**Important Questions** | **Answers** | **Why This Matters:**
---|---|---
**What is the overall deductible?** | In-Network - $2,500/individual or $5,000/family; Out-of-Network - $9,500/individual or $19,000/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/](https://www.healthcare.gov/coverage/preventive-care-benefits/) Refer to your Member Benefit Agreement for more information. 

**Are there other deductibles for specific services?** | Yes, $100/child for pediatric dental coverage. | Pediatric Dental Benefits are provided in partnership with Northeast Delta Dental. You must pay all of the costs (except where indicated) for these services up to the specific deductible amount before this plan begins to pay for these services. 

**What is the out-of-pocket limit for this plan?** | In-Network - $5,000/individual or $10,000/family; Out-of-Network - $13,000/individual or $26,000/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](http://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?** | No. | You can see the specialist you choose without a referral.
**All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 Copay</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0 Copay</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs (Tier 1)</td>
<td>$5 Copay (retail) and $10 Copay (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
</tr>
<tr>
<td></td>
<td>Generic drugs (Tier 2)</td>
<td>$25 Copay (retail) and $50 Copay (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 3)</td>
<td>$50 Copay (retail) and $100 Copay (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 4)</td>
<td>30% Coinsurance up to max of $300/script Deductible does not apply (retail) and 30% Coinsurance up to max of $600/script Deductible does not apply (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs (Tier 5)</td>
<td>50% Coinsurance up to max of $600/script Deductible does not apply (retail and mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>30% Coinsurance after Deductible</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% Coinsurance after Deductible</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 Copay</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 Copay</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 Copay</td>
<td>50% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at HealthOptions.org
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td></td>
<td>$30 Copay</td>
<td>50% Coinsurance after Deductible</td>
<td>Benefit is limited to 150 days per Member per Calendar Year.</td>
</tr>
<tr>
<td>Skilled nursing center</td>
<td></td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>Limited to One 48-hour Respite period, once per lifetime.</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>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.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$20 Copay</td>
<td>50% Coinsurance after Deductible</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>30% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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**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
- Cosmetic Surgery
- Covered Emergency services provided outside the U.S.
- Long-term care
- Private-duty nursing
- Dental care (Adult)
- Routine foot care
- Weight loss programs

**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
- Bariatric Surgery
- Chiropractic care
- Hearing Aids
- Infertility Treatment
- Routine eye care (Adult)

**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.

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* For more information about limitations and exceptions, see the plan or policy document at HealthOptions.org
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: $2,500
- Specialist copayment: $50
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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: $2,500
Copayments: $0
Coinsurance: $2,500

What isn’t covered
Limits or exclusions: $0
The total Peg would pay is: $5,000

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

- The plan’s overall deductible: $2,500
- Specialist copayment: $50
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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: $159
Copayments: $544
Coinsurance: $0

What isn’t covered
Limits or exclusions: $0
The total Joe would pay is: $703

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

- The plan’s overall deductible: $2,500
- Specialist copayment: $50
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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: $2,090
Copayments: $275
Coinsurance: $0

What isn’t covered
Limits or exclusions: $0
The total Mia would pay is: $2,365

The plan would be responsible for the other costs of these EXAMPLE covered services.