

 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 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/](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>Preferred In-Network- \$7,500 /individual or \$15,000 /family Standard In-Network- \$9,000 /individual or \$18,000 /family</b>	Generally, you must pay all of the costs from <a href="#">providers</a> 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). For more information see below.	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 <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Preferred In-Network- \$9,200 /individual or \$18,400 /family Standard In-Network- \$9,200 /individual or \$18,400 /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 <a href="#">plan's 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 <a href="#">provider's</a> 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> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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
		Preferred Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (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	\$0 Cost for your first visit then \$45 Copay, Deductible does not apply  Firefly Virtual PCP: \$25 Copay; Deductible does not apply	\$80 Copay; Deductible does not apply	Not Covered	This plan requires all Members to select a PCP that is in-network. Virtual PCPs are available. 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="#">Specialist</a> visit	\$80 Copay; Deductible does not apply	\$80 Copay after Deductible	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.
	<a href="#">Preventive care/screening/immunization</a>	\$0 Copay; deductible does not apply		Not Covered	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab Services from a Specified Location: \$25 Copay; Deductible does not apply All other: 50% Coinsurance after Deductible		Not Covered	Please refer to our website for a list of Specified Reference Lab locations or contact Member Services for additional information.

\* 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
		Preferred Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		X-Rays from a Specified Location: \$75 Copay; Deductible does not apply All other: 50% Coinsurance after Deductible			
	Imaging (CT/PET scans, MRIs)	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	Differences in Network are limited to Outpatient settings.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://www.healthoptions.org/FormularY">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)	30 Day Retail: \$5 Copay; Deductible does not apply 90 Day Mail Order: \$10 Copay; Deductible does not apply		Not Covered	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 Chronic Illness Support Program (CISP) and Script Saver program.
	Generic drugs (Tier 2)	30 Day Retail: \$30 Copay; Deductible does not apply 90 Day Mail Order: \$60 Copay; Deductible does not apply		Not Covered	
	Preferred brand drugs (Tier 3)	30 Day Retail: \$50 Copay after Deductible 90 Day Mail Order: \$100 Copay after Deductible		Not Covered	
	Non-preferred brand drugs (Tier 4)	30 Day Retail: \$100 Copay after Deductible 90 Day Mail Order: \$200 Copay after Deductible		Not Covered	
	<a href="#">Specialty drugs</a> (Tier 5)	30 Day Retail and Mail Order: \$250 Copay after Deductible		Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	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
		Preferred Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% Coinsurance after Deductible			None.
	<a href="#">Emergency medical transportation</a>	50% Coinsurance after Deductible			None.
	<a href="#">Urgent care</a>	Virtual via Amwell: \$0 Copay; Deductible does not apply Freestanding: \$50 Copay; Deductible does not apply		Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance after Deductible		Not Covered	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		Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 Cost for your first visit, then \$45 Copay; Deductible does not apply		Not Covered	Virtual Behavioral Health services are also available through Amwell®. Contact Member Services for additional resources.
	Inpatient services	50% Coinsurance after Deductible		Not Covered	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	Not Covered	Differences in Network are limited to services provided by a Preferred provider. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Visit <a href="http://healthcare.gov">healthcare.gov</a> for a full list of preventive services for people who are or may become pregnant. Pregnancy care may include tests
	Childbirth/delivery professional services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	

\* 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
		Preferred Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	and services described elsewhere in this document (i.e. ultrasounds).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	50% Coinsurance after Deductible		Not Covered	None.
	<a href="#">Rehabilitation services</a>	Physical Therapy: \$45 Copay; Deductible does not apply Occupational Therapy: \$45 Copay; Deductible does not apply Speech Therapy: \$45 Copay; Deductible does not apply	Physical Therapy: \$145 Copay; Deductible does not apply Occupational Therapy: \$145 Copay; Deductible does not apply Speech Therapy: \$145 Copay; Deductible does not apply	Not Covered	Differences in Network are limited to office-based therapies delivered by a Preferred provider. PT/OT/ST Benefits are limited to 60 total combined visits per year.
	<a href="#">Habilitation services</a>	Physical Therapy: \$45 Copay; Deductible does not apply Occupational Therapy: \$45 Copay; Deductible does not apply Speech Therapy: \$45 Copay; Deductible does not apply	Physical Therapy: \$145 Copay; Deductible does not apply Occupational Therapy: \$145 Copay; Deductible does not apply Speech Therapy: \$145 Copay; Deductible does not apply	Not Covered	Differences in Network are limited to office-based therapies delivered by a Preferred provider. PT/OT/ST Benefits are limited to 60 total combined visits per year.
	<a href="#">Skilled nursing center</a>	50% Coinsurance after Deductible		Not Covered	Benefit is limited to 150 days per Member per Calendar Year.
	<a href="#">Durable medical equipment</a>	50% Coinsurance after Deductible		Not Covered	Refer to the Member Benefit Agreement, Durable Medical Equipment section for details.
	<a href="#">Hospice services</a>	50% Coinsurance after Deductible		Not Covered	Limited to One 48-hour Respite period, once per lifetime.

\* 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
		Preferred Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$45 Copay; Deductible does not apply		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	50% Coinsurance after Deductible		Not Covered	For more information on eyewear and contacts, contact Member Services.
	Children's dental check-up	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](http://HealthOptions.org)

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Long-term care	• Weight loss programs
• Cosmetic Surgery	• Private-duty nursing	
• Dental care (Adult)	• Routine foot care	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Abortion for which public funding is prohibited	• Covered Emergency services provided outside the U.S	• Routine eye care (Adult)
• Bariatric Surgery	• Hearing Aids	
• Chiropractic care	• Infertility Treatment	

**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](http://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](http://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](http://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? **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 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](#) \$7,500
- [Specialist copayment](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$7,500
Copayments	\$0
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$9,200</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$532
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$932</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,090
Copayments	\$425
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,515</b>

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