


 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> - \$3,500/ individual or \$7,000/family;<br><b>Out-of-Network</b> - \$9,800/individual or \$19,600/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> - \$7,250/individual or \$14,500/family;<br><b>Out-of-Network</b> - \$18,200/individual or \$36,400/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> . |
|--|-----|--|

 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<br>(You will pay the least)  | Out-of-Network Provider<br>(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       | \$40 Copay  | 50% Coinsurance after Deductible                   | The first visit to your Network PCP is free. This plan requires all Members to select a PCP that is a Plan Provider.  |
|   | <a href="#">Specialist</a> visit                       | \$80 Copay  | 50% 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   | 50% 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)    | 40% Coinsurance after Deductible  | 50% Coinsurance after Deductible                   | None.   |
|   | Imaging (CT/PET scans, MRIs)                           | 40% Coinsurance after Deductible  | 50% Coinsurance after Deductible                   |   |
| <b>If you need drugs to treat your illness or condition</b><br>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)                       | \$5 Copay (retail) and \$10 Copay (mail order)                                      | 50% Coinsurance after Deductible (retail only)     | Refer to the Member Benefit Agreement for details on our 90-day mail-order program.   |
|   | Generic drugs (Tier 2)                                 | \$25 Copay (retail) and \$50 Copay (mail order)                                     | 50% Coinsurance after Deductible (retail only)     |   |
|   | Preferred brand drugs (Tier 3)                         | \$50 Copay (retail) and \$100 Copay (mail order)                                    | 50% Coinsurance after Deductible (retail only)     |   |
|   | Non-preferred brand drugs (Tier 4)                     | \$100 Copay after Deductible (retail) and \$200 Copay after Deductible (mail order) | 50% Coinsurance after Deductible (retail only)     |   |

\* 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<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Specialty drugs</a> (Tier 5)         | \$250 Copay after Deductible (retail and mail order) | 50% 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)   | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
|  | Physician/surgeon fees                           | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | 40% Coinsurance after Deductible                     | 40% Coinsurance after Deductible                   | None.   |
|  | <a href="#">Emergency medical transportation</a> | 40% Coinsurance after Deductible                     | 40% Coinsurance after Deductible                   | None.   |
|  | <a href="#">Urgent care</a>                      | \$40 Copay   | 50% Coinsurance after Deductible                   | None.   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
|  | Physician/surgeon fees                           | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | \$40 Copay   | 50% Coinsurance after Deductible                   | Cost-sharing is waived for the first outpatient MH/BH/SA office visit with a plan provider.   |
|  | Inpatient services                               | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
| <b>If you are pregnant</b>   | Office visits                                    | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .   |
|  | Childbirth/delivery professional services        | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .   |
|  | Childbirth/delivery facility services            | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | None.   |
|  | <a href="#">Rehabilitation services</a>          | 40% Coinsurance after Deductible                     | 50% Coinsurance after Deductible                   | PT/OT/ST Benefits are limited to 60 total combined visits per year.   |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">Habilitation services</a>     | 40% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   |  |
|   | <a href="#">Skilled nursing center</a>    | 40% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Benefit is limited to 150 days per Member per Calendar Year.   |
|   | <a href="#">Durable medical equipment</a> | 40% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.  |
|   | <a href="#">Hospice services</a>          | 40% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Limited to One 48-hour Respite period, once per lifetime.  |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | 40% Coinsurance after Deductible             | 50% 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                        | 40% Coinsurance after Deductible             | 50% 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.  |
|   | 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.   |

## 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](#) \$3,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,500        |
| Copayments                        | \$26           |
| Coinsurance                       | \$3,567        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$7,093</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$122        |
| Copayments                        | \$580        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$702</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,454        |
| Copayments                        | \$245          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,699</b> |

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