Tier 1) | No charge | Level 1 \$20/prescription, deductible does not apply (retail) and \$50/prescription, deductible does not apply (home delivery) Level 2 \$35/prescription, deductible does not apply (retail only) | Not covered (retail and home delivery) | For more information, refer to “Select Drug List” at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section. |
| | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | No charge | Level 1 \$50/prescription, deductible does not apply (retail) and \$150/prescription, deductible does not apply (home delivery) Level 2 \$60/prescription, deductible does not apply (retail only) | Not covered (retail and home delivery) | |
| | Typically Non-Preferred Brand (Tier 3) | No charge | Level 1 40% coinsurance (retail and home delivery) Level 2 50% coinsurance (retail only) | Not covered (retail and home delivery) | |
| | Typically Specialty (brand and generic) (Tier 4) | No charge | Level 1 40% coinsurance | Not covered (retail and home delivery) | |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| | | | (retail and home delivery) Level 2 50% coinsurance (retail only) | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . Same as In- Network Tier 1 for Ambulatory Surgical Center. |
| | Physician/surgeon fees | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . |
| If you need immediate medical attention | Emergency room care | No charge | Same as In- Network Tier 1 | Same as In- Network Tier 1 | Preferred Network 35% coinsurance . |
| | Emergency medical transportation | No charge | Same as In- Network Tier 1 | Same as In- Network Tier 1 | Preferred Network 35% coinsurance . Non-emergency non- network Ambulance Services are limited to \$50,000 per trip. |
| | Urgent care | No charge | Same as In- Network Tier 1 | Same as In- Network Tier 1 | Preferred Network \$55/visit deductible does not apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . 150 days/year for Inpatient rehabilitation for Indian Health Care Providers (IHCP) and Non-IHCP In- Network Providers combined. |
| | Physician/surgeon fees | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit No charge Other Outpatient No charge | Office Visit No charge for the first visit, then \$50/visit deductible does not apply Other Outpatient 50% coinsurance | Office Visit Not covered Other Outpatient Not covered | Office Visit Preferred Network No charge for the first visit, then \$20/visit deductible does not apply. Virtual visits (Telehealth) benefits available. Other Outpatient Preferred Network 35% coinsurance . |
| | Inpatient services | No charge | 50% coinsurance | Not covered | -----none----- Preferred Network 35% coinsurance . |
| If you are pregnant | Office visits | No charge | 50% coinsurance | Not covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge | 50% coinsurance | Not covered | |
| | Childbirth/delivery facility services | No charge | 50% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No charge | 50% coinsurance | Not covered | -----none----- Preferred Network 35% coinsurance . |
| | Rehabilitation services | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . *See Therapy Services section. |
| | Habilitation services | No charge | 50% coinsurance | Not covered | |
| | Skilled nursing care | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . 150 days/year for skilled nursing services for Indian Health Care Providers (IHCP) and Non-IHCP In- Network Providers combined. |
| | Durable medical equipment | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . *See Durable Medical Equipment Section. |
| | Hospice services | No charge | 50% coinsurance | Not covered | Preferred Network 35% coinsurance . |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|---|---|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-Of-Network Provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | Not covered | *See Vision Services section. |
| | Children's glasses | No charge | No charge | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | -----none----- |

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 • Dental care (Adult) • Private-duty nursing • Weight loss programs | <ul style="list-style-type: none"> • Children's dental check-up • 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 |
|--|--|---|

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 (including Non-Hyde Abortion Services) • Hearing aids 1 item(s) every 36 months | <ul style="list-style-type: none"> • Bariatric surgery for morbid obesity only • Infertility treatment | <ul style="list-style-type: none"> • Chiropractic care 40 visits/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 the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

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:

ATTN: Grievances and Appeals, P.O. Box 218, North Haven, CT 06473-0218

Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9VALIND01012024>.

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](#).

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

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 | \$6,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 35% |
| ■ Other copayment | \$15 |

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 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$60 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 35% |
| ■ Other copayment | \$15 |

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 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|-------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$20 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 35% |
| ■ Other copayment | \$15 |

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 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without [referral](#) from an IHCP your costs may be higher.

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 738-6674

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 738-6674 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 738-6674.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 738-6674:

Bassa (Bàsɔ̀ Wùdù): M̐ dyi dyi-diè-djé bě bédjé bá céè-djé nià kɛ dyí ní, ɔ m̀ò nì dyí-bédjéìn-djé bɛ̀ m̀ kɛ gbo-kpá-kpá kè b̃́ kp̃́ djé m̀ bídí-wùdùùn b́ó pídýi. Bɛ̀ m̀ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (855) 738-6674.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 738-6674 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 738-6674 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 738-6674。

Dinka (Dinka): Na n̄ɔŋ thiēēc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol (855) 738-6674.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 738-6674.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 738-6674 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 738-6674.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 738-6674.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 738-6674.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 738-6674.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 738-6674.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 738-6674 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 738-6674.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 738-6674.

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