2024 Schedule of Benefits

Health Options Clear Choice Bronze $7500 HMO Tiered NE Dental Off MP

Effective on or after: 01/01/2024

This Schedule of Benefits is a summary of Benefit Limits and Member Cost-Sharing amounts you must pay for Covered Benefits for effective coverage during the 2024 Calendar Year. Under this Plan, Referrals are required for certain services. Please refer to your Member Benefit Agreement (MBA) for more information.

General Cost Sharing Information	Preferred In-Network Providers	Standard In-Network Providers
Deductibles (Ded)		
Individual Deductible	$7,500	$9,000
Family Deductible	$15,000	$18,000
Under family coverage, once one covered family member meets the Individual Deductible for the Calendar Year, remaining family members, individually or collectively, must meet the remaining amount of the full Family Deductible. Once the full Family Deductible is met, services for all covered family members are subject to applicable coinsurance until the Out-of-Pocket Limit is reached. Preferred provider services performed by a Preferred provider will accumulate to the Preferred Network Deductible. Services, performed by a Standard provider will accumulate to the Standard Network Deductible.		
Member Coinsurance (Co)	50%	60%
For most services, the Member Coinsurance is cost-sharing you are responsible for after you have met the applicable Deductible.		
Out-of-Pocket (OOP) Maximums		
Individual OOP Maximum	$9,450	$9,450
Family OOP Maximum	$18,900	$18,900
Under family coverage, once one covered family member meets the Individual Out-of-Pocket Maximum for the Calendar Year, the Plan pays 100% of the Maximum allowable amount for Covered Services for that Member. Remaining family members individually or collectively can meet the remaining amount of the full Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, the Plan pays 100% of the Maximum allowable amount for Covered Services for all Members covered under the family policy. Services provided by a Preferred provider will accumulate to both the Preferred Network and Standard Network Out-of-Pocket Maximums. Services provided by a Standard provider will only apply to the Standard Out-of-Pocket Maximum. Any services completed by non-tiered providers will accumulate to the Preferred Network Deductible, and both the Preferred Network and Standard Network Out-of-Pocket Maximum. Total Out-of-Pocket expenses for covered benefits will not exceed the Standard Out-of-Pocket Maximum.		

Important Information About Out-of-Network Services

Community Health Options® Network consists of Network Providers throughout Maine and New Hampshire and select Providers in Massachusetts. Except for Emergency Services, health care received from non-Network Providers are not covered under this plan. This means you will be financially responsible for all charges from non-Network providers. These charges will not be applied to your plan's Deductible or Out-of-Pocket Maximum.

To find Network Providers go to www.healthoptions.org/Search-provider or call Member Services at (855) 624-6463.

For Emergency Services rendered by a non-Network provider, your Out-of-Pocket Costs for charges up to the Maximum Allowable Amount will be the same as though you received care from a Network Provider. Notification requirements may apply. Failure to comply with notification requirements, as described in your Member Benefit Agreement, may result in a benefit reduction penalty of up to $500 for each occurrence.

There is no coverage for non-Emergency services provided outside the United States. This plan provides coverage for Emergency Services outside the United States on an Out-of-Network basis.

Some Covered Services require Prior Approval (PA) or Notification before we will pay Benefits. Network Providers are responsible for obtaining PA on your behalf prior to the Services being rendered. A full listing of *Prior Approval and Notification Requirements* is available on our website at:

https://www.healthoptions.org/health-care-professionals/professional-document-and-forms

Our Member Services Team is available to answer questions regarding your coverage and any requirements, Monday through Friday 8a.m. to 6 p.m. at (855) 624-6463.

All Preferred providers are noted on the Provider Directory at HealthOptions.org. Be sure to verify tier status of all professional and institutional (facility) Providers. Members receiving services from a Preferred In-Network provider will have a lower member cost share, while services received at a Standard In-Network provider will have a higher cost share.

