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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network - $8,000/individual or $16,000/family; Out-of-Network - $16,000/individual or $32,000/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><strong>Are there services covered before you meet your deductible?</strong></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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network - $9,450/individual or $18,900/family; Out-of-Network - $18,900/individual or $37,800/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><strong>What is not included in the out-of-pocket limit?</strong></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><strong>Will you pay less if you use a network provider?</strong></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>
</tbody>
</table>
Do you need a referral to see a specialist? No.

You can see the specialist you choose without a referral.

---

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

---

**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>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</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>Primary care visit to treat an injury or illness</td>
<td>$40 Copay</td>
<td>50% Coinsurance after Deductible</td>
<td>The first visit to your Network PCP is free. This plan requires all Members to select a PCP that is a Plan Provider.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$80 Copay after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>Depending on the services provided in a single appointment it is possible you may be financially responsible for copay(s), your deductible, and or coinsurance for one date of service.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0 Copay</td>
<td>50% 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>Diagnostic test (x-ray, blood work)</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs (Tier 1)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5 Copay (retail) and $10 Copay (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs (Tier 2)</td>
<td>$25 Copay (retail) and $50 Copay (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 3)</td>
<td>30% Coinsurance after Deductible (retail) and 30% Coinsurance after Deductible (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 4)</td>
<td>50% Coinsurance after Deductible (retail) and 50% Coinsurance after Deductible (mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 5)</td>
<td>50% Coinsurance after Deductible (retail and mail order)</td>
<td>50% Coinsurance after Deductible (retail only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Speciality drugs must be filled through our Preferred Specialty Pharmacy or you will be required to pay 100% of the allowed drug cost.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$60 Copay</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

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

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<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$40 Copay 50% Coinsurance after Deductible Cost-sharing is waived for the first outpatient MH/BH/SA office visit with a plan provider.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible None.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible None.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 Copay 50% Coinsurance after Deductible PT/OT/ST Benefits are limited to 60 total combined visits per year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 Copay 50% Coinsurance after Deductible</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing center</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Benefit is limited to 150 days per Member per Calendar Year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>50% Coinsurance after Deductible 50% Coinsurance after Deductible Limited to One 48-hour Respite period, once per lifetime.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>$40 Copay 50% 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.</td>
</tr>
</tbody>
</table>

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<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>Children's glasses</td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

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.

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.

* 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>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</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>Limitations</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic Surgery</td>
<td>Dental care (Adult)</td>
</tr>
<tr>
<td>Long-term care</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td>Weight loss programs</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 Maine Marketplace. For more information about the Maine Marketplace, visit www.CoverMe.gov or call 1-866-636-0355 TTY: 711

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
Minimum Essential Coverage generally includes plans, health insurance available through the Maine Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 Maine Marketplace.

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

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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$8,000</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>50%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>50%</td>
</tr>
</tbody>
</table>

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: $12,687

In this example, Peg would pay:
- Deductibles: $8,000
- Copayments: $0
- Coinsurance: $1,450

The total Peg would pay is $9,450

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

<table>
<thead>
<tr>
<th>Service Type</th>
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<tr>
<td>Other coinsurance</td>
<td>50%</td>
</tr>
</tbody>
</table>

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: $5,600

In this example, Joe would pay:
- Deductibles: $437
- Copayments: $494
- Coinsurance: $0

The total Joe would pay is $931

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$8,000</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>50%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

Total Example Cost: $2,800

In this example, Mia would pay:
- Deductibles: $2,436
- Copayments: $165
- Coinsurance: $0

The total Mia would pay is $2,601

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