



# Option Plus *one*

## Medical Plan Schedule of Benefits

<b>Annual Deductible</b>	\$100 per person / \$300 maximum per family
<b>Stop Loss</b> (per calendar year, includes deductibles and copayments)	
Participating Provider	\$600 per person / \$1,800 per family
Non-Participating Provider	\$1,100 per person / \$3,300 per family
<b>Lifetime Maximum</b>	Unlimited

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
<b>Hospital and Facility Services</b>		
Ambulatory Surgical Center (ASC)	10%	20%
Hospital Ancillary Services	10%	20%*
Hospital Room and Board	10%	\$200 (per 1st confinement in cal. yr.) + 20%*
Outpatient Facility	10%	20%
Skilled Nursing Facility	10%	\$200 (per 1st confinement in cal. yr.) + 20%*
<b>Emergency Services</b>		
Emergency Room	10%	10%
Physician Visits	10%	10%
<b>Online Care and Telephonic Services</b>	None	Not Covered
<b>Physician Services</b>		
Physician Visits	10%	\$10 + 20%
Hospital Visits	10%	\$10 + 20%
Immunizations (standard, including travel)	None	30%
<b>Testing, Laboratory and Radiology</b>		
Allergy Testing	\$15 + 10%*	\$25 + 20%*
Allergy Treatment Materials	\$15 + 10%*	\$25 + 20%*
Diagnostic Testing	10%	20%*
Laboratory and Pathology	10%	20%*
Radiology	10%	20%*
<b>Chemotherapy and Radiation Therapy</b>		
Chemotherapy — Infusion/Injections	10%*	20%*
Radiation Therapy	10%	20%*
<b>Other Medical Services and Supplies</b>		
Acupuncture, Chiropractic and Naturopathic Services	10%	20%*
Ambulance (air)	20%*	20%*
Ambulance (ground)	20%*	20%*
Blood and Blood Products	10%*	20%*
Dialysis and Supplies	10%*	20%*
Durable Medical Equipment and Supplies	10%*	20%*
Evaluations for Hearing Aids	10%*	20%*
Growth Hormone Therapy	10%*	20%*
Home IV Therapy	\$5 + 10%	30%
Inhalation Therapy	10%*	20%*
Injections	10%*	20%*
Medical Foods	10%	20%
Orthotics and External Prosthetics	10%*	20%*
Vision and Hearing Appliances	10%*	20%*

\* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | \$ = Copayment (Fixed dollar amount)

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
<b>Rehabilitation Therapy</b>		
Physical and Occupational Therapy		
Inpatient	10%	20%*
Outpatient	\$5 + 10%*	30%*
Speech Therapy Services — Inpatient	10%	20%*
Outpatient	\$5 + 10%*	30%*
<b>Special Benefits – Disease Management and Preventive Services</b>		
Disease Management	None	Not covered
Preventive Services — Laboratory	None	20%*
Preventive Services — Physical Exam	None	\$10 + 20%*
Screening and Preventive Counseling	None	20%*
<b>Special Benefits for Children</b>		
Newborn Care	10%	20%*
Well Child Care Immunizations	None	None
Well Child Care Laboratory Tests	None	20%
Well Child Care Physician Office Visits	None	\$10 + 20%
<b>Special Benefits for Men</b>		
Prostate Specific Antigen Test (screening)	10%	20%
<b>Special Benefits for Women</b>		
Breast Pump	None	None
Chlamydia Screening	None	20%*
Contraceptive Implants (generic)	None	30%
Contraceptive Injectables (generic)	None	30%
Contraceptive IUD (generic)	None	30%
In Vitro Fertilization	10%	20%
Mammography (screening)	None	20%
Maternity Care	10%	20%*
Pap Smears (screening)	None	20%
Pregnancy Termination	10%	20%
Tubal Ligation	None	20%
Well Woman Exam	None	20%
<b>Special Benefits for Homebound, Terminal, or Long-Term Care</b>		
Home Health Care	None	30%
Hospice Services	None	None*
<b>Behavioral Health – Mental Health and Substance Abuse</b>		
Hospital and Facility Services — Inpatient	10%	\$200 (per 1st confinement in cal. yr.) + 20%*
Outpatient	10%	20%
Physician Services — Inpatient	10%	20%*
Outpatient	10%	\$10 + 20%
Psychological Testing	10%	20%*
<b>Special Offers</b>		
Employee Assistance Program (EAP)	Up to 6 fully-covered visits to assist subscribers with personal or family issues	
Health and Wellness Programs	A variety of solutions for healthy living including Active&Fit®, Flu Prevention, Colorectal Cancer Screening, Maternity & Baby Care Incentive Program, and more	
Member Plus Discount Program	Discounted prices and special offers from HMAA member groups and other participating merchants	

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**Note:** Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods. This document is intended to provide a condensed explanation of benefits. Please refer to the Description of Coverage (DOC) for details. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.