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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | In-Network- \$5,700/individual or \$11,400/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- \$8,700/individual or \$17,400/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. |

| | | |
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| 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 . |
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 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 | Visits 2-3 \$50 Copay, then 35% Coins after Ded | Not Covered | The first visit to your Network PCP is free. This plan requires all Members to select a PCP that is a Plan Provider. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Specialist visit | 35% Coinsurance after Deductible | Not Covered | 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. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | 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. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you have a test | Diagnostic test (x-ray, blood work) | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Imaging (CT/PET scans, MRIs) | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |

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

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.healthoptions.org/Formulary | Preferred generic drugs (Tier 1) | 35% Coinsurance after Deductible (retail) and 35% Coinsurance after Deductible (mail order) | Not Covered | Refer to the Member Benefit Agreement for details on our mail-order program. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Generic drugs (Tier 2) | 35% Coinsurance after Deductible (retail) and 35% Coinsurance after Deductible (mail order) | Not Covered | |
| | Preferred brand drugs (Tier 3) | 35% Coinsurance after Deductible (retail) and 35% Coinsurance after Deductible (mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | 35% Coinsurance after Deductible (retail) and 35% Coinsurance after Deductible (mail order) | Not Covered | |
| | Specialty drugs (Tier 5) | 35% Coinsurance after Deductible (retail) and 35% Coinsurance after Deductible (mail order) | Not Covered | Specialty drugs must be filled through our Preferred Specialty Pharmacy, or you will be required to pay 100% of the allowed drug cost. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Physician/surgeon fees | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you need immediate medical attention | Emergency room care | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Emergency medical transportation | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |

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| 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) | |
| | Urgent care | \$95 Copay | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Physician/surgeon fees | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 35% Coinsurance after Deductible | Not Covered | Cost-sharing is waived for the first 3 outpatient MH/BH/SA office visits with a plan provider. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Inpatient services | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you are pregnant | Office visits | 35% Coinsurance after Deductible | Not Covered | Cost sharing does not apply for preventive services. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Childbirth/delivery professional services | 35% Coinsurance after Deductible | Not Covered | Cost sharing does not apply for preventive services. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Childbirth/delivery facility services | 35% Coinsurance after Deductible | Not Covered | Cost sharing does not apply for preventive services. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If you need help recovering or have other special health needs | Home health care | 35% Coinsurance after Deductible | Not Covered | None. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Rehabilitation services | 35% Coinsurance after Deductible | Not Covered | PT/OT/ST Benefits are limited to 60 total combined visits per year. |
| | Habilitation services | 35% Coinsurance after Deductible | Not Covered | Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Skilled nursing center | 35% Coinsurance after Deductible | Not Covered | Benefit is limited to 150 days per Member per Calendar Year. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |

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

| 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) | |
| | Durable medical equipment | 35% Coinsurance after Deductible | Not Covered | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Hospice services | 35% Coinsurance after Deductible | Not Covered | Limited to One 48-hour Respite period, once per lifetime. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| If your child needs dental or eye care | Children's eye exam | 35% 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. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | Children's glasses | 35% 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. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |
| | 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. Cost sharing is waived at an IHCP or at a non-IHCP with an IHCP referral. |

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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 | • Infertility treatment | • Routine foot care |
| • Cosmetic Surgery | • Long-term care | • Weight loss programs |
| • Covered services provided outside the U.S. | • Private-duty nursing | |
| • 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 | • Chiropractic care | |
| • Bariatric surgery | • 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 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? Not Applicable

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.* -----

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](#) \$5,700
- [Specialist coinsurance](#) 35%
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,700 |
| Copayments | \$0 |
| Coinsurance | \$2,360 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$8,060 |

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

- The [plan's](#) overall [deductible](#) \$5,700
- [Specialist coinsurance](#) 35%
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$302 |
| Copayments | \$455 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$757 |

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

- The [plan's](#) overall [deductible](#) \$5,700
- [Specialist coinsurance](#) 35%
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |