

 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 Member Services at (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:
<u>What is the overall deductible?</u>	<u>In-Network</u> - \$6,300 /individual or \$12,600 /family; <u>Out-of-Network</u> - \$12,600 /individual or \$25,200 /family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Preventive Care (as defined in your Member Benefit Agreement). For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . Refer to your Member Benefit Agreement for more information.
<u>Are there other deductibles for specific services?</u>	Yes , \$100/child for pediatric dental coverage.	Pediatric Dental Benefits are provided in partnership with Northeast Delta Dental. You must pay all of the costs (except where indicated) for these services up to the specific deductible amount before this plan begins to pay for these services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>In-Network</u> - \$8,000 /individual or \$16,000 /family; <u>Out-of-Network</u> - \$16,000 /individual or \$32,000 /family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance billing</u> charges (charges above the <u>allowed amount</u>), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.healthoptions.org or call 1-855-624-6463 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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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	50% coinsurance after deductible Firefly Virtual PCP: 50% coinsurance after deductible	60% coinsurance after deductible	This plan requires all Members to select a PCP that is in-network. Virtual PCPs are available via Firefly Health. . 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.
	Specialist visit	50% coinsurance after deductible	60% coinsurance after deductible	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.
	Preventive care / screening / immunization	\$0 Copay; deductible does not apply	60% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Contact Member Services for questions on plan coverage. 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.

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 have a test	<u>Diagnostic test</u> (x-ray, blood work)	<p>Lab Services from a Specified Location: \$25 copay after deductible All other: 50% coinsurance after deductible</p> <p>X-Rays from a Specified Location: \$75 copay after deductible All other: 50% coinsurance after deductible</p>	<p>Lab: 60% coinsurance after deductible</p> <p>X-Rays: 60% coinsurance after deductible</p>	<p>Please refer to your Member portal or our website for a list of specified site of service locations or contact Member Services for additional information</p>
	Imaging (CT/PET scans, MRIs)	<p>Imaging from a Specified Location: 50% coinsurance after deductible</p> <p>All other: 50% coinsurance after deductible</p>	60% coinsurance after deductible	<p>Please refer to your Member portal or our website for a list of specified site of service locations or contact Member Services for additional information</p>

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 www.healthoptions.org/formulary	Preferred generic drugs (Tier 1)	30 Day Retail: 50% coinsurance after deductible 90 Day Mail Order: 50% coinsurance after deductible	60% coinsurance after deductible (retail only)	Members automatically receive the lower of the GoodRx price or our negotiated price on all generic medications at GoodRx participating pharmacies. Contact Member Services for additional opportunities to save on prescriptions including our Script Saver program. HSA Plus plans waive the deductible on select preventive medications (designated on our formulary with a 'HSA+').
	Generic drugs (Tier 2)	30 Day Retail: 50% coinsurance after deductible 90 Day Mail Order: 50% coinsurance after deductible	60% coinsurance after deductible (retail only)	
	Preferred brand and select generic drugs (Tier 3)	30 Day Retail: 50% coinsurance after deductible 90 Day Mail Order: 50% coinsurance after deductible	60% coinsurance after deductible (retail only)	
	Non-preferred brand drugs (Tier 4)	30 Day Retail: 50% coinsurance after deductible 90 Day Mail Order: 50% coinsurance after deductible	60% coinsurance after deductible (retail only)	
	Specialty drugs (Tier 5)	30 Day Retail and Mail Order: 50% coinsurance after deductible	60% coinsurance after deductible (retail only)	Specialty drugs must be filled through our Preferred Specialty Pharmacy or you will be required to pay 100% of the allowed drug cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	60% coinsurance after deductible	None.
	Physician/surgeon fees	50% coinsurance after deductible	60% coinsurance after deductible	None.
If you need immediate medical attention	Emergency room care	50% coinsurance after deductible	50% coinsurance after deductible	None.
	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	None.

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)	
	<u>Urgent care</u>	Virtual via Amwell: \$0 copay; deductible does not apply Freestanding: 50% coinsurance after deductible All Other: 50% coinsurance after deductible	60% coinsurance after deductible	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.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible	60% coinsurance after deductible	Our Care Managers are available to support and offer resources to Members. Contact Member Services to connect with a Care Manager.
	Physician/surgeon fees	50% coinsurance after deductible	60% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance after deductible	60% coinsurance after deductible	Virtual Behavioral Health services are also available through Amwell®. Contact Member Services for additional resources.
	Inpatient services	50% coinsurance after deductible	60% coinsurance after deductible	Our Care Managers are available to support and offer resources to Members. Contact Member Services to connect with a Care Manager.
If you are pregnant	Office visits	50% coinsurance after deductible	60% coinsurance after deductible	Routine pre- and post-natal care is included in your delivery charge. Many services are preventive with \$0 cost share, please refer to healthcare.gov/preventive-care-women/ for a full list of preventive pregnancy care. Please refer to diagnostic testing and specialist visits for additional non-routine pregnancy care.
	Childbirth/delivery professional services	50% coinsurance after deductible	60% coinsurance after deductible	
	Childbirth/delivery facility services	50% coinsurance after deductible	60% coinsurance after deductible	

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 help recovering or have other special health needs	<u>Home health care</u>	50% coinsurance after deductible	60% coinsurance after deductible	None.
	<u>Rehabilitation services</u>	Office Based: 50% coinsurance after deductible Outpatient Hospital: 50% coinsurance after deductible	60% coinsurance after deductible	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. PT/OT/ST Benefits are limited to 60 total combined visits per year.
	<u>Habilitation services</u>			
	<u>Skilled nursing center</u>	50% coinsurance after deductible	60% coinsurance after deductible	Benefit is limited to 150 days per Member per Calendar Year.
	<u>Durable medical equipment</u>	50% coinsurance after deductible	60% coinsurance after deductible	Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.
	<u>Hospice services</u>	50% coinsurance after deductible	60% coinsurance after deductible	Limited to One 48-hour Respite period, once per lifetime.
If your child needs dental or eye care	Children's eye exam	50% coinsurance after deductible	60% 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.
	Children's glasses	50% coinsurance after deductible	60% coinsurance after deductible	For more information on eyewear and contacts, contact Member Services.
	Children's dental check-up	0% coinsurance	0% coinsurance	Pediatric Dental Benefits are provided in partnership with Northeast Delta Dental. Refer to your Member Benefit Agreement and Schedule of Benefits for more information.

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	• Dental care (Adult)	• Routine foot care
• Cosmetic Surgery	• Long-term care	• Weight loss programs
• Covered Emergency services provided outside the U.S.	• Private-duty nursing	

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	• Hearing Aids	• Abortion for which public funding is prohibited
• Bariatric Surgery	• Infertility Treatment	• Bariatric Surgery
• Chiropractic care	• Routine eye care (Adult)	Chiropractic care

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: Community Health Options at (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: Community Health Options at (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	\$6,300
■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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:

Cost Sharing	
Deductibles	\$6,300
Copayments	\$0
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$8,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$6,300
■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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:

Cost Sharing	
Deductibles	\$1,380
Copayments	\$455
Coinsurance	\$457
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,292

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6,300
■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

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:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.