2020 Schedule of Benefits

Community Value HMO

Effective on or after:
01/01/2020

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 2020 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	Network Providers
Deductibles (Ded)	
Individual Deductible	**$3,350**
Family Deductible	**$6,700**
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.	
Member Coinsurance (Co)	**40%**
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	**$7,150**
Family OOP Maximum	**$14,300**
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.	

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.

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.

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Medical Benefit	Network Providers	Coverage Notes and Limits
Advanced Imaging (PET/MRI/CT)	40% Coinsurance after Deductible	
Allergy Testing and Injections	40% Coinsurance after Deductible	
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	40% Coinsurance after Deductible	
Autism Spectrum Disorders/ABA	40% Coinsurance after Deductible	
Blood Transfusions	40% Coinsurance after Deductible	
Cardiac Rehabilitation - Outpatient	40% Coinsurance after Deductible	36 visits per cardiac episode.
Chemotherapy, Radiation, Infusion Therapy	40% 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.
Chiropractic Manipulative Therapy	40% Coinsurance after Deductible	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	40% Coinsurance after Deductible	
Diabetic Services	40% Coinsurance after Deductible	
Dental Services – Emergency Dental Care	40% Coinsurance after Deductible	
Dental Services – Extraction of Impacted Teeth	40% Coinsurance after Deductible	
Dialysis Services	40% Coinsurance after Deductible	
Durable Medical Equipment/Prosthetics	50% Coinsurance after Deductible	
Prosthetics Replacement of Arms and Legs	20% Coinsurance after Deductible	
Elective Abortion	40% Coinsurance after Deductible	Abortion for which public funding is prohibited.
Emergency Room Care	50% Coinsurance after Deductible	

Medical Benefit	Network Providers	Coverage Notes and Limits
Foot Care- Medically Necessary	40% Coinsurance after Deductible	Routine foot care is not covered. Refer to MBA for details.
Formula/Medical Food	40% Coinsurance after Deductible	In certain cases, the Plan provides Benefits for Infant and Metabolic Formula. Refer to MBA for details.
Gender Reassignment Surgery	40% Coinsurance after Deductible	Cosmetic Surgery and Services are not covered.
Hearing Aids – Adult & Pediatric	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	40% Coinsurance after Deductible	Limited to 90 visits per continuous 12-month period.
Hospice Services	40% Coinsurance after Deductible	
Hospice Respite Care	40% Coinsurance after Deductible	Hospice Respite Care limited to one 48-hour period.
Inpatient Hospital Facility (including Acute Hospital care, maternity care)	40% Coinsurance after Deductible	
Inhalation Therapy	40% Coinsurance after Deductible	
Inpatient Rehabilitation	40% Coinsurance after Deductible	
Inpatient Physician Visits	40% Coinsurance after Deductible	
Laboratory and Radiology Services	40% Coinsurance after Deductible	
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	40% Coinsurance after Deductible	Limitations apply. See MBA for details.
Maternity	40% Coinsurance after Deductible	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.
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)	40% Coinsurance after Deductible	
Mental Health/Substance Use Disorder (Substance Abuse) - Inpatient	40% Coinsurance after Deductible	

Medical Benefit	Network Providers	Coverage Notes and Limits
Mental Health/Substance Use Disorder (Substance Abuse)- Outpatient	$25 Copay Waived for 1st 3 visits	The first 3 individual, family or group outpatient office visits each Calendar Year for Mental Health or Substance Use Disorder (Substance Abuse) services will be at zero-cost when rendered by a Network Provider.
Mental Health/Substance Use Disorder (Substance Abuse)– Partial Hospitalization Services	40% Coinsurance after Deductible	
Morbid Obesity	40% Coinsurance after Deductible	Limited to surgery for intestinal bypass, gastric bypass or gastroplasty for treatment of Morbid Obesity.
Nutritional Counseling	40% Coinsurance after Deductible	
Osteopathic Manipulative Therapy	40% 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. Benefit is limited to 40 visits per Member per Calendar Year. Refer to your MBA for details.
Organ and Tissue Transplants	40% Coinsurance after Deductible	
Orthotic Devices	40% Coinsurance after Deductible	Limitations apply. Refer to MBA for details.
Outpatient Facility	40% Coinsurance after Deductible	
Parenteral and Enteral Therapy	40% Coinsurance after Deductible	
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 section 2.J of your MBA for details.
Primary Care Office Visits	$25 Copay	
Prostate Cancer Screening	40% Coinsurance after Deductible	
Rehabilitation and Habilitation Services – Outpatient (includes Physical, Occupational, and Speech Therapy)	40% Coinsurance after Deductible	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	40% Coinsurance after Deductible	Limited to 150 days per Member per Calendar Year.
Sleep Studies	40% Coinsurance after Deductible	Limited to 2 per Calendar Year.
Your Member cost-sharing will be waived if you choose a home-based sleep study through certain Providers designated by Community Health Options®.		

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Specialty Care Office Visits	40% 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.
Surgery/Anesthesia	40% Coinsurance after Deductible	
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.
Urgent Care Visits	$95 Copay	
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible	

Pediatric Specific Medical Benefit*	Network Providers	Coverage Notes and Limits
Early Intervention Services	40% Coinsurance after Deductible	Limited to Members up to 36 months old with an identified Developmental Disability. Limited to 32 visits per Calendar Year.
Glasses/Contacts	40% Coinsurance after Deductible	This benefit is limited. Refer to your MBA for details.
Vision Exams	40% Coinsurance after Deductible	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	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.
Tier 2 – Generics	**Retail-** $30 Copay**; Mail Order-** $60 Copay	
Tier 3 – Preferred Brands & Non-Preferred Generics	**Retail-** 40% Coinsurance after Deductible**; Mail Order-** 40% Coinsurance after Deductible	
Tier 4 – Non-Preferred Brands	**Retail-** 50% Coinsurance after Deductible**; Mail Order-** 50% Coinsurance after Deductible	

Prescription Drug Benefit	Network Providers	Coverage Notes and Limits
Tier 5 – Specialty	**Retail-** 50% Coinsurance after Deductible**; Mail Order-** 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.
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.		

Pediatric Dental Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Deductible per Child	Not Covered	Not Covered	
Deductible per Family	Not Covered	Not Covered	
Diagnostic/Preventive	Not Covered	Not Covered	
Basic Restorative	Not Covered	Not Covered	
Major Restorative	Not Covered	Not Covered	
Medically Necessary Orthodontics	Not Covered	Not Covered	
This Plan does not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source.			

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 (including Cosmetic Gender Reassignment Surgeries)
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 are for sports or occupational purposes
Erectile/Sexual Dysfunction; Infertility; Surrogacy and Voluntary Induced Sterility Reversal
Experimental/Investigational Services (including biofeedback, shock wave treatment, homeopathy, etc.)
Free Care or Government Services and Supplies
Genetic Testing and Counseling
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