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://www.maine.gov/bhr/oeh. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-844-273-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600/individual or $1,200/family for network providers. $3,000/individual or $6,000/family for out-of-network providers.	Generally, you must pay all of the costs from providers up to the calendar year 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 and vision exam for network providers.	This plan covers some items and services even if you haven't yet met the calendar year 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 a separate deductible for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,000/individual or $4,000/family; for out-of-network providers $5,000/individual or $10,000/family.	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drugs, 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 or call 1-844-273-4614 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. Note, some specialists may require a referral regardless of plan rules.

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 copay/office visit	40% coinsurance	None
	Specialist visit	$40 copay/office visit	40% coinsurance	Specialist network office visit copay for mental health, behavioral health and substance abuse services $20. (See page 3.) Spinal manipulation office visits limited to 25 visits per calendar year. Referrals not required.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Routine eye exam limited to one per calendar year. Mammograms: No charge for screening, medically necessary, 2D & 3D. No charge for out-of-network providers. Colonoscopy (screening & medically necessary): No charge for prep age 40 and over. Nutritional counseling; unlimited visits & no diagnosis required. Tobacco cessation counseling visits unlimited. Hepatitis C Virus (HCV) test for people at high risk for infection and a one-time screening for adults born between 1945 and 1965. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

For more information about limitations and exceptions, see plan or policy document at www.maine.gov/bhr/oeh/.

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 have a test	Diagnostic test (lab work & imaging)	For independent facilities no charge; all other network providers 10% coinsurance	40% coinsurance	See above for preventive screening coverage. Not all providers perform the same services. To find a provider www.anthem.com or call Anthem Member Services 1-844-273-4614.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or by calling Express Scripts Member Services at 1-800-595-0817	Generic drugs (Tier 1)	$10 copay/prescription for up to a 30-day supply $15 copay/prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted network cost less applicable copay.	Livongo Diabetes Management: Blood glucose meter, strips & lancets covered 100% (no cost to member). Livongo Member Support 1-800-945-4355 or visit www.welcome.livongo.com/STATEOFME First two 90-day treatment regimens for certain tobacco cessation prescription drugs and over-the-counter drugs are covered 100% when obtained from a network pharmacy. Lifestyle medications (impotency/infertility) are covered at $50 copay for up to a 30-day supply and $75 copay for up to a 90-day supply. Individual lifetime fertility cap: $10,000. Prescription out-of-pocket maximum limits are $4,600 (individual) and $9,200 (family).
	Preferred brand drugs (Tier 2)	$30 copay/prescription for up to a 30-day supply $45 copay/prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted network cost less applicable copay.	
	Non-preferred brand drugs (Tier 3)	$45 copay/prescription for up to a 30-day supply $70 copay/prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted network cost less applicable copay.	
	Specialty drugs must be filled through Accredo Specialty Pharmacy 1-800-803-2523	25% coinsurance ($150 max) for up to a 30-day supply	n/a	

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)	
		25% coinsurance ($225 max) for up to a 90-day supply		
If you have outpatient surgery	Facility fee	For ambulatory surgery center 5% coinsurance; all other network providers 10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care & urgent care	$300 copay/visit	$300 copay/visit	If you are hospitalized inpatient status from the emergency room, the emergency room copayment is waived. All Inpatient admissions for emergency services are subject to postadmission review.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Ground, air or water ambulance must be medically necessary.
	Maine-based walk-in center	$25 copay/visit	40% coinsurance	Brighton First Care in Portland, ME is not considered a walk-in center; the copay for this facility would be $300.
	LiveHealth Online	No charge	n/a	Includes board certified doctors and licensed therapists.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-admission review required. If you do not receive preadmission review before you are admitted for non-emergency services, benefits will be reduced by up to $500 for the admission. Facility fees will be waived for certain procedures (e.g. bariatric, cardiac, joint replacement, spine) coordinated through the Carrum Health surgery benefit. Call 1-888-855-7806 for more information.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Physician/surgeon fees will be waived for certain procedures (e.g. bariatric, cardiac, joint replacement, spine) coordinated

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)	
				through the Carrum Health surgery benefit. Call 1-888-855-7806 for more information.
	Travel expenses	Travel expenses are covered for procedures coordinated through the Carrum Health surgery benefit; all other providers not covered	Not covered	Contact Carrum Health at 1-888-855-7806 or visit my.carrumhealth.com/StateOfMaine for more information.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit and 10% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	$20 PCP copay $40 specialist copay	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound). All Inpatient admissions for maternity services are subject to postadmission review.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	None
	Rehabilitation services	$40 copay/visit	40% coinsurance	Cardiac rehabilitation limited to 36 visits per episode.
	Habilitation services	$40 copay/visit	40% coinsurance	None
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 150 days per calendar year.

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)	
	Durable medical equipment	10% coinsurance	40% coinsurance	Automatic Blood Pressure Monitor with Cuff (medical billing code A4670) covered 100% with a prescription from provider and filled with a network durable medical equipment provider. Prosthetics for limb replacement 10% coinsurance (no deductible); 20% coinsurance (no deductible) out-of-network.
	Hospice services	10% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	None

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.)

- Cosmetic Surgery
- Glasses for a child
- Dental Care
- Long Term Care
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes

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

- Acupuncture
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Infertility Treatment
- Hearing Aids

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov or Consumers for Affordable Health Care, Maine Health Insurance Consumer Assistance Program, 1-800-965-7476, www.mainecahc.org. 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.

For more information about limitations and exceptions, see plan or policy document at www.maine.gov/bhr/oeh/.

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 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: Anthem Blue Cross & Blue Shield at 1-844-273-4614 or the Maine Bureau of Insurance at 1-800-300-5000.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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:

TTY/TDD: Dial 711

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 (844) 273-4614。

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 (844) 273-4614.

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 (844) 273-4614.

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 (844) 273-4614

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、(844) 273-4614　　にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 273-4614 로 문의하십시오.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ąh íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíílnih (844) 273-4614.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 273-4614.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (844) 273-4614.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 273-4614.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 273-4614.

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 plan or policy document at https://eoc.anthem.com/eocdps/aso.

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	$600
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$40
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$1,940

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

The plan's overall deductible	$600
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	$6,810

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

The plan's overall deductible	$600
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,890