


 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.healthoptions.org](http://www.healthoptions.org) or call 1-855-624-6463. 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 1-855-624-6463 (TTY/TDD:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network</b> - \$7,000/ individual or \$14,000/family; <b>Out-of-Network</b> - \$14,000/individual or \$28,000/family	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. Preventive Care (as defined in your Member Benefit Agreement) and most services that require a <a href="#">copayment</a> .	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> . Refer to your Member Benefit Agreement for more information.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network</b> - \$7,000/individual or \$14,000/family; <b>Out-of-Network</b> - \$15,400/individual or \$30,800/family	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> ?	Premiums, <a href="#">balance billing</a> charges (charges above the <a href="#">allowed amount</a> ), 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.healthoptions.org">www.healthoptions.org</a> or call 1-855-624-6463 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <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 provider's 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 you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 All [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)	
<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	0% Coinsurance after Deductible	20% Coinsurance after Deductible	This plan requires all Members to select a PCP that is a Plan Provider.
	<a href="#">Specialist</a> visit	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Depending on the services provided in a single appointment it is possible you may be financially responsible for copay(s), your deductible, and or coinsurance for one date of service.
	<a href="#">Preventive care/screening/immunization</a>	\$0 Copay	20% Coinsurance after Deductible	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
	Imaging (CT/PET scans, MRIs)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	

\* For more information about limitations and exceptions, see the plan or policy document at HealthOptions.org

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthoptions.org/formulary">www.healthoptions.org/formulary</a>	Preferred generic drugs (Tier 1)	0% Coinsurance after Deductible (retail) and 0% Coinsurance after Deductible (mail order)	20% Coinsurance after Deductible (retail only)	Refer to the Member Benefit Agreement for details on our 90-day mail-order program.
	Generic drugs (Tier 2)	0% Coinsurance after Deductible (retail) and 0% Coinsurance after Deductible (mail order)	20% Coinsurance after Deductible (retail only)	
	Preferred brand drugs (Tier 3)	0% Coinsurance after Deductible (retail) and 0% Coinsurance after Deductible (mail order)	20% Coinsurance after Deductible (retail only)	
	Non-preferred brand drugs (Tier 4)	0% Coinsurance after Deductible (retail) and 0% Coinsurance after Deductible (mail order)	20% Coinsurance after Deductible (retail only)	
	<a href="#">Specialty drugs</a> (Tier 5)	0% Coinsurance after Deductible (retail and mail order)	20% Coinsurance after Deductible (retail only)	Specialty drugs must be filled through our Preferred Specialty Pharmacy or you will be required to pay 100% of the allowed drug cost.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
	Physician/surgeon fees	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% Coinsurance after Deductible	0% Coinsurance after Deductible	None.
	<a href="#">Emergency medical transportation</a>	0% Coinsurance after Deductible	0% Coinsurance after Deductible	None.
	<a href="#">Urgent care</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
	Physician/surgeon fees	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.

\* For more information about limitations and exceptions, see the plan or policy document at [HealthOptions.org](http://HealthOptions.org)

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 need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
	Inpatient services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
If you are pregnant	Office visits	0% Coinsurance after Deductible	20% Coinsurance after Deductible	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery facility services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	None.
	<a href="#">Rehabilitation services</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	PT/OT/ST Benefits are limited to 60 total combined visits per year.
	<a href="#">Habilitation services</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
	<a href="#">Skilled nursing center</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Benefit is limited to 150 days per Member per Calendar Year.
	<a href="#">Durable medical equipment</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.
	<a href="#">Hospice services</a>	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to One 48-hour Respite period, once per lifetime.
If your child needs dental or eye care	Children's eye exam	0% Coinsurance after Deductible	20% 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.
	Children's glasses	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Eyewear includes standard (CR39) eyeglass lenses with factory scratch coating at no additional cost (up to

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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)	
				55mm), basic frames and contact lenses. Designer and deluxe glasses and frames are excluded.
	Children's dental check-up	Not Covered	Not Covered	This Plan does not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source that offers such benefits.

\* For more information about limitations and exceptions, see the plan or policy document at [HealthOptions.org](http://HealthOptions.org)

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Cosmetic Surgery	• Infertility treatment	• Routine foot care
• Covered services provided outside the U.S.	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Abortion for which public funding is prohibited	• Chiropractic care	• Routine eye care (Adult)
• Bariatric surgery	• 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: 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). Other coverage options may be available to you too, including buying individual insurance coverage through the Maine Marketplace. For more information about the Maine Marketplace, visit [www.CoverMe.gov](http://www.CoverMe.gov) or call 1-866-636-0355 TTY: 711

**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: 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).

### Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the Maine 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 Maine 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 [plan's](#) overall [deductible](#) \$7,000
- [Specialist coinsurance](#) 0%
- [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*)

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

Cost Sharing	
Deductibles	\$7,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7,000</b>

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

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist coinsurance](#) 0%
- [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*)

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

Cost Sharing	
Deductibles	\$2,295
Copayments	\$455
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,750</b>

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

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist coinsurance](#) 0%
- [Hospital \(facility\) coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*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:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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