



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthoptions.org or by calling 1-855-624-6463.

Table with 3 columns: Important Questions, Answers, Why this Matters. Rows include deductible amounts, out-of-pocket limits, annual limits, and network provider information.

Questions: Call 1-855-624-6463 or visit us at www.healthoptions.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.healthoptions.org or call 1-855-624-6463 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event                                   | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|--|--|---|---|---|
| If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness | 30% Coinsurance after deductible            | 70% Coinsurance after deductible                | This plan requires all Members to select a PCP. Members are not permitted to designate an out-of-network provider as a PCP. |
|  | Specialist visit                                 | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None  |
|  | Other practitioner office visit                  | 30% Coinsurance after deductible            | 70% Coinsurance after deductible                | In primary care setting only.   |

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## Community Align (Bronze)

Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individuals & Families | Plan Type: PPO

| Common Medical Event  | Services You May Need                          | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions   |
|---|--|---|---|--|
|   | Preventive care/screening/immunization         | \$0 Co-Pay                                  | 70% Coinsurance after deductible                | When prescribed by a Plan Provider, certain Preventative Care services, as defined in federal law, are covered by the Plan with no Out-of-Pocket Costs for the Member. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements. Refer to your Member Benefit Agreement for more information. |
| If you have a test  | Diagnostic test (x-ray, blood work)            | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|   | Imaging (CT/PET scans, MRIs)                   | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | Certain imaging services require prior authorization   |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.healthoptions.org">www.healthoptions.org</a> . | Generic drugs                                  | 30% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|   | Preferred brand drugs                          | 30% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|   | Non-preferred brand drugs                      | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|   | Specialty drugs                                | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|   | Physician/surgeon fees                         | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |

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## Community Align (Bronze)

Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individuals & Families | **Plan Type:** PPO

| Common Medical Event                           | Services You May Need              | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions   |
|--|------------------------------------|---|---|--|
| <b>If you need immediate medical attention</b> | Emergency room services            | 50% Coinsurance after deductible            | 50% Coinsurance after deductible                | None   |
|  | Emergency medical transportation   | 50% Coinsurance after deductible            | 50% Coinsurance after deductible                | Prior approval is required for non-emergency ambulance transport. Out-of-Network non-emergency ambulance transport has a 70% coinsurance after deductible. |
|  | Urgent care                        | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room) | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |
|  | Physician/surgeon fee              | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | None   |

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**Community Align (Bronze)**

Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individuals & Families | Plan Type: PPO

| Common Medical Event  | Services You May Need                        | Your Cost If You Use an In-network Provider                          | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions   |
|---|--|--|---|--|
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 30% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Cost-sharing is waived for the first 3 outpatient office visits for mental health, behavioral health or substance use services.  |
|   | Mental/Behavioral health inpatient services  | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Non-emergent Inpatient Mental Health Hospital stays require Prior Approval.  |
|   | Substance use disorder outpatient services   | 30% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Cost-sharing is waived for the first 3 outpatient office visits for mental health, behavioral health or substance use services.  |
|   | Substance use disorder inpatient services    | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Non-emergent Inpatient Substance Abuse Hospital stays require Prior Approval.  |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | 50% Coinsurance after deductible except for preventive care services | 70% Coinsurance after deductible                | Pre- and postnatal care that is considered preventive under the Affordable Care Act is covered with no cost-sharing when received in-network. All other care will be subject to the cost sharing listed in the Schedule of Benefits. |
|   | Delivery and all inpatient services          | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | None   |

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Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individuals & Families | Plan Type: PPO

| Common Medical Event  | Services You May Need     | Your Cost If You Use an In-network Provider                          | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions   |
|---|---------------------------|--|---|--|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | A written plan of care is required.  |
|   | Rehabilitation services   | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Benefits are limited to 60 visits per Calendar year for physical, occupational and speech therapy.   |
|   | Habilitation services     | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Benefits are limited to 60 visits per Calendar year for physical, occupational and speech therapy.   |
|   | Skilled nursing care      | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | The benefit is limited to 150 days per member per Calendar year, and Prior Approval is required.   |
|   | Durable medical equipment | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Prior approval is required for DME. Prosthesis designed for athletic purposes are not covered.   |
|   | Hospice service           | 50% Coinsurance after deductible                                     | 70% Coinsurance after deductible                | Prior approval is required   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | 50% Coinsurance after deductible except for preventive care services | 70% Coinsurance after deductible                | Preventive vision screening for all children as specified by the Affordable Care Act is provided with no cost-sharing when received in-network and is limited to one visit per Calendar year. Pediatric eye exams that are not covered under federal guidance as “preventive” are subject to cost-sharing. |

