2025 Schedule of Benefits

Health Options Clear Choice Silver $3500 HMO Tiered NE Dental Off MP

Effective on or after: 01/01/2025

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 2025 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	$3,500	$4,200
Family Deductible	$7,000	$8,400
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)	30%	50%
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	$8,500	$8,500
Family OOP Maximum	$17,000	$17,000
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 Maximums. 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, healthcare 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 HealthOptions.org 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.

There is not coverage for non-Emergency Services provided outisde the United States. This plan provides coverage for Emergency Services outside the United States on an Out-of-Network basis.
Chronic Illness Support Program Members who manage their conditions through in-network office visits can save on routine care. Additionally, Members can save on CISP designated medications when ordering through the Express Scripts (ESI) mail order pharmacy. Members who manage their conditions through in-network office visits can save on routine care. Additionally, Members can save on CISP designated medications when ordering through the Express Scripts (ESI) mail order pharmacy.

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.

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.

Emergency and Urgent Care		
Medical Benefit	**In-Network Providers**	**Coverage Notes and Limits**
Emergency Room Care	30% Coinsurance after Deductible	
Emergency Ambulance Transport	30% Coinsurance after Deductible	Coverage includes transportation to the nearest hospital that can provide the required care. Refer to your MBA for details.
Emergency Dental Care	30% Coinsurance after Deductible	
Urgent Care		Amwell® telehealth can be accessed through your member portal.
Amwell® Telehealth	$0 Copay; Deductible does not apply	
Freestanding Facility	$40 Copay; Deductible does not apply	
Other Urgent Care Facility	$40 Copay; Deductible does not apply	

Office Visits and Preventive Care			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Firefly Virtual Primary Care Office Visit	$40 Copay; Deductible does not apply		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.
Primary Care Office Visits	$0 Cost for your first visit then $40 Copay; Deductible does not apply	$70 Copay; Deductible does not apply	
Preventive Care	$0 Copay; Deductible does not apply		When prescribed by a network provider, certain Preventive Care Services, as defined by federal law, are available with no Out-of-Pocket Cost. For details on what is covered contact Member Services.

Tobacco/Smoking Cessation	$0 Copay; Deductible does not apply		The Plan provides Benefits for FDA-approved tobacco cessation medications, tobacco cessation programs, follow-up education and counseling. Please refer to your MBA or call Member Services for details.
Specialty Care Office Visits	$60 Copay; Deductible does not apply	$60 Copay 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.
Mental Health and Substance Use Disorder Services			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Mental Health/Substance Use - Outpatient	$0 Cost for your first visit then $40 Copay; Deductible does not apply		Virtual Behavioral Health services are also available through Amwell®. Contact Member Services for additional resources.
Mental Health/Substance Use - Partial Hospitalization Services	30% Coinsurance after Deductible		Our Care Managers are available to support and offer resources to Members. Contact Member Services to connect with a Care Manager.
Mental Health/Substance Use - Inpatient	30% Coinsurance after Deductible		
Diagnostic Services			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Labs Specified Reference Lab All Other Locations	$25 Copay; Deductible does not apply 30% Coinsurance after Deductible		Please refer to our website for a list of Specified Reference Lab locations or contact Member Services for additional information.
X-Ray Specified Radiology Center All Other Locations	$75 Copay; Deductible does not apply 30% Coinsurance after Deductible		Please refer to our website for a list of Specified Radiology centers or contact Member Services for additional information.
Other Radiology Services (i.e. Ultrasound)	30% Coinsurance after Deductible		
Advanced Imaging (PET/MRI/CT)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Prostate Cancer Screening	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Inpatient Hospital			

Medical Benefit	In-Network Providers: Preferred	In-Network Providers: Standard	Coverage Notes and Limits
Inpatient Physician Visits	30% Coinsurance after Deductible		Our Care Managers are available to support and offer resources to Members. Contact Member Services to connect with a Care Manager.
Inpatient Hospital Facility	30% Coinsurance after Deductible		
Inpatient Rehabilitation Care	30% Coinsurance after Deductible		
Skilled Nursing Facility Care	30% Coinsurance after Deductible		Limit to 150 days per calendar year.

