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?	$4,000/Individual or $8,000/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. Preventive Care	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?	$7,000/Individual or $14,000/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 to see a specialist?	No.	You can see the specialist you choose without a referral.

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	20% coinsurance after deductible	Not covered	None
	Specialist visit	20% coinsurance after deductible	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)	20% coinsurance after deductible	Not covered	Cost sharing driven by provider/setting
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	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	$25 copay after deductible	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. 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	$50 copay after deductible	Not covered	
	Non-preferred brand drugs	$100 copay after deductible	Not covered	
	Specialty drugs	$250 copay 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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	Preauthorization may be required
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Preauthorization may be required
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Out-of-Network Emergency Room services are covered if the services are for an

* 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)	
				emergency condition
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	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)	20% coinsurance after deductible	Not covered	Preauthorization is required
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Preauthorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not covered	Preauthorization may be required for outpatient non-office services.
	Inpatient services	20% coinsurance after deductible	Not covered	Preauthorization is required
If you are pregnant	Office visits	20% coinsurance after deductible	Not covered	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	20% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	Preauthorization is required
	Rehabilitation services	20% coinsurance after deductible	Not covered	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	20% coinsurance after deductible	Not covered	

* 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)	
	Skilled nursing care	20% coinsurance after deductible	Not covered	150 Days per Benefit Period. Preauthorization is required
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization may be required
	Hospice services	20% coinsurance after deductible	Not covered	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; Deductible does not apply	Not covered	Limited to one exam per Year
	Children's glasses	No charge; Deductible 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.)

- Acupuncture
- Infertility Treatment
- Private Duty Nursing
- Weight Loss Programs
- Cosmetic Surgery
- Long-Term Care
- Routine Eye Care (Adult)
- Dental Care (Adult)
- 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
- Hearing Aids (1 hearing aid per ear every 3 years; up to $3,000 per ear for members over age 18)
- Bariatric Surgery (limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty)
- 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.mainecahc.org,

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

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	$4,000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$4,000
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,770**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$4,000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$4,000
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,290**

Mia's Simple Fracture

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

The plan's overall deductible	$4,000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$2,800
Copayments	$0
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.

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