COMMUNITY Health Options

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services
**Health Options Clear Choice Silver $6000 PPO National Dental Off MP**

**Coverage Period: 01/01/2027 through 12/31/2027**
**Coverage for: Individual and Family | Plan Type: PPO**

**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: |
|---|---|---|
| **What is the overall deductible?** | **In-Network - $6,000 /individual or $12,000 /family; Out-of-Network - $12,000 /individual or $24,000 /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), Primary Care visits, Specialist Visits, X-ray and Lab services from certain locations, Rehabilitation services and Habilitation services from certain locations, certain Prescription Drugs, routine eye exams are covered before you meet your In-network deductible. | 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?** | **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. |
| **What is the out-of-pocket limit for this plan?** | **In-Network - $10,000 /individual or $20,000 /family; Out-of-Network - $20,000 /individual or $40,000 /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 (unless balanced billing is prohibited), 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. |



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 | $0 Cost for your first visit then $40 copay; deductible does not apply<br><br>Firefly Virtual PCP: $40 copay; deductible does not apply | 50% coinsurance after deductible | This plan requires all Members to select a PCP that is in-network. Virtual PCPs are also available via Firefly Health. Any Copays will accumulate towards your DeductibleDepending on the services provided in a single appointment it is possible you may be financially responsible for additional copay(s), your deductible and or coinsurance for one date of service. |
| | Specialist visit | $60 copay; deductible does not apply | 50% coinsurance after deductible | Depending on the services provided in a single appointment it is possible you may be financially responsible for additional copay(s), your deductible, and or coinsurance for one date of service. |
| | Preventive care/screening/ immunization | $0 Copay; deductible does not apply | 50% 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 additional copay(s), your deductible and or coinsurance for one date of service. |



* 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 have a test** | Diagnostic test (x-ray, blood work) | Lab Services from a Specified Location: $35 copay; deductible does not apply All other: 30% coinsurance after deductible<br><br>X-Rays from a Specified Location: $75 copay; deductible does not apply All other: 30% coinsurance after deductible | Lab: 50% coinsurance after deductible<br><br>X-Rays: 50% coinsurance after deductible | 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. |
| | Imaging (CT/PET scans, MRIs) | Imaging from a Specified location: $350 copay; deductible does not apply All other: 30% coinsurance after deductible | 50% coinsurance after deductible | 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. |



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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) | |
| **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: $5 copay; deductible does not apply 90 Day Mail Order: $10 copay; deductible does not apply | 50% 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. |
| | Generic drugs (Tier 2) | 30 Day Retail: $25 copay; deductible does not apply 90 Day Mail Order: $50 copay; deductible does not apply | 50% coinsurance after deductible (retail only) | |
| | Preferred brand and select generic drugs (Tier 3) | 30 Day Retail: $50 copay; deductible does not apply 90 Day Mail Order: $100 copay; deductible does not apply | 50% coinsurance after deductible (retail only) | |
| | Non-preferred brand drugs (Tier 4) | 30 Day Retail: 30% coinsurance up to max of $300 / script after deductible 90 Day Mail Order: 30% coinsurance up to max of $600 / script after deductible | 50% coinsurance after deductible (retail only) | |
| | Specialty drugs (Tier 5) | 30 Day Retail and Mail Order: 50% coinsurance up to max of $600 / script after deductible | 50% coinsurance up to max of $600 / script 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) | 30% coinsurance after deductible | 50% coinsurance after deductible | None. |
| | Physician/surgeon fees | 30% coinsurance after deductible | 50% coinsurance after deductible | None. |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance after deductible | 30% coinsurance after deductible | None. |
| | Emergency medical transportation | 30% coinsurance after deductible | 30% coinsurance after deductible | None. |



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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 | Virtual via Amwell: $0 copay; deductible does not apply<br><br>Freestanding: $40 copay; deductible does not apply<br><br>All Other: $40 copay; deductible does not apply | 50% coinsurance after deductible | Depending on the services provided in a single appointment it is possible you may be financially responsible for additional copay(s), your deductible and or coinsurance for one date of service. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | 50% 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 | 30% coinsurance after deductible | 50% coinsurance after deductible | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $0 Cost for your first visit, then $40 copay; deductible does not apply | 50% coinsurance after deductible | Virtual Behavioral Health services are also available through Amwell®. Contact Member Services for additional resources. Any Copays will accumulate towards your Deductible. |
| | Inpatient services | 30% coinsurance after deductible | 50% 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 | 30% coinsurance after deductible | 50% coinsurance after deductible | Routine pre- and post-natal care is included in your benefits. 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 | 30% coinsurance after deductible | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | 30% coinsurance after deductible | 50% coinsurance after deductible | |
| **If you need help recovering or have** | Home health care | 30% coinsurance after deductible | 50% coinsurance after deductible | None. |



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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) | |
| **other special health needs** | Rehabilitation services | Office Based: $40 copay; deductible does not apply<br><br>Outpatient Hospital: 30% coinsurance after deductible | 50% coinsurance after deductible | Depending on the services provided in a single appointment it is possible you may be financially responsible for additional 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. |
| | Habilitation services | | | |
| | Skilled nursing center | 30% coinsurance after deductible | 50% coinsurance after deductible | Benefit is limited to 150 days per Member per Calendar Year. |
| | Durable medical equipment | 30% coinsurance after deductible | 50% coinsurance after deductible | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details. |
| | Hospice services | 30% coinsurance after deductible | 50% 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 | $40 copay; deductible does not apply | 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. |
| | Children's glasses | 30% coinsurance after deductible | 50% 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. |



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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.) | | |
|---|---|---|
| • Cosmetic Surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |
| **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 | • Covered Emergency services provided outside the U.S. | • Infertility Treatment |
| • Acupuncture | • Chiropractic care | • Routine eye care (Adult) |
| • 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: Community Health Options at (855)-624-6463. You may also contact the Maine Bureau of Insurance at 800-300-5000 or 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 (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.*



* 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 | $6,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $6,000 |
| Copayments | $26 |
| Coinsurance | $1,926 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$7,952** |

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

| | |
|---|---|
| The plan's overall deductible | $6,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $122 |
| Copayments | $1,550 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,672** |

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

| | |
|---|---|
| The plan's overall deductible | $6,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $2,090 |
| Copayments | $345 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,435** |

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