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Advanced Imaging (PET/MRI/CT)	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient settings.
Allergy Testing and Injections	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to services provided by a Preferred provider.
Ambulance Transport – Emergency	50% Coinsurance after Deductible		Coverage includes transportation to nearest hospital that can provide the required care. Refer to your MBA for details.
Ambulance Transport – Non-Emergency	50% Coinsurance after Deductible		
Autism Spectrum Disorders/ABA	50% Coinsurance after Deductible		
Blood Transfusions	50% Coinsurance after Deductible		
Cardiac Rehabilitation - Outpatient	50% Coinsurance after Deductible	60% Coinsurance after Deductible	36 visits per cardiac episode. Differences in Network are limited to Outpatient Services; does not apply to Professional services.
Chemotherapy, Radiation	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider.
Chiropractic Manipulative Therapy	$45 Copay		Benefit includes physical therapy provided by a Chiropractor. 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. Limited to 40 visits per Member per Calendar Year. Refer to your MBA for details.
Clinical Trials	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to services provided by a Preferred provider.
Diabetic Services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient Services provided by a Preferred provider
Dental Services – Emergency Dental Care	50% Coinsurance after Deductible		
Dental Services – Extraction of Impacted Teeth	50% Coinsurance after Deductible		

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Dialysis Services	50% Coinsurance after Deductible		
Durable Medical Equipment/Prosthetics	50% Coinsurance after Deductible		
Prosthetics Replacement of Arms and Legs	20% Coinsurance after Deductible		
Elective Abortion	$0 Copay	$0 Copay	Differences in Network are limited by services provided by a Preferred provider. Abortion for which public funding is prohibited.
Emergency Room Care	50% Coinsurance after Deductible		
Foot Care- Medically Necessary	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider. Routine foot care is not covered. Refer to MBA for details.
Formula/Medical Food	50% Coinsurance after Deductible		In certain cases, the Plan provides Benefits for Infant and Metabolic Formula. Subject to annual benefit limits as required by law. Refer to your MBA for details.
Gender-Affirming Surgery	50% Coinsurance after Deductible		Prior Approval is required. Cosmetic Surgery and Services are not covered. See Transgender Health Services (below) or your MBA for additional information on benefits and coverage.
Health Care Services for COVID-19	No cost sharing for COVID-19 screening, testing or immunization as required or limited by law.		
Hearing Aids – Pediatric & Adult	50% Coinsurance after Deductible		The benefit is limited to a maximum of $3,000 per hearing aid for each hearing-impaired ear every 36 months.
Home Healthcare	50% Coinsurance after Deductible		
Hospice Services	50% Coinsurance after Deductible		
Hospice Respite Care	50% Coinsurance after Deductible		Hospice Respite Care limited to one 48-hour period per lifetime.

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Infusion Therapy	50% Coinsurance after Deductible		An alternate infusion location such as home-based, may save you money over facility-based infusion. Ask your Provider if home-based infusion is an appropriate option for you. Call Member Services at (855) 624-6463 Monday-Friday, 8am-6pm, if you need assistance finding a Network home-infusion Provider.
Inhalation Therapy	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider
Inpatient Hospital Facility (including Acute Hospital care, maternity care)	50% Coinsurance after Deductible		
Inpatient Rehabilitation	50% Coinsurance after Deductible		
Inpatient Physician Visits	50% Coinsurance after Deductible		
Laboratory and Radiology Services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient settings by a Preferred provider.
In many cases, you will have lower Out-of-Pocket costs when you use a Network independent laboratory for routine laboratory services. Your Provider may already have regularly scheduled pickups by independent labs. Talk to your Provider about your laboratory options. Visit www.HealthOptions.org/provider for a complete listing of our Network Providers.			
Leukocyte Antigen Testing	$0 Copay		Limitations apply. See MBA for details.
Massage Therapy	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider. Limitations apply. See MBA for details.
Maternity	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider. Coverage for routine newborn care will be attributed to the mother's coverage until the mother's discharge. If the newborn remains in the Hospital after the mother is discharged, or if services beyond the scope of routine newborn care are provided, those services will be subject to deductible and coinsurance, if applicable, to the newborn.