Surgery

Medical Benefit	In-Network Providers: Preferred	In-Network Providers: Standard	Coverage Notes and Limits
Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Anesthesia	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Organ and Tissue Transplants	30% Coinsurance after Deductible		
Outpatient Facility Fee	OutpatFacInnPref»	50% Coinsurance after Deductible	
Gender Affirming Surgery	30% Coinsurance after Deductible		Gender Affirming Care coverage includes medical and behavioral health provider visits, outpatient prescription drugs, and gender-affirming surgery (requires Prior Approval). Refer to your MBA or call Member Services for additional information on benefits and coverage.

Therapy Services

Medical Benefit	In-Network Providers: Preferred	In-Network Providers: Standard	Coverage Notes and Limits
Rehabilitative and Habilitative Therapy			
Physical Therapy	$40 Copay; Deductible does not apply	$140 Copay; Deductible does not apply	Limited to 60 visits combined PT/OT/ST 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.
Occupational Therapy	$40 Copay; Deductible does not apply	$140 Copay; Deductible does not apply	
Speech Therapy	$40 Copay; Deductible does not apply	$140 Copay; Deductible does not apply	

Chiropractic Manipulative Therapy	$40 Copay; Deductible does not apply		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.
Osteopathic Manipulative Therapy	$40 Copay; Deductible does not apply		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.
Massage Therapy (See MBA)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Limitations apply. See MBA for details.
Outpatient Cardiac Rebab	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Limited to 36 visits per cardiac episode per calendar year.
Inhalation Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Infusion Therapy	30% Coinsurance after Deductible		You may qualify for financial incentive payments of up to $1,000 annually for infusion drug therapy if you receive your infusion drug therapy at specified locations (including in your home). Contact Member Services for more information.
Chemotherapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Radiation Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Parenteral and Enteral Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Food and Nutrition			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**

Medical Nutrition Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Cost share waived for preventive visits for select conditions. and for members with specified benefits through the Chronic Illness Support Program.
Infant Formula and Donor Breast Milk	30% Coinsurance after Deductible		Limitations apply. Refer to your MBA or call Member Services for more information.
Medical Food Coverage for Inborn Error of Metabolism	30% Coinsurance after Deductible		
Reproductive Care			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Pregnancy Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	The Plan provides Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn and complications of pregnancy. For more information, please refer to your MBA or call Member Services.
Fertility	30% Coinsurance after Deductible		
Medical Devices			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Durable Medical Equipment (DME)	30% Coinsurance after Deductible		Coverage is available for select DME with no cost share for Members with eligible chronic illnesses via the Chronic Illness Support Program (CISP).
Prosthetic Devices	30% Coinsurance after Deductible		
Prosthetic Replacement of Arms and Legs	20% Coinsurance after Deductible		Coverage for medically necessary prosthetics for recreational purposes is limited to members under 18 years of age.
Orthotic Devices	30% Coinsurance after Deductible		Limitations apply. Refer to your MBA or call Member Services for more information.
Vision and Hearing			
Medical Benefit	**In-Network Providers: Preferred**	**In-Network Providers: Standard**	**Coverage Notes and Limits**
Pediatric Routine Vision Exams*	$40 Copay; Deductible does not apply		Limited to 1 routine exam every 12 calendar months.

Pediatric Glasses / Contacts*	30% Coinsurance after Deductible	Limited to once every 24 calendar months.
Adult Routine Vision Exams	30% Coinsurance after Deductible	Not an Essential Health Benefit: Cost share does not accumulate to out-of-pocket limits. Limited to 1 routine exam every 12 calendar months.
Hearing Aids-Pediatric and Adult	30% Coinsurance after Deductible	The benefit is limited to a maximum of $3,000 per hearing aid for each hearing-impaired ear every 36 months.
Pediatric Cochlear Implants*	30% Coinsurance after Deductible	
*Members are eligible for Pediatric Benefits up to the end of the month in which the Member turns age 19.		

