|  |
| --- |
| **The Summary of Plan Benefits, Limits, and Exclusions document shows how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, [insert contact information]. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/). |

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **$**  |  |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** |  |  |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | **$** |  |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | **$** |  |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** |  |  |
| **What is the annual dollar limit on benefits?** | **$** |  |
| **Are there other annual dollar limits for specific services?** |  |  |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** |  |  |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** |  |  |

| **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**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness |  |  |  |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit |  |  |  |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization |  |  |  |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) |  |  |  |
| Imaging (CT/PET scans, MRIs)  |  |  |  |
| **If you need drugs to treat your illness or condition**More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at www.[insert].com | Generic drugs |  |  |  |
| Preferred brand drugs |  |  |  |
| Non-preferred brand drugs |  |  |  |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug)  |  |  |  |
| **If you have outpatient surgery** | Facility fee (*e.g.,* ambulatory surgery center) |  |  |  |
| Physician/surgeon fees |  |  |  |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) |  |  |  |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) |  |  |  |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) |  |  |  |
| **If you have a hospital stay** | Facility fee (*e.g.,* hospital room) |  |  |  |
| Physician/surgeon fees |  |  |  |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services |  |  |  |
| Inpatient services |  |  |  |
| **If you are pregnant** | Office visits |  |  |  |
| Childbirth/delivery professional services |  |  |  |
| Childbirth/delivery facility services |  |  |  |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) |  |  |  |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) |  |  |  |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) |  |  |  |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) |  |  |  |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) |  |  |  |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) |  |  |  |

**Excluded Services & Other Covered Services:**

|  |
| --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
|  |  |  |

|  |
| --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list.****Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** |
|  |  |  |

**Your Grievance and Appeal Rights:** There are agencies that can help if you have a complaint against your [plan](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, visit [www.maine.gov/pfr/insurance/consumer/](https://www.maine.gov/pfr/insurance/consumer/) or call 1‑800-300-5000.

**Does this plan provide Minimum Essential Coverage under the federal Affordable Care Act? [Yes/No]**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

–––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–*–

**Coverage Examples:**

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

**Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $**

◼ **Hospital (facility) *[cost sharing]* %**

◼ **Other** ***[cost sharing]* %**

**This EXAMPLE includes services like:**

Specialist office visits (*prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (*ultrasounds, blood work)*

Specialist visit *(anesthesia)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$** |

 **In this example, you would pay:**

|  |
| --- |
| *Cost Sharing* |
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total you would pay:** | **$** |
| **The total the plan would pay:** | **$** |

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $**

◼ **Hospital (facility) *[cost sharing]* %**

◼ **Other *[cost sharing]* %**

**This EXAMPLE includes services like:**

Primary care physician office visits

Diagnostic tests *(blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$****The plan would be responsible for the other costs of these EXAMPLE covered services.** |

 **In this example, you would pay:**

|  |
| --- |
| *Cost Sharing* |
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total you would pay:** | **$** |
| **The total the plan would pay:** | **$** |

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $**

◼ **Hospital (facility) *[cost sharing]* %**

◼ **Other *[cost sharing]* %**

**This EXAMPLE includes services like:**

Emergency room care *(including medical supplies)*

Diagnostic test *(x-ray)*

Durable medical equipment *(crutches)*

Rehabilitation services *(physical therapy)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$** |

 **In this example, you would pay:**

|  |
| --- |
| *Cost Sharing* |
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total you would pay:** | **$** |
| **The total the plan would pay:** | **$** |