



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 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/ or call 1-855-624-6463 (TTY/TDD:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network - \$2,900/individual or \$5,800/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 - \$6,550/individual or \$13,100/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	15% coinsurance after deductible	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.
	Specialist visit	15% coinsurance after deductible	Not Covered	
	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)	15% coinsurance after deductible	Not Covered	
	Imaging (CT/PET scans, MRIs)	15% coinsurance after deductible	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthoptions.org/formulary	Preferred generic drugs (Tier 1)	15% coinsurance after deductible	Not Covered	Refer to the Member Benefit Agreement for details on our 90-day mail-order program.
	Generic drugs (Tier 2)	15% coinsurance after deductible	Not Covered	
	Preferred brand & non-preferred generic drugs (Tier 3)	15% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs (Tier 4)	50% coinsurance after deductible	Not Covered	
	Specialty drugs (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)	15% coinsurance after deductible	Not Covered	
	Physician/surgeon fees	15% coinsurance after deductible	Not Covered	

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

If you need immediate medical attention	Emergency room care	50% coinsurance after deductible	50% coinsurance after deductible	
	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	
	Urgent care	15% coinsurance after deductible	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after deductible	Not Covered	
	Physician/surgeon fees	15% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance after deductible	Not Covered	
	Inpatient services	15% coinsurance after deductible	Not Covered	
If you are pregnant	Office visits	15% coinsurance after deductible	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	15% coinsurance after deductible	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery facility services	15% 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	Home health care	15% coinsurance after deductible	Not Covered	
	Rehabilitation services	15% 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.
	Habilitation services	15% 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.
	Skilled nursing care	15% coinsurance after deductible	Not Covered	Benefit is limited to 150 days per Member per Calendar Year.
	Durable medical equipment	50% coinsurance after deductible	Not Covered	
	Hospice services	15% coinsurance after deductible	Not Covered	

If your child needs dental or eye care	Children's eye exam	15% 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	15% 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. 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 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.

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](#) \$2,900
- [Specialist](#) cost-sharing 15% coins
- Hospital (facility) cost-sharing 15% coins
- Other cost-sharing 15% 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*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,900
Copayments	\$0
Coinsurance	\$1,455
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,355

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

- The [plan's](#) overall [deductible](#) \$2,900
- [Specialist](#) cost-sharing 15% coins
- Hospital (facility) cost-sharing 15% coins
- Other cost-sharing 15% 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*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,900
Copayments	\$0
Coinsurance	\$615
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,515

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

- The [plan's](#) overall [deductible](#) \$2,900
- [Specialist](#) cost-sharing 15% coins
- Hospital (facility) cost-sharing 15% coins
- Other cost-sharing 15% 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*)

Total Example Cost	\$1,925
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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
The total Mia would pay is	\$1,925



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; 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>.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-624-6463 (TTY/TDD: 711)	Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-624-6463 (TTY/TDD: 711)	Chinese 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)。
Cushite XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 855-624-6463 (TTY/TDD: 711)	Vietnamese 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)	Arabic انتبه: إذا كنت تتكلم العربية، خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بالرقم 855-624-6463 (رقم الجهاز النصي للصم: 711).
Cambodian, Mon-Khmer យកចិត្តទុកដាក់: ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ជាអនាមិកភាសាខ្មែរ ឬ ភាសាខ្មែរដទៃទៀត ឥតគិតថ្លៃ សូមទូរស័ព្ទ: 855-624-6463 (711 TTY / TDD) ។	Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-624-6463 (телетайп: 711)	Tagalog 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).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711).	Thai หมายเหตุ: หากคุณพูดภาษาไทยคุณสามารถขอรับบริการช่วยเหลือฟรีทางภาษาไทย โทร 855-624-6463 (TTY/TDD: 711).	Nilotic-Dinka PIN KENE: Na ye jam nē Thuɔɔɔjan, ke kuɔny yenē koc waar thook atɔ kuka lēu yök abac ke cīn wēnh cuatē piny. Yuɔpē 855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-624-6463 (TTY/TDD: 711).	Japanese 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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