
 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 or call (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/ or call (855) 624-6463 (TTY/TDD:711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | In-Network- \$0/individual or \$0/family | Generally, you must pay all of the costs from providers up to the 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 (as defined in your Member Benefit Agreement) and most services that require a copayment . | This plan covers some items and services even if you haven't yet met the 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/ . Refer to your Member Benefit Agreement for more information. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | In-Network- \$0,000/individual or \$0/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums, balance billing charges (charges above the allowed amount), 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.healthoptions.org or call 1-855-624-6463 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 ? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |
|------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

 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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$0 Copay | Not Covered | This plan requires all Members to select a PCP that is a Plan Provider. |
| | Specialist visit | \$0 Copay | Not Covered | 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. |
| | Preventive care/screening/immunization | \$0 Copay | Not Covered | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$0 Copay | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | \$0 Copay | Not Covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.healthoptions.org/Formulary | Preferred generic drugs (Tier 1) | \$0 Copay (retail) and \$0 Copay (mail order) | Not Covered | Refer to the Member Benefit Agreement for details on our mail-order program. |
| | Generic drugs (Tier 2) | \$0 Copay (retail) and \$0 Copay (mail order) | Not Covered | |
| | Preferred brand drugs (Tier 3) | \$0 Copay (retail) and \$0 Copay (mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | \$0 Copay (retail) and \$0 Copay (mail order) | Not Covered | |
| | Specialty drugs (Tier 5) | \$0 Copay (retail and mail order) | Not Covered | Specialty drugs must be filled through our Preferred Specialty Pharmacy or you will be required to pay 100% of the allowed drug cost. |

* 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) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$0 Copay | Not Covered | None. |
| | Physician/surgeon fees | \$0 Copay | Not Covered | None. |
| If you need immediate medical attention | Emergency room care | \$0 Copay | \$0 Copay | None. |
| | Emergency medical transportation | \$0 Copay | \$0 Copay | None. |
| | Urgent care | \$0 Copay | Not Covered | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$0 Copay | Not Covered | None. |
| | Physician/surgeon fees | \$0 Copay | Not Covered | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0 Copay | Not Covered | None. |
| | Inpatient services | \$0 Copay | Not Covered | None. |
| If you are pregnant | Office visits | \$0 Copay | Not Covered | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery professional services | \$0 Copay | Not Covered | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery facility services | \$0 Copay | Not Covered | Cost sharing does not apply for preventive services . |
| If you need help recovering or have other special health needs | Home health care | \$0 Copay | Not Covered | None. |
| | Rehabilitation services | \$0 Copay | Not Covered | PT/OT/ST Benefits are limited to 60 total combined visits per year. |
| | Habilitation services | \$0 Copay | Not Covered | |
| | Skilled nursing center | \$0 Copay | Not Covered | Benefit is limited to 150 days per Member per Calendar Year. |

* 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) | |
| | Durable medical equipment | \$0 Copay | Not Covered | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details. |
| | Hospice services | \$0 Copay | Not Covered | Limited to One 48-hour Respite period, once per lifetime. |
| If your child needs dental or eye care | Children's eye exam | \$0 Copay | Not Covered | 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 Copay | Not Covered | 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. |

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

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 | • Infertility treatment | • Routine foot care |
| • Cosmetic Surgery | • Long-term care | • Weight loss programs |
| • Covered services provided outside the U.S. | • Private-duty nursing | |
| • Dental care (Adult) | | |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan 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. 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 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.

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](#) \$0
- [Specialist copayment](#) \$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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$0 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

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