# Option Plus One

## Medical Plan Schedule of Benefits 2027

**Annual Deductible** $100 per person / $300 maximum per family

**Out-of-Pocket Maximum** (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

**Lifetime Maximum** Unlimited

| Benefit | Coinsurance/Copayment | |
|---|---|---|
| | Participating | Non-Participating |
| **Hospital and Facility Services** | | |
| Ambulatory Surgical Center (ASC) | 10% | 20% |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Facilities) | 10% | $200 (per first confinement in calendar year) + 20%* |
| Hospital Ancillary Services | 10% | 20%* |
| Hospital Room and Board | 10% | $200 (per first confinement in calendar year) + 20%* |
| Outpatient Facility | 10% | 20% |
| **Emergency Services and Urgent Care** | | |
| Emergency Room | 10% | 10% |
| Physician Visits | 10% | 10% |
| Urgent Care | $25 | $50 |
| **Physician Services** | | |
| Physician Visits | 10% | $10 + 20% |
| Hospital Visits | 10% | $10 + 20% |
| Immunizations (standard, including travel) | None | 30% |
| Online and Telephonic Care via HMAA's HiDoc® Service | None | Not Covered |
| Telehealth Services | Your deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive. | |
| **Testing, Laboratory and Radiology** | | |
| 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%* |
| **Chemotherapy and Radiation Therapy** | | |
| Chemotherapy — Infusion/Injections | 10%* | 20%* |
| Radiation Therapy | 10% | 20%* |
| **Other Medical Services and Supplies** | | |
| Acupuncture, Chiropractic, Massage, and Naturopathic Services | 10% | 20%* |
| Ambulance (air or 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 – Self Administered | 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)

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| Benefit | Coinsurance/Copayment | |
|---|---|---|
| | Participating | Non-Participating |
| **Rehabilitation Therapy** | | |
| Physical and Occupational Therapy | | |
| Inpatient | 10% | 20%* |
| Outpatient | $5 + 10%* | 30%* |
| Speech Therapy Services | | |
| Inpatient | 10% | 20%* |
| Outpatient | $5 + 10%* | 30%* |
| **Special Benefits – Disease Management and Preventive Services** | | |
| Disease Management | None | Not Covered |
| Preventive Services — Laboratory | None | 20%* |
| Preventive Services — Physical Exam | None | $10 + 20%* |
| Screening and Preventive Counseling | None | 20%* |
| **Special Benefits for Children** | | |
| 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% |
| **Special Benefits for Men** | | |
| Prostate Specific Antigen Test (screening) | 10% | 20% |
| **Special Benefits for Women** | | |
| 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 | None | 20%* |
| Pap Smears (screening) | None | 20% |
| Pregnancy Termination | 10% | 20% |
| Tubal Ligation | None | 20% |
| Well Woman Exam | None | 20% |
| **Special Benefits for Homebound, Terminal, or Long-Term Care** | | |
| Home Health Care | None | 30% |
| Hospice Services | None | None* |
| **Behavioral Health – Mental Health and Substance Abuse** | | |
| Hospital and Facility Services | | |
| Inpatient | 10% | $200 (per first confinement in calendar year) + 20%* |
| Outpatient | 10% | 20% |
| Physician Services | | |
| Inpatient | 10% | 20%* |
| Outpatient | 10% | $10 + 20% |
| Psychological Testing | 10% | 20%* |

| **Special Offers** | |
|---|---|
| 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, Baby & Me (our free maternity 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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* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

**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.