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## Community Align (Bronze)

Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individuals & Families | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|----------------------|-----------------------|---|---|---|
|                      | Glasses               | 50% Coinsurance after deductible            | 70% Coinsurance after deductible                | Eyewear includes standard (CR39) eyeglass lenses with factory scratch coating at no additional cost (up to 55mm), basic frames and contact lenses. Designer and deluxe glasses and frames are excluded. |
|                      | Dental check-up       | \$0 Co-Pay                                  | \$0 Co-Pay                                      | Pediatric Dental coverage is offered in partnership with Northeast Delta Dental. Please see your Member Benefit Agreement for details.  |

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Adult Dental Services
- Food or dietary supplements
- Abortions for which Federal funding is prohibited
- Cosmetic Services
- Medically unnecessary services

#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

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### Your Rights to Continue Coverage:

Federal and State law may provide protections that allow you to keep health coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- Health Options stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue, contact Health Options at 1-855-624-6463. You may also contact the Maine Bureau of Insurance at 800-300-5000 or (in-state) 207-624-8475. You may also visit [www.maine.gov/pfr/insurance](http://www.maine.gov/pfr/insurance).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Options at 1-855-624-6463 or the Maine Bureau of Insurance at 800-300-5000 or (in-state) 207-624-8475. You may also visit [www.maine.gov/pfr/insurance](http://www.maine.gov/pfr/insurance).

Maine’s consumer assistance program can help you file your appeal. Contact: Consumers for Affordable Health Care at 800-965-7476 or visit [www.maine cahc.org](http://www.maine cahc.org). You may also email [consumerhealth@maine cahc.org](mailto:consumerhealth@maine cahc.org).

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$1,080
- Patient pays \$6,460

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$5,500        |
| Copays               | \$0            |
| Coinsurance          | \$960          |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$6,460</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,085
- Patient pays \$315

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |              |
|----------------------|--------------|
| Deductibles          | \$0          |
| Copays               | \$0          |
| Coinsurance          | \$315        |
| Limits or exclusions | \$0          |
| <b>Total</b>         | <b>\$315</b> |

The numbers in "Managing type 2 diabetes" assume the patient is actively participating in all recommended diabetes care. If you have diabetes and do not follow your Provider's plan of care, your costs may be higher.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**NON-DISCRIMINATION NOTICE**

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at [Compliance@healthoptions.org](mailto:Compliance@healthoptions.org); or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Mail: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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| <b>French</b><br>ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)        | <b>Spanish</b><br>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711) | <b>Chinese</b><br>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-624-6463 (TTY/TDD: 711)。   |
| <b>Cushite</b><br>XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)           | <b>Vietnamese</b><br>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)             | <b>Arabic</b><br>لك تتوافر اللغوية المساعدة خدمات فإن اللغة، انكر تتحدث كنت إذا ملحوظة رقم 1-855-624-6463 برقم اتصل بالمجان. هالصم والبيكم: 711 TTY/TDD                      |
| <b>Cambodian, Mon-Khmer</b><br>ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយខ្មែរ, ខ្មែរស្រីឈ្មោះខ្មែរ ខ្មែរមិនគិតថ្លៃសេវាជំនួយភាសាខ្មែរឡើយ។ ទូរស័ព្ទ 1-855-624-6463 (TTY/TDD: 711)។      | <b>Russian</b><br>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телефакс: 711)          | <b>Tagalog</b><br>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711). |
| <b>German</b><br>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711). | <b>Thai</b><br>īขณ: ถ้ำคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).  | <b>Nilotic-Dinka</b><br>PINJ KENE: Na ye jam në Thuonjan, ke kuony yenë koc waar thook atō kuka lëu yök a bac ke cın wënh cuatë piny. Yuopë 1-855-624-6463 (TTY/TDD: 711).   |
| <b>Korean</b><br>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.   | <b>Polish</b><br>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).         | <b>Japanese</b><br>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463 (TTY/TDD: 711) まで、お電話にてご連絡ください。  |