**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/9V69IND01012024. 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?** | $3,500/person or $7,000/family for Tier 1 In-Network Providers. $4,100/person or $8,200/family for Tier 2 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. Primary Care. Preventive Care. Certain Prescription Drugs. Vision. 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?** | $9,100/person or $18,200/family for Tier 1 In-Network Providers and Tier 2 In-Network Providers combined. | 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 you use a network provider?** | Yes. See www.anthem.com/find-care/?alphaprefix=MAN or call (855) 738-6674 for a list of network providers. Lower cost shares may apply when using a | You pay the least if you use a provider in Tier 1 In-Network. You pay more if you use a provider in Tier 2 In-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 |

| | | |
|---|---|---|
| | Value Based Provider*. Costs may vary by site of service and how the provider bills. | 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 |
|---|---|---|---|---|---|
| | | Tier 1 In-Network Provider (You will pay the least) | Tier 2 In-Network Provider (You will pay more) | 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 for the first visit, then $40/visit deductible does not apply | No charge for the first visit, then $60/visit deductible does not apply | Not covered | Virtual visits (Telehealth) benefits available. |
| | Specialist visit | $80/visit deductible does not apply | $110/visit | Not covered | 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 $15/service deductible does not apply X-Ray – Office 40% coinsurance | Lab – Office Same as In-Network Tier 1 X-Ray – Office 50% coinsurance | Lab – Office Not covered X-Ray – Office Not covered | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is | Typically Generic (Tier 1) | $25/prescription, deductible does not apply (retail) and $62.50/prescription , deductible does not apply (home delivery) | $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 |

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9V69IND01012024.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 In-Network Provider (You will pay the least) | Tier 2 In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| available at http://www.anthem.com/pharmacyinformation/ | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | $50/prescription, deductible does not apply (retail) and $150/prescription, deductible does not apply (home delivery) | $60/prescription, deductible does not apply (retail only) | Not covered (retail and home delivery) | |
| | Typically Non-Preferred Brand and Generic drugs (Tier 3) | $100/prescription (retail) and $300/prescription (home delivery) | $150/prescription (retail only) | Not covered (retail and home delivery) | |
| | Typically Preferred Specialty (brand and generic) (Tier 4) | $250/prescription (retail and home delivery) | $300/prescription (retail only) | Not covered (retail and home delivery) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | 50% coinsurance | Not covered | $300/visit deductible does not apply for Ambulatory Surgical Center. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | Same as In-Network Tier 1 | Same as In-Network Tier 1 | --------none-------- |
| | Emergency medical transportation | 40% coinsurance | Same as In-Network Tier 1 | Same as In-Network Tier 1 | Non-emergency non-network Ambulance Services are limited to $50,000 per trip. |
| | Urgent care | $40/visit deductible does not apply | Same as In-Network Tier 1 | Same as In-Network Tier 1 | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | Not covered | 150 days/year for Inpatient rehabilitation for Tier 1 In-Network and Tier 2 In-Network Providers combined. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9V69IND01012024.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 In-Network Provider (You will pay the least) | Tier 2 In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit<br>No charge for the first visit, then $40/visit<br>deductible does not apply<br>Other Outpatient<br>40% coinsurance | Office Visit<br>No charge for the first visit, then $60/visit<br>deductible does not apply<br>Other Outpatient<br>50% coinsurance | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>--------none-------- |
| | Inpatient services | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |
| **If you are pregnant** | Office visits | 40% coinsurance | 50% coinsurance | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 40% coinsurance | 50% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 40% coinsurance | 50% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |
| | Rehabilitation services | $40/visit<br>deductible does not apply | $60/visit<br>deductible does not apply | Not covered | *See Therapy Services section. |
| | Habilitation services | $40/visit<br>deductible does not apply | $60/visit<br>deductible does not apply | Not covered | |
| | Skilled nursing care | 40% coinsurance | 50% coinsurance | Not covered | 150 days/year for skilled nursing services for Tier 1 In-Network and Tier 2 In-Network Providers combined. |
| | Durable medical equipment | 40% coinsurance | 50% coinsurance | Not covered | *See Durable Medical Equipment Section |
| | Hospice services | 40% coinsurance | 50% coinsurance | Not covered | --------none-------- |
| **If your child needs dental or eye care** | Children's eye exam | Not Applicable | No charge | Not covered | *See Vision Services section |
| | Children's glasses | Not Applicable | No charge | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | --------none-------- |

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9V69IND01012024.

## 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
- Dental care (Adult)
- Private-duty nursing
- Weight loss programs
- Children's dental check-up
- Long-term care
- Routine eye care (Adult)
- 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.)**

- Abortion (including Non-Hyde Abortion Services)
- Hearing aids 1 item(s) every 36 months
- Bariatric surgery for morbid obesity only
- Infertility treatment
- 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

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.

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9V69IND01012024.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9V69IND01012024.

## 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 | $3,500 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| 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 | $3,500 |
| Copayments | $300 |
| Coinsurance | $3,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,060** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $3,500 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| 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 | $1,900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,920** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $3,500 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| 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 | $2,100 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,500** |

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 (Bǎsɔ́ɔ̀ Wùdù):** Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dɔ̀ gbo wùdù kɛ, dá (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 အခမဲ့ကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (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 nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (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** (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای 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):** Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 738-6674.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 738-6674.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 738-6674.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 738-6674

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (855) 738-6674 にお電話ください。

## Language Access Services:

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