2017 Schedule of Benefits

Community Choice (Silver)

	In-Network	Notes
Individual Deductible (Ded)	$2,000	
Family Deductible [1]	$4,000	[1] Under family coverage, once one Member of the family 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)	30%	
OOP Maximum (Individual)	$6,500	
OOP Maximum (Family) [2]	$13,000	[2] Under family coverage, once any one Member of the family 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.
Inpatient [3] Hospice Services Hospital Skilled Nursing Facility [4] Mental Health/Substance Abuse	 Ded/Co Ded/Co Ded/Co Ded/Co	[3] All elective inpatient procedures or scheduled inpatient stays require Prior Approval. Emergent Inpatient Admissions require Notification on admission. [4] Benefit is limited to 150 days per Member per Calendar year.
Outpatient Emergency Room Surgery/Surgical Services Other Services [5] Mental Health/Substance Abuse [6] Rehab/Habilitative Serv. (PT/OT) [7] Rehab/Habilitative Serv. (ST) [8] Autism Spectrum Disorders/ABA Early Childhood Intervention [9]	 Ded/50% Co Ded/Co Ded/Co $30 Co-Pay Ded/Co Ded/Co Ded/Co Ded/Co	[5] Other Services includes: medical exams, management of therapy, injections, removal of sutures, application or removal of a cast, Diagnostic Services, anesthesia, removal of impacted or unerupted teeth, endoscopic procedures, blood administration, radiation therapy, outpatient rehabilitation programs and certain outpatient educational programs. Refer to your Member Benefit Agreement for details. [6] The first three individual, family or group outpatient office visits each Calendar Year for Mental Health and Substance Abuse services will be at zero-cost when rendered by a Plan Provider. [7] Benefits are limited to 60 combined visits per year for physical, occupational and speech therapy. [8] Benefits are limited to 60 combined visits per year for physical, occupational and speech therapy. [9] Benefits are limited to 50 visits per Calendar Year for Members from birth to 36 months of age with an identified Developmental Disability and/or delay. Prior Approval is required.

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	In-Network	Notes
Physician		
Preventive Care [10]	$0 Co-Pay	[10] When prescribed by a Plan Provider, certain Preventive 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.H of your Member Benefit Agreement.
Office Visits – Primary [11]	$30 Co-Pay	[11] Members who have been diagnosed with hypertension (high blood pressure), diabetes, asthma, chronic obstructive pulmonary disease (COPD or emphysema), or coronary artery disease (CAD) may be eligible for reduced cost-sharing through our Chronic Illness Support Program. For more information on the Chronic Illness Support Program, please refer to your Member Benefit Agreement.
Office Visits – Specialty Care	Ded/Co	[12] Benefit is limited to 40 visits per Member per Calendar year.
Urgent Care Visits	Ded/Co	[13] Routine foot care is not covered. See your Member Benefit Agreement for more detail.
Allergy Testing and Injections	Ded/Co	[14] The Plan provides Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. Routine newborn care does not include any services provided after the mother has been discharged from the Hospital. For discharge timeframes and coverage after discharge, please refer to your Member Benefit Agreement.
Chiropractic/Manipulative Therapy [12]	Ded/Co	[15] Benefits are limited to surgery for intestinal bypass, gastric bypass or gastroplasty for treatment of Morbid Obesity. Prior Approval is required.
Diabetic Services	Ded/Co	[16] Prior Approval is required.
Foot Care [13]	Ded/Co	[17] The Plan provides Benefits for a complete vision exam, including refraction, as needed to detect vision impairment by a Plan Provider for Members to the end of the month in which they turn age 19.
Inhalation Therapy	Ded/Co	
Inpatient Visits	Ded/Co	
Massage Therapy	Ded/Co	
Maternity [14]	Ded/Co	
Morbid Obesity [15]	Ded/Co	
Nutritional Counseling	Ded/Co	
Outpatient Lab and Professional Svs.	Ded/Co	
Surgery/Anesthesia [16]	Ded/Co	
Vision Exams – Pediatric [17]	Ded/Co	
Vision Exams – Adult	Not Covered	
Other		[18] Coverage includes transportation to nearest hospital that can provide the required care. Refer to your Member Benefit Agreement for more information.
Emergency Transport [18]	Ded/50% Co	[19] Non-Emergency transport requires Prior Approval.
Non-Emergency Transport [19]	Ded/50% Co	[20] Certain DME requires Prior Approval.
Blood Transfusions	Ded/Co	[21] In certain cases, the Plan provides Benefits for Infant and Metabolic Formula. Prior Approval is required. See your Member Benefit Agreement for details.
Chemotherapy Services	Ded/Co	[22] Benefits are limited to Members to the end of the month in which they turn age 19 or certain medical conditions. See your Member Benefit Agreement for details.
Clinical Trials	Ded/Co	[23] The Plan provides Benefits for Hearing Aids for Members to the end of the month in which they turn age 19. Please refer to your Member Benefit Agreement for more details.
DME/Prosthetics [20]	Ded/Co	
Formula/Medical Food [21]	Ded/Co	
Glasses/Contacts [22]	Ded/Co	
Hearing Aids [23]	Ded/Co	

