



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> - \$2,500/individual or \$5,000/family	Generally, you must pay all of the costs from providers 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 preventive services without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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> - \$7,150/individual or \$14,300/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> ?	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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 Copay	Not Covered	This plan requires all Members to select a PCP that is a Plan Provider. 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.
	<a href="#">Specialist</a> visit	40% coinsurance after deductible	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	\$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	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% coinsurance after deductible	Not Covered	
	Imaging (CT/PET scans, MRIs)	40% coinsurance after deductible	Not Covered	
If you need drugs to treat your illness or condition 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	Not Covered	Refer to the Member Benefit Agreement for details on our 90-day mail-order program.
	Generic drugs (Tier 2)	\$30 Copay	Not Covered	
	Preferred brand & non-preferred generic drugs (Tier 3)	40% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs (Tier 4)	50% coinsurance after deductible	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 5)	50% coinsurance after deductible	Not Covered	Specialty drugs must be filled through mail-order program or you will be required to pay 100% of the allowed drug cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not Covered	
	Physician/surgeon fees	40% coinsurance after deductible	Not Covered	

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

If you need immediate medical attention	<a href="#">Emergency room care</a>	50% coinsurance after deductible	50% coinsurance after deductible	
	<a href="#">Emergency medical transportation</a>	50% coinsurance after deductible	50% coinsurance after deductible	
	<a href="#">Urgent care</a>	40% coinsurance after deductible	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible	Not Covered	
	Physician/surgeon fees	40% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Co-pay	Not Covered	Cost-sharing is waived for the first 3 outpatient MH/BH/SA office visits with Network Provider
	Inpatient services	40% coinsurance after deductible	Not Covered	
If you are pregnant	Office visits	40% coinsurance after deductible	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	40% coinsurance after deductible	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery facility services	40% coinsurance after deductible	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% coinsurance after deductible	Not Covered	
	<a href="#">Rehabilitation services</a>	40% coinsurance after deductible	Not Covered	ST Benefits are limited to 20 visits per year. PT/OT Benefits are limited to 20 total combined visits per year.
	<a href="#">Habilitation services</a>	40% coinsurance after deductible	Not Covered	ST Benefits are limited to 20 visits per year. PT/OT Benefits are limited to 20 total combined visits per year.
	<a href="#">Skilled nursing care</a>	40% coinsurance after deductible	Not Covered	Benefit is limited to 150 days per Member per Calendar Year.
	<a href="#">Durable medical equipment</a>	50% coinsurance after deductible	Not Covered	
	<a href="#">Hospice services</a>	40% coinsurance after deductible	Not Covered	

If your child needs dental or eye care	Children's eye exam	40% coinsurance after deductible	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	40% coinsurance after deductible	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.

### 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                                | • Hearing aids (Adult)     | • Routine foot care    |
| • Cosmetic Surgery                           | • Infertility treatment    | • Weight loss programs |
| • Covered services provided outside the U.S. | • Long-term care           | •                      |
| • Dental care (Adult)                        | • Routine eye care (Adult) | •                      |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |                     |                           |
|---|---------------------|---------------------------|
| • Bariatric surgery                               | • Chiropractic care | • Hearing aids (children) |
| • Abortion for which public funding is prohibited | •                   | •                         |

**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 Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet the Minimum Value Standards? Yes

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 [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](#) \$2,500
- [Specialist](#) cost-sharing 40% coins
- Hospital (facility) cost-sharing 40% coins
- Other cost-sharing 40% coins

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>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$28
Coinsurance	\$4,020
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,548</b>

**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](#) cost-sharing 40% coins
- Hospital (facility) cost-sharing 40% coins
- Other cost-sharing 40% coins

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>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$857
Copayments	\$515
Coinsurance	\$618
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,990</b>

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist](#) cost-sharing 40% coins
- Hospital (facility) cost-sharing 40% coins
- Other cost-sharing 40% coins

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>





## 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, Mail Stop 100, Lewiston, ME 04243; by telephone at 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: 800-368-1019 or 800-537-7697 (TDD)
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

<b>French</b> ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-624-6463 (TTY/TDD: 711)	<b>Spanish</b> ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-624-6463 (TTY/TDD: 711)	<b>Chinese</b> 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 855-624-6463 (TTY/TDD: 711)。
<b>Cushite</b> XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 855-624-6463 (TTY/TDD: 711)	<b>Vietnamese</b> CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-624-6463 (TTY/TDD: 711)	<b>Arabic</b> انتبه: إذا كنت تتكلم العربية، خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بالرقم 855-624-6463 (رقم الجهاز النصي للصم: 711).
<b>Cambodian, Mon-Khmer</b> យកចិត្តទុកដាក់: ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ជាអនាមិកភាសាដទៃ ឬ ភាសាដទៃដទៃទៀត ឥតគិតថ្លៃ សូមទូរស័ព្ទ: 855-624-6463 (711 TTY / TDD) ។	<b>Russian</b> ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-624-6463 (телетайп: 711)	<b>Tagalog</b> PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-624-6463 (TTY/TDD: 711).
<b>German</b> ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711).	<b>Thai</b> หมายเหตุ: หากคุณพูดภาษาไทยคุณสามารถขอรับบริการช่วยเหลือทางภาษาไทยฟรี โทร 855-624-6463 (TTY/TDD: 711).	<b>Nilotic-Dinka</b> PIN KENE: Na ye jam nē Thuɔŋjan, ke kuɔny yenē koc waar thook atɔ̄ kuka lēu yök abac ke cīn wēnh cuatē piny. Yuɔpē 855-624-6463 (TTY/TDD: 711).
<b>Korean</b> 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	<b>Polish</b> UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-624-6463 (TTY/TDD: 711).	<b>Japanese</b> 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。855-624-6463 (TTY/TDD: 711) まで、お電話にてご連絡ください。

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