



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 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$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, Preventive Care, Tier 1 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 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 |
|---|--|----------------------------------|--|---|---|
| | | 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 | \$50 <u>copay</u> ; <u>Deductible</u> does not apply | Not covered | <u>Cost sharing</u> begins after the first visit. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | <u>Specialist</u> visit | No Charge | \$80 <u>copay</u> /visit; <u>Deductible</u> does not apply | Not covered | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | <u>Preventive care/screening</u> /immunization | No Charge | No Charge; <u>Deductible</u> does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | No charge after <u>deductible</u> | Not covered | <u>Cost sharing</u> driven by provider/setting. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Imaging (CT/PET scans, MRIs) | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.tarohealth.com/ | Generic drugs | No Charge | \$30 <u>copay</u> ; <u>Deductible</u> 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 <u>cost sharing</u> amount. Narcotics are limited to a 30-day supply. Your cost for a covered insulin drug will not exceed \$35 per 30-day supply or \$105 per 90-day supply. <u>Preauthorization</u> /step therapy may be required. If you don't get <u>preauthorization</u> payment may be |
| | Preferred brand drugs | No Charge | No charge after <u>deductible</u> | Not covered | |
| | Non-preferred brand drugs | No Charge | No charge after <u>deductible</u> | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|----------------------------------|--|---|---|
| | | 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) | |
| | | | | | denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Specialty drugs | No Charge | No charge after <u>deductible</u> | Not covered | Limited to a 30-day supply. <u>Preauthorization</u> /step therapy may be required. If you don't get <u>preauthorization</u> payment may be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Physician/surgeon fees | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If you need immediate medical attention | Emergency room care | No Charge | 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. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Emergency medical transportation | No Charge | 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. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Urgent care | No Charge | \$50 <u>copay</u> ; <u>Deductible</u> does not apply | \$50 <u>copay</u> ; <u>Deductible</u> does not apply | When temporarily out of the State, <u>Out-of-Network Urgent Care</u> services are covered. <u>Cost sharing</u> is driven by provider/setting. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |

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|---|---|----------------------------------|--|---|--|
| | | 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 have a hospital stay | Facility fee (e.g., hospital room) | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Physician/surgeon fees | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | \$50 <u>copay</u> ; <u>Deductible</u> does not apply | Not covered | <u>Preauthorization</u> may be required for outpatient non-office services. Outpatient Mental Health Office Visit <u>cost sharing</u> applies for services to treat Autism. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Inpatient services | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If you are pregnant | Office visits | No Charge | \$80 <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). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Childbirth/delivery professional services | No Charge | No charge after <u>deductible</u> | Not covered | |
| | Childbirth/delivery facility services | No Charge | No charge after <u>deductible</u> | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Rehabilitation services | No Charge | \$50 <u>copay</u> ; <u>Deductible</u> does not apply | Not covered | Rehabilitation services and Habilitation services for physical therapy and occupational therapy are limited to 20 visits per year, combined. |
| | Habilitation services | No Charge | \$50 <u>copay</u> ; | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|---|---|
| | | 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) | |
| | | | <u>Deductible</u> does not apply | | Rehabilitation services and Habilitation services for speech therapy are limited to 20 visits per year, combined. <u>Cost sharing</u> is driven by provider/setting. Visit limits do not apply to treatment of Autism Spectrum Disorder. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Skilled nursing care | No Charge | No charge after <u>deductible</u> | Not covered | 150 Days per Benefit Period. <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Durable medical equipment | No Charge | No charge after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Hospice services | No Charge | No charge after <u>deductible</u> | Not covered | Respite care covered for up to a 48-hour period. <u>Preauthorization</u> is required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| If your child needs dental or eye care | Children's eye exam | No Charge | No charge; <u>Deductible</u> does not apply | Not covered | Limited to one exam per Year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Children's glasses | No charge; <u>Deductible</u> does not apply | No charge; <u>Deductible</u> does not apply | Not covered | Child frames and lenses or contact lenses covered once every 24 months. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Children's dental check-up | Not Covered | 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.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 | \$80 |
| ■ 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 | \$9,450 |
| ■ Specialist copayment | \$80 |
| ■ 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 | \$9,450 |
| ■ Specialist copayment | \$80 |
| ■ 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 |

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 a [referral](#) from an IHCP your costs may be higher.

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

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