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	In-Network	Notes
Home Healthcare [24]	Ded/Co	[24] Benefits are provided for services performed and billed by a Home Health Care Agency. Prior Approval is required.
Hospice/Hospice Respite Care [25]	Ded/Co	[25] Hospice Respite Care limited to one 48-hour period. Prior Approval is required.
Imaging (PET/MRI/CT) [26]	Ded/Co	[26] Prior Approval is required for non-emergency advanced diagnostic imaging services.
Infusion Therapy [27]	Ded/Co	[27] Home-based infusion 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 an in-network home-infusion Provider.
Leukocyte Antigen Testing [28]	Ded/Co	[28] Limitations apply. See your Member Benefit Agreement for details.
Organ and Tissue Transplants	Ded/Co	
Orthotic Devices [29]	Ded/Co	[29] No Benefits are available for: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts. See your Member Benefit Agreement for details.
Parenteral and Enteral Therapy	Ded/Co	
Sleep Studies [30]	Ded/Co	[30] Your Member cost-sharing will be waived if you choose a home-based sleep study through certain Providers designated by Community Health Options. Ask your Provider if a home-based sleep study is an appropriate option for you. Call Member Services at 855-624-6463 for more information on home-based sleep studies.
Pediatric Dental	Not Covered	
Prostate Cancer Screening	Ded/Co	
Radiation Therapy	Ded/Co	
Telemedicine Services	Ded/Co	
Tobacco/Smoking Cessation [31]	$0 Co-Pay	[31] The Plan provides Benefits for certain tobacco cessation medications, programs, education and counseling at no-cost to you. See your Member Benefit Agreement for details.
X-rays and Diagnostic Imaging	Ded/Co	
Prescription Drugs [32]		[32] For access to the formulary, please visit our website at https://www.healthoptions.org/Documents/2017_Individual_Formulary.
Tier 1: (Preferred Generics)	$5 Co-Pay	
Tier 2: (Non-Preferred Generics)	$30 Co-Pay	
Tier 3: (Preferred Brands)	Ded/Co	
Tier 4: (Non-Preferred Brands)	Ded/50% Co	
Tier 5: (Specialty)	Ded/50% Co	

