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** - $1,500/individual or $3,000/family; **Out-of-Network** - $3,000/individual or $6,000/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/. Refer to your Member Benefit Agreement for more information.
Are there other **deductibles** for specific services? | No. | None
What is the **out-of-pocket limit** for this **plan**? | **In-Network** - $3,000/individual or $6,000/family; **Out-of-Network** - $6,000/individual or $12,000/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 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**.

**OGM Control Numbers 1545-2229, 1210-0147, and 0938-1146**

Released on April 6, 2016
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></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs (Tier 1)</td>
<td>$5 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Generic drugs (Tier 2)</td>
<td>$25 Copay</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preferred brand &amp; non-preferred generic drugs (Tier 3)</td>
<td>$50 Copay</td>
<td>40% Coinsurance after Deductible</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</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>
<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></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></td>
<td></td>
<td>30% Coinsurance up to max of $500/script Deductible does not apply</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs (Tier 5)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</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>Emergency room care</td>
<td>$250 Copay</td>
<td>$250 Copay</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</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>If you have a hospital stay</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>If you have a hospital stay</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>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</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
### Common Medical Event

**Services You May Need**

<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
</tr>
<tr>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Habilitation services</td>
</tr>
<tr>
<td>Skilled nursing care</td>
</tr>
<tr>
<td>Durable medical equipment</td>
</tr>
<tr>
<td>Hospice services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What You Will Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

### Limitations, Exceptions, & Other Important Information

- **Home health care**: None
- **Rehabilitation services**: PT/OT/ST Benefits are limited to 60 total combined visits per year.
- **Habilitation services**: Benefit is limited to 150 days per Member per Calendar Year.
- **Skilled nursing care**: Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.
- **Durable medical equipment**: Limited to One 48-hour Respite period, once per lifetime.
- **Hospice services**: 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 eye exam**: 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 glasses**: 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**: None

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

- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Covered services provided outside the U.S.
- Long-term care
- Weight loss programs
- 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.)**

- Abortion for which public funding is prohibited
- Bariatric Surgery
- Chiropractic care
- Hearing aids

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**: $1,500
- **Specialist copayment**: $50
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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:**
- **Cost Sharing**
  - Deductibles: $1,500
  - Copayments: $0
  - Coinsurance: $1,500

**What isn't covered**
- Limits or exclusions: $0

**The total Peg would pay is**: $3,000

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

- **The plan's overall deductible**: $1,500
- **Specialist copayment**: $50
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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:**
- **Cost Sharing**
  - Deductibles: $1,500
  - 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**: $1,500
- **Specialist copayment**: $50
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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:**
- **Cost Sharing**
  - Deductibles: $1,255
  - Copayments: $541
  - Coinsurance: $0

**What isn't covered**
- Limits or exclusions: $0

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

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