

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. 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 | | \$8,700 |
| Family Deductible | | \$17,400 |
| 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. | | |
| Member Coinsurance (Co) | | 0% |
| 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 | | \$8,700 |
| Family OOP Maximum | | \$17,400 |
| 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. | | |
| 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. 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.

| Medical Benefit | Network Providers | Coverage Notes and Limits |
|--|---------------------------------|---|
| Advanced Imaging (PET/MRI/CT) | 0% Coinsurance after Deductible | |
| Allergy Testing and Injections | 0% Coinsurance after Deductible | |
| Ambulance Transport - Emergency | 0% 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 | 0% Coinsurance after Deductible | |
| Autism Spectrum Disorders/ABA | 0% Coinsurance after Deductible | |
| Blood Transfusions | 0% Coinsurance after Deductible | |
| Cardiac Rehabilitation - Outpatient | 0% Coinsurance after Deductible | 36 visits per cardiac episode. |
| Chemotherapy, Radiation, Infusion Therapy | 0% 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 | 0% 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 | 0% Coinsurance after Deductible | |
| Diabetic Services | 0% Coinsurance after Deductible | |
| Dental Services - Emergency Dental Care | 0% Coinsurance after Deductible | |
| Dental Services - Extraction of Impacted Teeth | 0% Coinsurance after Deductible | |
| Dialysis Services | 0% Coinsurance after Deductible | |
| Durable Medical Equipment/Prosthetics | 0% Coinsurance after Deductible | |
| Prosthetics Replacement of Arms and Legs | 0% Coinsurance after Deductible | |
| Elective Abortion | 0% Coinsurance after Deductible | Abortion for which public funding is prohibited. |

| Medical Benefit | Network Providers | Coverage Notes and Limits |
|---|--|---|
| Emergency Room Care | 0% Coinsurance after Deductible | |
| Foot Care- Medically Necessary | 0% Coinsurance after Deductible | Routine foot care is not covered. Refer to MBA for details. |
| Formula/Medical Food | 0% 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 | 0% 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 | 0% 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 | 0% Coinsurance after Deductible | |
| Hospice Services | 0% Coinsurance after Deductible | |
| Hospice Respite Care | 0% Coinsurance after Deductible | Hospice Respite Care limited to one 48-hour period per lifetime. |
| Inpatient Hospital Facility (including Acute Hospital care, maternity care) | 0% Coinsurance after Deductible | |
| Inhalation Therapy | 0% Coinsurance after Deductible | |
| Inpatient Rehabilitation | 0% Coinsurance after Deductible | |
| Inpatient Physician Visits | 0% Coinsurance after Deductible | |
| Laboratory and Radiology Services | 0% Coinsurance after Deductible | |
| <p>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.</p> | | |
| Leukocyte Antigen Testing | \$0 Copay | Limitations apply. See MBA for details. |

| Medical Benefit | Network Providers | Coverage Notes and Limits |
|--|---------------------------------|---|
| Massage Therapy | 0% Coinsurance after Deductible | Limitations apply. See MBA for details. |
| Maternity | 0% 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) | 0% Coinsurance after Deductible | |
| Mental Health/Substance Use Disorder (Substance Abuse) - Inpatient | 0% Coinsurance after Deductible | |
| Mental Health/Substance Use Disorder (Substance Abuse)- Outpatient | \$50 Copay | 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 | 0% Coinsurance after Deductible | |
| Morbid Obesity | 0% Coinsurance after Deductible | Limited to surgery for intestinal bypass, gastric bypass or gastroplasty for treatment of Morbid Obesity. |
| Nutritional Counseling | 0% Coinsurance after Deductible | |
| Osteopathic Manipulative Therapy | 0% 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 | 0% Coinsurance after Deductible | |
| Orthotic Devices | 0% Coinsurance after Deductible | Limitations apply. Refer to MBA for details. |

| Medical Benefit | Network Providers | Coverage Notes and Limits |
|---|---------------------------------|--|
| Outpatient Facility | 0% Coinsurance after Deductible | |
| Parenteral and Enteral Therapy | 0% 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 2.1 of your MBA for details. |
| Primary Care Office Visits | \$50 Copay | The first visit to your Network PCP is free. The second and third Copayments will accumulate towards your deductible. |
| Prostate Cancer Screening | 0% Coinsurance after Deductible | |
| Rehabilitation and Habilitation Services – Outpatient (includes Physical, Occupational, and Speech Therapy) | 0% 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 | 0% Coinsurance after Deductible | Limited to 150 days per Member per Calendar Year. |
| Sleep Studies | 0% 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®. | | |
| Specialty Care Office Visits | \$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 | 0% 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. |

| Medical Benefit | Network Providers | Coverage Notes and Limits |
|--------------------------------------|---------------------------------|--|
| 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 | 0% 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 needs. |
| X-rays and Diagnostic Imaging | 0% Coinsurance after Deductible | |

| Pediatric Specific Medical Benefit | Network Providers | Coverage Notes and Limits |
|---|---------------------------------|---|
| Cochlear Implants | 0% Coinsurance after Deductible | This benefit is limited. Refer to your MBA for details. |
| Early Intervention Services | 0% 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* | 0% Coinsurance after Deductible | This benefit is limited. Refer to your MBA for details. |
| Vision Exams* | 0% 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- \$25 Copay; Mail Order- \$50 Copay | |
| Tier 3 – Preferred Brands | Retail- 0% Coinsurance after Deductible; Mail Order- 0% Coinsurance after Deductible | |
| Tier 4 – Non-Preferred Brands | Retail- 0% Coinsurance after Deductible; Mail Order- 0% Coinsurance after Deductible | Insulin is covered at \$35 for up to each 30-day supply of medication. |

| Prescription Drug Benefit | Network Providers | Coverage Notes and Limits |
|---|--|--|
| Tier 5 – Specialty | Retail- 0% Coinsurance after Deductible; Mail Order- 0% 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. |
| <p>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 Costs (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.</p> | | |

| 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 | |
| <p>This Plan does not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source.</p> | | | |

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 Prosthesis

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