**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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. | 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?** | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not Applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| 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 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 | None |
| | Specialist visit | No Charge | No Charge | None |
| | Preventive care/screening/ immunization | No Charge | No Charge | 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) | No Charge | No Charge | Cost sharing driven by provider/setting |
| | Imaging (CT/PET scans, MRIs) | No Charge | No Charge | 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 | No Charge | No Charge | 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. Your cost for a 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 |
| | Preferred brand drugs | No Charge | No Charge | |
| | Non-preferred brand drugs | No Charge | No Charge | |
| | Specialty drugs | No Charge | No Charge | Limited to a 30-day supply. Preauthorization/step therapy may be required. If you don't get preauthorization payment may be denied |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | Preauthorization may be required |
| | Physician/surgeon fees | No Charge | No Charge | Preauthorization may be required |
| **If you need immediate medical attention** | Emergency room care | No Charge | No Charge | Out-of-Network Emergency Room services are covered if the services are for an emergency condition |
| | Emergency medical transportation | No Charge | No Charge | Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition |

| 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 Provider (You will pay the most) | |
| | Urgent care | No Charge | No Charge | When temporarily out of the State, Out-of-Network Urgent Care services are covered. Cost sharing is driven by provider/setting |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | No Charge | Preauthorization is required |
| | Physician/surgeon fees | No Charge | No Charge | Preauthorization is required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | No Charge | Preauthorization may be required for outpatient non-office services. |
| | Inpatient services | No Charge | No Charge | Preauthorization is required |
| **If you are pregnant** | Office visits | No Charge | No Charge | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) |
| | Childbirth/delivery professional services | No Charge | No Charge | |
| | Childbirth/delivery facility services | No Charge | No Charge | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge | Preauthorization is required |
| | Rehabilitation services | No Charge | No Charge | Rehabilitation services and Habilitation services for physical therapy and occupational therapy are limited to 20 visits per year, combined. Rehabilitation services and Habilitation services for speech therapy are limited to 20 visits per year, combined. Cost sharing is driven by provider/setting. Visit limits do not apply to treatment of Autism Spectrum Disorder |
| | Habilitation services | No Charge | No Charge | |
| | Skilled nursing care | No Charge | No Charge | 150 Days per Benefit Period. Preauthorization is required |
| | Durable medical equipment | No Charge | No Charge | Cost sharing for prosthetic devices to replace arms and legs, in whole or in part, is 20% coinsurance. Preauthorization may be required |

| 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 Provider (You will pay the most) | |
| | Hospice services | No Charge | No Charge | Respite care covered for up to a 48-hour period. Preauthorization is required |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Limited to one exam per Year |
| | Children's glasses | No Charge | No Charge | Child frames and lenses or contact lenses covered once every 24 months. |
| | Children's dental check-up | No Charge | No Charge | 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.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion
- Bariatric Surgery (limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty)
- Chiropractic Care (40 visits per Year)
- Hearing Aids (1 hearing aid per ear every 3 years; up to $3,000 per ear for members over age 18)

**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.mainecahc.org, consumerhealth@mainecahc.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.*

## 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 | $0 |
| Specialist *copayment* | $0 |
| 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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

### Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *copayment* | $0 |
| 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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

### Mia's Simple Fracture

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *copayment* | $0 |
| 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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

The plan would be responsible for the other costs of these EXAMPLE covered services.