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
The Plan provides Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. If a newborn receives services that are beyond the scope of routine newborn care prior approval must be obtained. For discharge timeframes and coverage after discharge, please refer to your MBA.			
Medical Drugs (drugs that cannot be self-administered)	50% Coinsurance after Deductible		
Mental Health/Substance Use Disorder (Substance Abuse) - Inpatient	50% Coinsurance after Deductible		
Mental Health/Substance Use Disorder (Substance Abuse)- Outpatient	$45 Copay		The first outpatient office visit each CalenDBr Year for Mental Health or Substance-Use Disorder (Substance Abuse) services will be at zero-cost when rendered by a Network Provider. Any subsequent Copayments will accumulate towards your deductible.
Mental Health/Substance Use Disorder (Substance Abuse)– Partial Hospitalization Services	50% Coinsurance after Deductible		
Morbid Obesity	50% Coinsurance after Deductible		Limited to surgery for intestinal bypass, gastric bypass or gastroplasty for treatment of Morbid Obesity.
Nutritional Counseling	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited by services provided by a Preferred provider.
Osteopathic Manipulative Therapy	$45 Copay		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. Benefit is limited to 40 visits per Member per Calendar Year. Refer to your MBA for details.
Organ and Tissue Transplants	50% Coinsurance after Deductible		
Orthotic Devices	50% Coinsurance after Deductible		Limitations apply. Refer to MBA for details.
Outpatient Facility	50% Coinsurance after Deductible	60% Coinsurance after Deductible	
Parenteral and Enteral Therapy	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Professional Services delivered by a Preferred Provider.

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Preventive Care	$0 Copay		When prescribed by a network provider, certain Preventative Care Services, as defined by federal law, are available with no Out-of-Pocket Cost. For details on what is covered with no Out-of-Pocket Cost. Refer to your MBA for details.
Primary Care Office Visits	$45 Copay	$65 Copay	The first visit to your Network PCP is free. Any subsequent Copayments will accumulate towards your deductible.
Prostate Cancer Screening	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient Services delivered by a Preferred Provider.
Rehabilitation and Habilitation Services – Outpatient (includes Physical, Occupational, and Speech Therapy)	$45 Copay	$145 Copay	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 Calendar year. When PT/OT/ST are part of a home health care visit, the limits for PT/OT/ST will not apply if the care is obtained as part of the Home Health care benefit.
Skilled Nursing Facility Care	50% Coinsurance after Deductible		Limited to 150 days per Member per Calendar Year.
Sleep Studies	50% Coinsurance after Deductible		Limited to 2 per Calendar Year.
Home-based sleep studies may save you money over facility-based sleep studies. Ask your Provider if a home-based sleep study is an appropriate option for you. Call Member Services at (855) 624-6463 Monday-Friday, 8am-6pm, if you need assistance finding an In Network home sleep study Provider.			
Specialty Care Office Visits	$80 Copay	$100 Copay	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.
Surgery/Anesthesia	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient settings.

Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Tobacco/Smoking Cessation	$0 Copay		The Plan provides Benefits for FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications with no Out-of-Pocket costs when prescribed by a health care Provider (limited to two 90-day treatment regimens for prescription medications per Member per Calendar Year.) The Plan provides Benefits for tobacco cessation programs, follow-up education, counseling, and completion of a Health Options approved smoking cessation program. Please refer to your MBA for details.
Transgender Health Services	Benefits include medical and behavioral health provider visits, outpatient prescription drugs (hormone prescriptions are processed without regard to gender), and gender-affirming surgery (requires Prior Approval). Preventive services that are aligned with biologic anatomy are covered as preventive in accordance with the United States Preventive Service Task Force (USPSTF) "A" or "B" rating. Refer to your MBA for details.		
Urgent Care Visits	$60 Copay	$80 Copay	
Amwell Telehealth	$0 Copay		Visit our website www.healthoptions.org for more information, including how to access this network of clinicians for your non-emergency medical care.
Vision Exams – Adult	50% Coinsurance after Deductible		The Plan provides Benefits for one routine vision exam, including refraction, per 12 Calendar months. Refer to your MBA for details.
X-rays and Diagnostic Imaging	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to Outpatient settings and applies to technical services only. Preferred providers are independent freestanding and mobile imaging centers.

Pediatric Specific Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Cochlear Implants	50% Coinsurance after Deductible		This benefit is limited. Refer to your MBA for details.

