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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network - $4,000/individual or $8,000/family; Out-of-Network - $8,000/individual or $16,000/family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive Care (as defined in your Member Benefit Agreement) and most services that require a copayment.</td>
<td>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 <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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>None</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network - $5,500/individual or $11,000/family; Out-of-Network - $11,000/individual or $22,000/family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing charges (charges above the allowed amount), and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.healthoptions.org">www.healthoptions.org</a> or call 1-855-624-6463 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
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></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<td>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.</td>
</tr>
<tr>
<td><strong>Specialist</strong> visit</td>
<td>$25 Copay</td>
<td>40% Coinsurance after Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>$0 Copay</td>
<td>40% Coinsurance after Deductible</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred generic drugs (Tier 1)</td>
<td>$5 Copay</td>
<td>40% Coinsurance after Deductible</td>
<td>Refer to the Member Benefit Agreement for details on our 90-day mail-order program.</td>
</tr>
<tr>
<td>Generic drugs (Tier 2)</td>
<td>$25 Copay</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Preferred brand &amp; non-preferred generic drugs (Tier 3)</td>
<td>$50 Copay</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (Tier 4)</td>
<td>30% Coinsurance up to max of $300/script Deductible does not apply</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (Tier 5)</td>
<td>30% Coinsurance up to max of $500/script Deductible does not apply</td>
<td>50% Coinsurance after Deductible</td>
<td>Specialty drugs must be filled through mail-order program or you will be required to pay 100% of the allowed drug cost.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at HealthOptions.org
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<tbody>
<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 need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$250 Copay</td>
<td>$250 Copay</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$100 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 Copay Waived for the 1st 3 visits</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% 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>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$50 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Network Provider (You will pay the least)</td>
<td>$50 Copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Network Provider (You will pay the least)</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at HealthOptions.org
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Covered services provided outside the U.S.</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion for which public funding is prohibited</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
</tr>
<tr>
<td>• Hearing aids (children)</td>
</tr>
</tbody>
</table>

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.

* 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** $4,000
- **Specialist cost sharing** $50 Copay
- **Hospital (facility) cost sharing** 20% Coins
- **Other cost sharing** 20% 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

**In this example, Peg would pay:**
- **Deductibles** $4,000
- **Copayments** $0
- **Coinsurance** $1,500

**What isn’t covered**
- **Limits or exclusions** $0

**The total Peg would pay is** $5,500

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

- The **plan’s overall deductible** $4,000
- **Specialist cost sharing** $50 Copay
- **Hospital (facility) cost sharing** 20% Coins
- **Other cost sharing** 20% 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

**In this example, Joe would pay:**
- **Deductibles** $56
- **Copayments** $1,461
- **Coinsurance** $0

**What isn’t covered**
- **Limits or exclusions** $0

**The total Joe would pay is** $1,517

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

- The **plan’s overall deductible** $4,000
- **Specialist cost sharing** $50 Copay
- **Hospital (facility) cost sharing** 20% Coins
- **Other cost sharing** 20% 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

**In this example, Mia would pay:**
- **Deductibles** $1,255
- **Copayments** $541
- **Coinsurance** $0

**What isn’t covered**
- **Limits or exclusions** $0

**The total Mia would pay is** $1,796

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