**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, coinsurance, 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- $0/individual or $0/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?** | **Yes, $0/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 befor this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **In-Network- $0/individual or $0/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?** | **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 | $0 Copay | Not Covered | This plan requires all Members to select a PCP that is a Plan Provider. |
| | Specialist visit | $0 Copay | 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. |
| | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $0 Copay | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $0 Copay | Not Covered | None |
| **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) | $0 Copay | Not Covered | Refer to the Member Benefit Agreement for details on our mail-order program. |
| | Generic drugs (Tier 2) | $0 Copay | Not Covered | |
| | Preferred brand & non-preferred generic drugs (Tier 3) | $0 Copay | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | $0 Copay | Not Covered | |
| | Specialty drugs (Tier 5) | $0 Copay | 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. |



* 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 outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $0 Copay | Not Covered | None |
| | Physician/surgeon fees | $0 Copay | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $0 Copay | $0 Copay | None |
| | Emergency medical transportation | $0 Copay | $0 Copay | None |
| | Urgent care | $0 Copay | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $0 Copay | Not Covered | None |
| | Physician/surgeon fees | $0 Copay | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $0 Copay | Not Covered | None |
| | Inpatient services | $0 Copay | Not Covered | None |
| **If you are pregnant** | Office visits | $0 Copay | Not Covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | $0 Copay | Not Covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery facility services | $0 Copay | Not Covered | Cost sharing does not apply for preventive services. |
| **If you need help recovering or have** | Home health care | $0 Copay | Not Covered | Limited to 90 visits per continuous 12-month period. |



* 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) | |
| **other special health needs** | Rehabilitation services | $0 Copay | Not Covered | PT/OT/ST Benefits are limited to 60 total combined visits per year. |
| | Habilitation services | $0 Copay | Not Covered | |
| | Skilled nursing care | $0 Copay | Not Covered | Benefit is limited to 150 days per Member per Calendar Year. |
| | Durable medical equipment | $0 Copay | Not Covered | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details. |
| | Hospice services | $0 Copay | Not Covered | Limited to One 48-hour Respite period, once per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | $0 Copay | 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. |
| | Children's glasses | $0 Copay | 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. |
| | Children's dental check-up | $0 Copay | $0 Copay | Pediatric Dental Benefits are provided in partnership with Northeast Delta Dental. Refer to your Member Benefit Agreement and Schedule of Benefits for more information. |



* 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.) | | |
|---|---|---|
| • Acupuncture | • Infertility treatment | • Weight loss programs |
| • Cosmetic Surgery | • Long-term care | |
| • Covered services provided outside the U.S. | • Routine eye care (Adult) | |
| • Dental care (Adult) | • Routine foot 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 | • Bariatric Surgery |
| • Hearing aids | • 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: 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 $0
- Specialist coinsurance $0
- Hospital (facility) coinsurance $0
- Other coinsurance $0

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

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

- The plan's overall deductible $0
- Specialist coinsurance $0
- Hospital (facility) coinsurance $0
- Other coinsurance $0

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

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

- The plan's overall deductible $0
- Specialist coinsurance $0
- Hospital (facility) coinsurance $0
- Other coinsurance $0

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

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