Pediatric Specific Medical Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Early Intervention Services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Differences in Network are limited to office-based therapies delivered by a Preferred provider. Limited to Members up to 36 months old with an identified Developmental Disability. Limited to 33 visits per Calendar Year.
Glasses/Contacts*	50% Coinsurance after Deductible		This benefit is limited. Refer to your MBA for details.
Vision Exams*	$45 Copay		The Plan provides Benefits for a complete vision exam, including refraction, as needed to detect vision impairment by a Network Provider.
*Members are eligible for Pediatric Benefits up to the end of the month in which the Member turns age 19.			

Prescription Drug Benefit	Preferred: In-Network Providers	Standard: In-Network Providers	Coverage Notes and Limits
Tier 1 – Preferred Generics	**Retail-**$5 Copay**; Mail Order-** $10 Copay		You may obtain a 90-day supply of covered maintenance drugs and certain covered controlled substances by mail through our preferred home delivery pharmacy. The use of home delivery is recommended for drugs used to treat chronic, long-term conditions. Insulin is covered at $35 for up to each 30-day supply of medication.
Tier 2 – Generics	**Retail-**$30 Copay; **Mail Order-** $60 Copay		
Tier 3 – Preferred Brands	**Retail-**$50 Copay after Deductible; **Mail Order-** $100 Copay after Deductible		
Tier 4 – Non-Preferred Brands	**Retail-**$100 Copay after Deductible; **Mail Order-** $200 Copay after Deductible		
Tier 5 – Specialty	**Retail-**$250 Copay after Deductible**; Mail Order-** $250 Copay 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.
Visit our website at https://www.healthoptions.org/Documents/Formulary for access to our formulary. Our Home Delivery program can save you money. Refer to your MBA for details. This plan includes the Chronic Illness Support Program. This Program provides reduced Out-of-Pocket (Copayments, Coinsurance, and Deductibles) when services are performed by a Network Provider. Select Tier 1, Tier 2 and Tier 3 preferred Medications. will also have reduced Out-of-Pocket Costs. The drugs selected as part of the Chronic Illness Support Program will be designated on our formulary and must be filled through the Home Delivery Program to receive the reduced cost-sharing. Refer to your Member Agreement for more information.			

Pediatric Dental Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Deductible per Child	$100	$100	
Deductible per Family	N/A	N/A	Each child meets their Deductible.
Diagnostic/Preventive	0% Coinsurance	0% Coinsurance	
Basic Restorative	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Major Restorative	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
Medically Necessary Orthodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

Pediatric Dental coverage is offered in partnership with Northeast Delta Dental. Charges from Non-Network Providers above Network Provider rates are your responsibility [also known as balance billing]. Only your payments to Delta Dental PPO Dentists shall accrue to the Out -of-Pocket Costs for Network Providers. See the description of Dental Benefits Program in Section 12 of your MBA.

Acupuncture
• This plan does not provide Benefits for Acupuncture.

General List of Exclusions
The following list identifies services that are generally excluded from Health Options Plans. For more details and a complete list of exclusions please refer to your Member Benefit Agreement (MBA).
Administrative Exams/Services, Court Ordered Testing/Care or Workers' Compensation
Alternative/Complementary Treatment and Therapy
Cosmetic Services
Dental Care (except coverage detailed in your MBA) and Dental Prostheses
Domiciliary, Custodial Care or Private Duty Nursing
DME and Prosthetic Devices that are spares or back-ups or occupational purposes (except coverage detailed in your MBA)
Experimental/Investigational Services (including biofeedback, shock wave treatment, homeopathy, etc.)
Free Care or Government Services and Supplies
Hearing Care (except coverage detailed in your MBA)
Maintenance and Regression Services, Treatments or Therapy
Massage Therapy (except coverage detailed in your MBA)
Non-emergency Ambulance Services (except coverage detailed in your MBA)
Orthognathic Surgery
Orthotic Devices, Shoe Inserts
Over the Counter Equivalents, Non-prescriptive Birth Control, and Food or Dietary Supplements
Out-of-Network non-Emergency Services
Personal Comfort and Convenience
Personal Enrichment/Lifestyle Services; Diet Plans and Programs; Gym or Spa Memberships
Routine Circumcisions
Routine Foot Care and Surgical Treatment of Certain Foot Conditions
Services provided before your coverage began or after your coverage ends
Unlicensed or Ineligible Providers
Vision Care and Refractive Eye Surgery