




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/9VAUIND01012024>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 330-1097 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,500/person or \$7,000/family for Tier 1 In- <a href="#">Network Providers</a> . \$4,100/person or \$8,200/family for Tier 2 In- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care. <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . Vision. For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,100/person or \$18,200/family for Tier 1 In- <a href="#">Network Providers</a> and Tier 2 In- <a href="#">Network Providers</a> combined.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=MEB">www.anthem.com/find-care/?alphaprefix=MEB</a> or call (855) 330-1097 for a list of <a href="#">network providers</a> . Lower cost shares may apply when using a	You pay the least if you use a <a href="#">provider</a> in Tier 1 In- <a href="#">Network</a> . You pay more if you use a <a href="#">provider</a> in Tier 2 In- <a href="#">Network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before

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	Value Based Provider*. Costs may vary by site of service and how the <a href="#">provider</a> bills.	you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge for the first visit, then \$40/visit <a href="#">deductible</a> does not apply	No charge for the first visit, then \$60/visit <a href="#">deductible</a> does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$80/visit <a href="#">deductible</a> does not apply	\$110/visit	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab – Office \$15/visit <a href="#">deductible</a> does not apply X-Ray – Office 40% <a href="#">coinsurance</a>	Lab – Office Same as In- <a href="#">Network</a> Tier 1 X-Ray – Office 50% <a href="#">coinsurance</a>	Lab – Office Not covered X-Ray – Office Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is	Typically Generic (Tier 1)	\$25/prescription, <a href="#">deductible</a> does not apply (retail) and \$62.50/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$35/prescription, <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	For more information, refer to “Select Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug section

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9VAUIND01012024>.

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 <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$150/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$60/prescription, <a href="#">deductible</a> 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 <a href="#">Specialty</a> (brand and generic) (Tier 4)	\$250/prescription (retail and home delivery)	\$300/prescription (retail only)	Not covered (retail and home delivery)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	\$300/visit <a href="#">deductible</a> does not apply for Ambulatory Surgical Center.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	Same as In- <a href="#">Network</a> Tier 1	Same as In- <a href="#">Network</a> Tier 1	-----none-----
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	Same as In- <a href="#">Network</a> Tier 1	Same as In- <a href="#">Network</a> Tier 1	Non-emergency Non- <a href="#">Network</a> Ambulance Services are limited to \$50,000 per trip.
	<a href="#">Urgent care</a>	\$40/visit <a href="#">deductible</a> does not apply	Same as In- <a href="#">Network</a> Tier 1	Same as In- <a href="#">Network</a> Tier 1	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	150 days/year for Inpatient rehabilitation for Tier 1 In- <a href="#">Network</a> and Tier 2 In- <a href="#">Network Providers</a> combined.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	-----none-----

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9VAUIND01012024>.

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 No charge for the first visit, then \$40/visit <a href="#">deductible</a> does not apply Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit No charge for the first visit, then \$60/visit <a href="#">deductible</a> does not apply Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	-----none-----
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	\$40/visit <a href="#">deductible</a> does not apply	\$60/visit <a href="#">deductible</a> does not apply	Not covered	*See Therapy Services section.
	<a href="#">Habilitation services</a>	\$40/visit <a href="#">deductible</a> does not apply	\$60/visit <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	150 days/year for skilled nursing services for Tier 1 In- <a href="#">Network</a> and Tier 2 In- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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/9VAUIND01012024>.

## 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](http://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.maine cahc.org](http://www.maine cahc.org), [consumerhealth@maine cahc.org](mailto: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](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,060</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>

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) 330-1097

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 330-1097 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) 330-1097.

**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) 330-1097:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄èdjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-ziiin-nyò d̀ò gbo wùdù ke, d̀á (855) 330-1097.

**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) 330-1097 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 330-1097 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) 330-1097。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 330-1097.

**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) 330-1097.

**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) 330-1097 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) 330-1097.

**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) 330-1097.

**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) 330-1097.

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