Other Services

Medical Benefit	In-Network Providers: Preferred	In-Network Providers: Standard	Coverage Notes and Limits
Allergy Testing and Injections	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Ambulance Transport - Non-Emergency	30% Coinsurance after Deductible		
Autism Spectrum Disorders/ Applied Behavioral Analysis (ABA)	30% Coinsurance after Deductible		
Blood Transfusions	30% Coinsurance after Deductible		
Clinical Trials	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Dental Services - Extraction of Impacted Teeth	30% Coinsurance after Deductible		
Diabetic Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	The cost share is waived for many diabetic services that are designated as preventive. and for members with specified benefits through the Chronic Illness Support Program. Contact Member Services for more information.
Dialysis Services	30% Coinsurance after Deductible		
Early Intervention Services (birth to 36 months)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Limited to 40 visits per calendar year.
Elective Abortion	$0 Copay; Deductible does not apply	$0 Copay; Deductible does not apply	
Foot Care Medically Necessary	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Routine foot care is not covered. Refer to MBA for details.
Health Care Services for COVID-19	No cost sharing for COVID-19 screening, testing or immunization as required or limited by law.		

Home Healthcare	30% Coinsurance after Deductible	
Hospice Services	30% Coinsurance after Deductible	
Hospice Respite Care	30% Coinsurance after Deductible	Limited to one 48-hour respite period, once per lifetime.
Leukocyte Antigen Testing to Establish Bone Marrow Donor	$0 Copay; Deductible does not apply	Limited to $150 for laboratory services, one test per lifetime.
Medical Drugs (that cannot be self-administered)	30% Coinsurance after Deductible	
Morbid Obesity	30% Coinsurance after Deductible	Limitations apply. Refer to your MBA or call Member Services for more information.
Sleep Studies	30% Coinsurance after Deductible	Limited to 2 per calendar year. Home-based sleep studies may less costly alternative-ask your Provider if a home-based sleep study is an appropriate option for you.

Pharmacy Benefits

Prescription Drug Benefit	In-Network Providers	Coverage Notes and Limits
Tier 1 – Preferred Generics	30 Day Retail: $5 Copay; Deductible does not apply 90 Day Mail Order: $10 Copay; Deductible does not apply	Members automatically pay 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 ScriptSaver program.
Tier 2 – Generics	30 Day Retail: $25 Copay; Deductible does not apply 90 Day Mail Order: $50 Copay; Deductible does not apply	
Tier 3 – Preferred Brands	30 Day Retail: $50 Copay; Deductible does not apply 90 Day Mail Order: $100 Copay; Deductible does not apply	
Tier 4 – Non-Preferred Brands	30 Day Retail: $100 Copay after Deductible 90 Day Mail Order: $200 Copay after Deductible	
Tier 5 – Specialty	30 Day Retail: $250 Copay after Deductible 30 Day 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/members/medications/#drug-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 with 35 day+ prescription throughHome Delivery Program to receive the reduced cost-sharing. Refer to your Member Agreement for more information.

Pediatric Dental			
Pediatric Dental Benefit	**In-Network Providers**	**Non-Network Providers**	**Coverage Notes and Limits**
Deductible Per Child	$100	$100	
Deductible Per Family	N/A	N/A	
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	
This Plan does not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source.			

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 overage 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 (except coverage detailed in your MBA)
- Over the Counter Equivalents 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
- Temporomandibular Joint Disorders (TMJ)
- Unlicensed or Ineligible Providers
- Vision Care and Refractive Eye Surgery (except coverage detailed in your MBA)