


**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](http://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/](http://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 <a href="#">deductible</a> ?                                | <b>In-Network - \$2,600/individual or \$5,200/family;</b><br><b>Out-of-Network - \$5,200/individual or \$10,400/family</b>                                      | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive Care (as defined in your Member Benefit Agreement) and most services that require a <a href="#">copayment</a> .                                 | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . Refer to your Member Benefit Agreement for more information.  |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes, \$100/child for pediatric dental coverage.   | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>In-Network - \$7,500/individual; or \$15,000/family;</b><br><b>Out-of-Network - \$15,000/individual or \$30,000/family</b>                                   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, <a href="#">balance billing</a> charges (charges above the <a href="#">allowed amount</a> ), and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.healthoptions.org">www.healthoptions.org</a> or call 1-855-624-6463 for a list of <a href="#">network providers</a> .              | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



All [coinsurance](#) and most services that require a copayment. 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<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>  | Primary care visit to treat an injury or illness       | \$35 Copay   | 50% Coinsurance after Deductible                   | This plan requires all Members to select a PCP that is a Plan Provider.   |
|  | <a href="#">Specialist</a> visit                       | \$85 Copay   | 50% 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. |
|  | <a href="#">Preventive care/screening/immunization</a> | \$0 Copay  | 50% 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.                               |
| <b>If you have a test</b>  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% Coinsurance after Deductible                           | 50% Coinsurance after Deductible                   | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 30% Coinsurance after Deductible                           | 50% Coinsurance after Deductible                   |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.healthoptions.org/Formulary">https://www.healthoptions.org/Formulary</a> | Preferred generic drugs (Tier 1)                       | \$5 Copay  | 50% Coinsurance after Deductible                   | Refer to the Member Benefit Agreement for details on our 90-day mail-order program.   |
|  | Generic drugs (Tier 2)                                 | \$35 Copay   | 50% Coinsurance after Deductible                   |   |
|  | Preferred brand & non-preferred generic drugs (Tier 3) | 30% Coinsurance after Deductible                           | 50% Coinsurance after Deductible                   |   |
|  | Non-preferred brand drugs (Tier 4)                     | 30% Coinsurance after Deductible up to max of \$300/script | 50% Coinsurance after Deductible                   |   |
|  | <a href="#">Specialty drugs</a> (Tier 5)               | 30% Coinsurance after Deductible up to max of \$500/script | 50% Coinsurance after Deductible                   | 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| 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                                   | <a href="#">Emergency room care</a>              | 30% Coinsurance after Deductible             | 30% Coinsurance after Deductible                   | None  |
|   | <a href="#">Emergency medical transportation</a> | 30% Coinsurance after Deductible             | 30% Coinsurance after Deductible                   | None  |
|   | <a href="#">Urgent care</a>                      | \$85 Copay                                   | 50% Coinsurance after Deductible                   | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | None  |
|   | 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                              | \$35 Copay<br>Waived for 1st 3 visits        | 50% Coinsurance after Deductible                   | Cost-sharing is waived for the first 3 outpatient MH/BH/SA office visits with Network Provider. |
|   | Inpatient services                               | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | None  |
| If you are pregnant   | Office visits                                    | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | <u>Cost sharing</u> does not apply for <u>preventive services</u> .                             |
|   | Childbirth/delivery professional services        | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | <u>Cost sharing</u> does not apply for <u>preventive services</u> .                             |
|   | Childbirth/delivery facility services            | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | <u>Cost sharing</u> does not apply for <u>preventive services</u> .                             |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | None  |
|   | <a href="#">Rehabilitation services</a>          | \$35 Copay                                   | 50% Coinsurance after Deductible                   | PT/OT/ST Benefits are limited to 60 total combined visits per year. None                        |

\* 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">Habilitation services</a>     | \$35 Copay                                   | 50% Coinsurance after Deductible                   |  |
|   | <a href="#">Skilled nursing care</a>      | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Benefit is limited to 150 days per Member per Calendar Year.   |
|   | <a href="#">Durable medical equipment</a> | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.  |
|   | <a href="#">Hospice services</a>          | 30% Coinsurance after Deductible             | 50% Coinsurance after Deductible                   | Limited to One 48-hour Respite period, once per lifetime.  |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | \$35 Copay                                   | 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                   | 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                | 20% Coinsurance                              | 20% Coinsurance                                    | Pediatric Dental coverage is offered in partnership with Northeast Delta Dental. Please see your Member Benefit Agreement for details.   |

\* 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                           | • Infertility treatment | • Weight loss programs |
| • Covered services provided outside the U.S. | • Long-term care        |                        |
| • 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 |
| • Chiropractic care                               | • 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](http://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](http://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](http://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.* —————

**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](#) \$2,600
- [Specialist copayment](#) \$85
- 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** \$12,731

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,600        |
| <a href="#">Copayments</a>        | \$28           |
| <a href="#">Coinsurance</a>       | \$2,985        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$5,613</b> |

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

- The [plan's](#) overall [deductible](#) \$2,600
- [Specialist copayment](#) \$85
- 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** \$7,389

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$56           |
| <a href="#">Copayments</a>        | \$565          |
| <a href="#">Coinsurance</a>       | \$704          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,325</b> |

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

- The [plan's](#) overall [deductible](#) \$2,600
- [Specialist copayment](#) \$85
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,527        |
| <a href="#">Copayments</a>        | \$298          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,825</b> |