COMMUNITY Health Options

2022 Schedule of Benefits

Health Options CC Platinum PPO NE

Effective on or after: 01/01/2022

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 2022 Calendar Year. Please refer to your Member Benefit Agreement (MBA) for more information.

General Cost Sharing Information	Network Providers	Non-Network Providers
Deductibles (Ded)		
Individual Deductible	$500	$13,000
Family Deductible	$1,000	$26,000
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.		
Member Coinsurance (Co)	20%	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	$3,000	$20,000
Family OOP Maximum	$6,000	$40,000
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.		

Important Information About Services from Non-Plan Providers

For Out-of-Network Services, the Plan will pay Benefits for Covered Services up to the Maximum Allowable Amount, determined by us. Charges above the Maximum Allowable Amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the non-Network Provider chooses to bill you (known as Balance Billing). This means you may have a financial responsibility greater than the cost-sharing described on this Schedule of Benefits. To find Network Providers go to www.healthoptions.org/Search-provider or call Member services at (855) 624-6463.

If you receive Covered Services from a non-Network Provider, you are responsible for ensuring Prior Approval is obtained, if necessary. If you are admitted to a non-Network Provider facility due to an Emergency, it is your responsibility to ensure Health Options is notified within 48 hours of admission. Failure to obtain Prior Approval or provide Notification, as described in your Member Benefit Agreement, may result in a benefit reduction penalty of up to $500 for each occurrence.

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.

This plan does not provide any coverage outside the United States.

Some Covered Services require Prior Approval (PA) or Notification before we will pay Benefits. 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.

Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Advanced Imaging (PET/MRI/CT)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Allergy Testing and Injections	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Ambulance Transport – Emergency	20% Coinsurance after Deductible	20% 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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Autism Spectrum Disorders/ABA	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Blood Transfusions	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Cardiac Rehabilitation - Outpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	36 visits per cardiac episode.
Chemotherapy, Radiation, Infusion Therapy	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Diabetic Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Dental Services – Emergency Dental Care	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Dental Services – Extraction of Impacted Teeth	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Dialysis Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Durable Medical Equipment/Prosthetics	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Prosthetics Replacement of Arms and Legs	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Elective Abortion	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Abortion for which public funding is prohibited.
Emergency Room Care	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Foot Care- Medically Necessary	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Routine foot care is not covered. Refer to MBA for details.
Formula/Medical Food	20% Coinsurance after Deductible	40% 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	20% Coinsurance after Deductible	40% 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	20% Coinsurance after Deductible	40% 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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Hospice Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Hospice Respite Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Hospice Respite Care limited to one 48-hour period per lifetime.
Inpatient Hospital Facility (including Acute Hospital care, maternity care)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inhalation Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Physician Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Laboratory and Radiology Services	20% Coinsurance after Deductible	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	$0 Copay	Limitations apply. See MBA for details.
Massage Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Limitations apply. See MBA for details.
Maternity	20% Coinsurance after Deductible	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)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Mental Health/Substance Use Disorder (Substance Abuse) - Inpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Mental Health/Substance Use Disorder (Substance Abuse)- Outpatient	$20 Copay	40% Coinsurance after Deductible	The first outpatient office visit each Calendar Year for Mental Health or Substance-Use Disorder (Substance Abuse) services will be at zero-cost when rendered by a Network Provider. The second and third Copayments will accumulate towards your deductible.
Mental Health/Substance Use Disorder (Substance Abuse)– Partial Hospitalization Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Morbid Obesity	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Limited to surgery for intestinal bypass, gastric bypass or gastroplasty for treatment of Morbid Obesity.
Nutritional Counseling	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Osteopathic Manipulative Therapy	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Orthotic Devices	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Limitations apply. Refer to MBA for details.
Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Parenteral and Enteral Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preventive Care	$0 Copay	40% Coinsurance after Deductible	
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.I of your MBA for details.			
Primary Care Office Visits	$20 Copay	40% Coinsurance after Deductible	The first visit to your Network PCP is free. The second and third Copayments will accumulate towards your deductible.
Prostate Cancer Screening	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Rehabilitation and Habilitation Services – Outpatient (includes Physical, Occupational, and Speech Therapy)	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Limited to 150 days per Member per Calendar Year.
Sleep Studies	20% Coinsurance after Deductible	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®.			

Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Specialty Care Office Visits	$40 Copay	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 that one date of service.
Surgery/Anesthesia	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Tobacco/Smoking Cessation	$0 Copay	40% Coinsurance after Deductible	
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	$25 Copay	40% Coinsurance after Deductible	
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.
X-rays and Diagnostic Imaging	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

Pediatric Specific Medical Benefit	Network Providers	Non-Network Providers	Coverage Notes and Limits
Cochlear Implants	20% Coinsurance after Deductible	40% Coinsurance after Deductible	This benefit is limited. Refer to your MBA for details.
Early Intervention Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Limited to Members up to 36 months old with an identified Developmental Disability. Limited to 33 visits per Calendar Year.
Glasses/Contacts*	20% Coinsurance after Deductible	40% Coinsurance after Deductible	This benefit is limited. Refer to your MBA for details.
Vision Exams*	20% Coinsurance after Deductible	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	Non-Network Providers	Coverage Notes and Limits
Tier 1 – Preferred Generics	**Retail-** $0 Copay; **Mail Order-** $0 Copay	40% Coinsurance after Deductible	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-** $0 Copay; **Mail Order-** $0 Copay	40% Coinsurance after Deductible	
Tier 3 – Preferred Brands	**Retail-** $15 Copay; **Mail Order-** $30 Copay	40% Coinsurance after Deductible	
Tier 4 – Non-Preferred Brands	**Retail-** $100 Copay after Deductible; **Mail Order-** $200 Copay after Deductible	40% Coinsurance after Deductible	
Tier 5 – Specialty	**Retail-** $250 Copay after Deductible; **Mail Order-** $250 Copay after Deductible	40% 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 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	N/A	N/A	
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
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
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