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 - $2,500/individual or $5,000/family; Out-of-Network - $5,000/individual or $10,000/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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network - $5,000/individual or $10,000/family; Out-of-Network - $10,000/individual or $20,000/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.

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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	$25 Co-pay	40% Coinsurance after deductible	This plan requires all Members to select a PCP that is a Plan Provider. 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.
	Specialist visit	$50 Co-pay	40% Coinsurance after deductible	
	Preventive care/screening/ immunization	$0 Copay	40% Coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	
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)	$5 copay	40% Coinsurance after deductible	Refer to the Member Benefit Agreement for details on our 90-day mail-order program.
	Generic drugs (Tier 2)	$35 copay	40% Coinsurance after deductible	
	Preferred brand & non-preferred generic drugs (Tier 3)	$70 copay	40% Coinsurance after deductible	
	Non-preferred brand drugs (Tier 4)	30% coinsurance, up to max of $300 per script	50% Coinsurance after deductible	
	Specialty drugs (Tier 5)	30% coinsurance, up to max of $500 per script	50% Coinsurance after deductible	Specialty drugs must be filled through mail-order program 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)	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	

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

If you need immediate medical attention	Emergency room care	$250 Co-pay	$250 Co-pay	
	Emergency medical transportation	20% Coinsurance after deductible	20% Coinsurance after deductible	
	Urgent care	$100 Co-pay	40% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Co-pay	40% Coinsurance after deductible	Cost-sharing is waived for the first 3 outpatient MH/BH/SA office visits with Network Provider
	Inpatient services	20% Coinsurance after deductible	40% Coinsurance after deductible	
If you are pregnant	Office visits	20% Coinsurance after deductible	40% Coinsurance after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance after deductible	40% Coinsurance after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery facility services	20% Coinsurance after deductible	40% Coinsurance after deductible	Cost sharing does not apply for preventive services.
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Rehabilitation services	$50 Co-pay	40% Coinsurance after deductible	ST Benefits are limited to 20 visits per year. PT/OT Benefits are limited to 20 total combined visits per year.
	Habilitation services	$50 Co-pay	40% Coinsurance after deductible	ST Benefits are limited to 20 visits per year. PT/OT Benefits are limited to 20 total combined visits per year.
	Skilled nursing care	20% Coinsurance after deductible	40% Coinsurance after deductible	Benefit is limited to 150 days per Member per Calendar Year.
	Durable medical equipment	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Hospice services	20% Coinsurance after deductible	40% Coinsurance after deductible	

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

If your child needs dental or eye care	Children's eye exam	$50 Co-pay	40% 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 costsharing.
	Children's glasses	20% Coinsurance after deductible	40% Coinsurance after deductible	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	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.

* 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	• Hearing aids (Adult)	• Routine foot care
• Covered services provided outside the U.S.	• Infertility treatment	• Weight loss programs
• Dental care (Adult)	• Long-term care	•

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	• Routine eye exam (Adult)
• Bariatric Surgery	• Hearing aids (children)	•

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	$2,500
Specialist *cost sharing*	$50 Co-pay
Hospital (facility) *cost sharing*	20% Coins
Other *cost sharing*	20% Coins

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	$2,500
Copayments	$28
Coinsurance	$2,010
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,538

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

The plan's overall deductible	$2,500
Specialist *cost sharing*	$50 Co-pay
Hospital (facility) *cost sharing*	20% Coins
Other *cost sharing*	20% Coins

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	$56
Copayments	$1,605
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,661

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

The plan's overall deductible	$2,500
Specialist *cost sharing*	$50 Co-pay
Hospital (facility) *cost sharing*	20% Coins
Other *cost sharing*	20% Coins

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.

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your Member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Mail Stop 100, Lewiston, ME 04243; by telephone at 855-624-6463 TTY/TDD 711; by email at compliance@healthoptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 800-368-1019 or 800-537-7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-624-6463 (TTY/TDD: 711)	**Arabic** إنتبه: إذا كنت تتكلّم العربية، خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بالرقم 855-624-6463 (رقم الجهاز النصي للصم: 711).
Cambodian, Mon-Khmer យកចិត្តទុកដាក់: ប្រសិនបើ អ្នក និយាយភាសា ខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ សូមទូរស័ព្ទ: 855-624-6463 (711 TTY / TDD)។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711).	**Thai** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjäŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。

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