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	Out-of-Network [33]	Notes
Individual Deductible (Ded)	$14,300	[33] If you receive Covered Services from a Non-Plan Provider, you are responsible for ensuring Prior Authorization is obtained, if necessary. 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-Plan Provider chooses to bill you. This means you may have a financial responsibility greater than the cost-sharing described on this Schedule of Benefits. To find Plan Providers go to www.healthoptions.org/Search-provider or call Member services at 1-855-624-6463.
Family Deductible	$28,600	
Member Coinsurance (Co)	50%	
OOP Maximum (Individual)	$21,450	
OOP Maximum (Family)	$42,900	
Inpatient [34]		[34] All elective inpatient procedures or scheduled inpatient stays require Prior Approval. Emergent Inpatient Admissions require Notification on admission. If you are admitted to a Non-Plan Provider facility, it is your responsibility to ensure Health Options is notified within 48 hours of admission.
Hospice Services	Ded/Co	
Hospital	Ded/Co	
Skilled Nursing Facility	Ded/Co	
Mental Health/Substance Abuse	Ded/Co	
Outpatient		
Emergency Room [35]	Ded/Co	[35] For Medical Emergency services rendered by a non-Plan 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 Plan Provider.
Surgery/Surgical Services	Ded/Co	
Other Services [36]	Ded/Co	[36] Other Services includes: medical exams, management of therapy, injections, removal of sutures, application or removal of a cast, Diagnostic Services, anesthesia, removal of impacted or unerupted teeth, endoscopic procedures, blood administration, radiation therapy, outpatient rehabilitation programs and certain outpatient educational programs. Refer to your Member Benefit Agreement for details.
Mental Health/Substance Abuse	Ded/Co	
Rehab/Habilitative Serv. (PT/OT)	Ded/Co	
Rehab/Habilitative Serv. (ST)	Ded/Co	
Autism Spectrum Disorders/ABA	Ded/Co	
Early Childhood Intervention	Ded/Co	

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Community Choice (Silver)

	Out-of-Network [33]	Notes
Physician		
Preventive Care [37]	Ded/Co	[37] Preventive Care Services rendered by non-Plan Providers will be subject to cost-sharing.
Office Visits – Primary	Ded/Co	
Office Visits – Specialty Care	Ded/Co	
Urgent Care Visits	Ded/Co	
Allergy Testing and Injections	Ded/Co	
Chiropractic/Manipulative Therapy	Ded/Co	
Diabetic Services	Ded/Co	
Foot Care	Ded/Co	
Inhalation Therapy	Ded/Co	
Inpatient Visits	Ded/Co	
Massage Therapy	Ded/Co	
Maternity	Ded/Co	
Morbid Obesity	Ded/Co	
Nutritional Counseling	Ded/Co	
Outpatient Lab and Professional Svs.	Ded/Co	
Surgery/Anesthesia	Ded/Co	
Vision Exams – Pediatric	Ded/Co	
Vision Exams – Adult	Not Covered	
Other		
Emergency Transport [38]	Ded/Co	[38] For Medical Emergency transportation rendered by a non-Plan 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 Plan Provider. Coverage includes transportation to the nearest hospital that can provide the required care. Refer to your Member Benefit Agreement for more information. [39] Non-Emergency Transport requires Prior Approval.
Non-Emergency Transport [39]	Ded/Co	
Blood Transfusions	Ded/Co	
Chemotherapy Services	Ded/Co	
Clinical Trials	Ded/Co	
DME/Prosthetics	Ded/Co	
Formula/Medical Food	Ded/Co	
Glasses/Contacts	Ded/Co	
Hearing Aids	Ded/Co	
Home Healthcare	Ded/Co	
Hospice/Hospice Respite Care	Ded/Co	
Imaging (PET/MRI/CT)	Ded/Co	
Infusion Therapy	Ded/Co	
Leukocyte Antigen Testing	Ded/Co	
Organ and Tissue Transplants	Ded/Co	

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	Out-of-Network [33]	Notes
Orthotic Devices	Ded/Co	
Parenteral and Enteral Therapy	Ded/Co	
Sleep Studies	Ded/Co	
Pediatric Dental	Not Covered	
Prostate Cancer Screening	Ded/Co	
Radiation Therapy	Ded/Co	
Telemedicine Services	Ded/Co	
Tobacco/Smoking Cessation	Ded/Co	
X-rays and Diagnostic Imaging	Ded/Co	
Prescription Drugs		
Tier 1: (Preferred Generics)	Ded/Co	
Tier 2: (Non-Preferred Generics)	Ded/Co	
Tier 3: (Preferred Brands)	Ded/Co	
Tier 4: (Non-Preferred Brands)	Ded/70% Co	
Tier 5: (Specialty)	Ded/70% Co	

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@healthoptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)	**Arabic** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-624-6463 رقم ه الصم والبكم: TTY/TDD 711.
Cambodian, Mon-Khmer ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-624-6463 (TTY/TDD: 711)។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711).	**Thai** ียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cï̈n wënh cuatë piny. Yuɔpë 1-855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。