**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthoptions.org or by calling 1-855-624-6463.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $2,000 Individual/$4,000; Family<br>Out-of-Network: $4,000 Individual/$8,000 Family | For most services, you must pay all the costs for Covered Services up to the **deductible** amount before this plan begins to pay. Check your Member Benefit Agreement to see when the **deductible** starts over (usually January 1st). The chart beginning on page 2 for how much you pay for Covered Services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No | |
| **Is there an out–of–pocket limit on my expenses?** | In-Network: $4,000 Individual/$8,000 Family; Out-of-Network: $8,000 Individual/$16,000 Family | The **out–of–pocket limit** is the most you will pay for all **deductibles**, **co-insurance**, and **co-payments** for Covered Services. Plan premiums and out-of-network charges above the allowed amount are not applied to your **out-of-pocket limit**. |
| **What is not included in the out–of–pocket limit?** | Non-covered services, premiums and charges above the allowed amount. | |
| **Is there an overall annual limit on what the plan pays?** | No | The chart starting on page 2 describes an office visit or other plan limits that may apply for Covered services. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network providers, visit www.healthoptions.org or call 1-855-624-6463 | We use the term in-network or Plan Provider for providers in our network. When you use a Plan Provider, this plan will pay for Covered Services according to the in-network cost-sharing. Your in-network **provider** or hospital may use an out-of-network **provider** for some services. The chart starting on page 2 explains how different providers are paid. |
| **Do I need a referral to see a specialist?** | No | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes | Refer to your Member Benefit Agreement for full details on excluded services. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 Co-Pay | 40% Coinsurance after deductible | This plan requires all Members to select a PCP. Members are not permitted to designate an out-of-network provider as a PCP. |
| | Specialist visit | $50 Co-Pay | 40% Coinsurance after deductible | None |
| | Other practitioner office visit | $25 Co-Pay | 40% Coinsurance after deductible | In the primary care setting only. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Preventive care/screening/immunization | $0 Co-Pay | 40% Coinsurance after deductible | When prescribed by a Plan Provider, certain Preventative Care services, as defined in federal law, are covered by the Plan with no Out-of-Pocket Costs for the Member. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical managment, will be covered without cost sharing requirements. Refer to your Member Benefit Agreement for more information. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Certain imaging services require prior authorization |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.healthoptions.org. | Generic drugs | $5 Co-Pay (Low) and $35 Co-Pay (High) | 40% Coinsurance after deductible | 90-day supply, in-network Mail Order co-pay is equal to two times a 30-day supply, in-network Mail Order co-pay |
| | Preferred brand drugs | $70 Co-Pay | 40% Coinsurance after deductible | None |
| | Non-preferred brand drugs | 50% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Specialty drugs | 50% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $250 Co-Pay | 40% Coinsurance after deductible | None |
| | Physician/surgeon fees | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $250 Co-Pay | $250 Co-Pay | None |
| | Emergency medical transportation | 20% Coinsurance after deductible | 20% Coinsurance after deductible | None |
| | Urgent care | $100 Co-Pay | 40% Coinsurance after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Physician/surgeon fee | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 Co-Pay | 40% Coinsurance after deductible | Cost-sharing is waived for the first 3 in-network outpatient office visits for mental health, behavioral health or substance use services. |
| | Mental/Behavioral health inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Non-emergent Inpatient Mental Health Hospital stays require Prior Approval. |
| | Substance use disorder outpatient services | $25 Co-Pay | 40% Coinsurance after deductible | Cost-sharing is waived for the first 3 outpatient office visits for mental health, behavioral health or substance use services. |
| | Substance use disorder inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Non-emergent Inpatient Substance Abuse Hospital stays require Prior Approval. |
| **If you are pregnant** | Prenatal and postnatal care | 20% Coinsurance after deductible except for preventive care services | 40% Coinsurance after deductible | Pre- and postnatal care that is considered preventive under the Affordable Care Act is covered with no cost-sharing when received in-network. All other care will be subject to the cost sharing listed in the Schedule of Benefits. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Delivery and all inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | A written plan of care is required. |
| | Rehabilitation services | $50 Co-Pay | 40% Coinsurance after deductible | Benefits are limited to 60 visits per Calendar year combined for physical, occupational and speech therapy. |
| | Habilitation services | $50 Copay | 40% Coinsurance after deductible | Benefits are limited to 60 visits per Calendar year combined for physical, occupational and speech therapy. |
| | Skilled nursing care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | The benefit is limited to 150 days per member per Calendar year, and Prior Approval is required. |
| | Durable medical equipment | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Prior approval is required for DME. Prosthesis designed for athletic purposes are not covered. |
| | Hospice service | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Prior approval is required |
| **If your child needs dental or eye care** | Eye exam | $50 Co-Pay | 40% 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. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Glasses | 20% Coinsurance after deductible | 40% 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. |
| | 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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Adult Dental Services
- Cosmetic Services
- Food or dietary supplements
- Medically unnecessary services
- Abortions for which Federal funding is prohibited

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care

## Your Rights to Continue Coverage:

Federal and State law may provide protections that allow you to keep health coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- Community Health Options stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue, 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.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Options at 1-855-624-6463 or the Maine Bureau of Insurance at 800-300-5000 or (in-state) 207-624-8475. You may also visit www.maine.gov/pfr/insurance.
Maine's consumer assistance program can help you file your appeal. Contact: Consumers for Affordable Health Care at 800-965-7476 or visit www.mainecahc.org. You may also email consumerhealth@mainecahc.org.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,430
- **Patient pays** $3,110

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $2,000 |
| Copays | $50 |
| Coinsurance | $1,060 |
| Limits or exclusions | $0 |
| **Total** | **$3,110** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,350
- **Patient pays** $2,050

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,700 |
| Copays | $350 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$** |

The numbers in "Managing type 2 diabetes" assume the patient is actively participating in all recommended diabetes care. If you have diabetes and do not follow your Provider's plan of care, your costs may be higher.

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# 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**<br>ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 855-624-6463 (TTY/TDD: 711) | **Spanish**<br>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-624-6463 (TTY/TDD: 711) | **Chinese**<br>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**<br>XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 855-624-6463 (TTY/TDD: 711) | **Vietnamese**<br>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**<br>**ﺗﻨﺒﻴﻪ**: إذاكنتتتكلّمالعربية، خدماتالمساعدةاللغويةمتاحةلكمجّاناً.اتصلبالرقم 855-624-6463 (الصمالبكم: 711). |
| **Cambodian, Mon-Khmer** យកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, ជំនួយសេវាកម្មជំនួយភាសាគឺអាចមានជូនអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទ: 855-624-6463 (711 TTY / TDD) ។ | **Russian**<br>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-624-6463 (телетайп: 711) | **Tagalog**<br>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.<br>Tumawag sa 855-624-6463 (TTY/TDD: 711). |
| **German**<br>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711). | **Thai**<br>ี ยน: ถาีีั คุณพดู ภาษาไทยคุณสามารถใชบั รก ิ ารชว ่ ยเหลอ ื ทางภาษาไดฟ้ ร โทร 855-624-6463 (TTY/TDD: 711). | **Nilotic-Dinka**<br>PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 855-624-6463 (TTY/TDD: 711). |
| **Korean**<br>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오. | **Polish**<br>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-624-6463 (TTY/TDD: 711). | **Japanese**<br>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<br>、お電話にてご連絡ください。 |