2018 Member Handbook

Community HEALTH OPTIONS®

MembHandbk2018-00-11-121217

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, Mail Stop 100, Lewiston, ME 04243; by telephone at (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: (800) 368-1019 or (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 855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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 855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 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 855-624-6463 (TTY/TDD: 711)	**Arabic** إنتبه: إذا كنت تتكلّم العربية، خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بالرقم 855-624-6463 (رقم الجهاز النصي للصم: 711).
Cambodian, Mon-Khmer យកចិត្តទុកដាក់: ប្រសិនអ្នកនិយាយភាសាខ្មែរ, ជាអ្នកគាំទ្រការបកប្រែភាសាគឺឥតគិតថ្លៃសម្រាប់អ្នក។ សូមទូរស័ព្ទ: 855-624-6463 (711 TTY / TDD)	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 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 855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711).	**Thai** ี ยน: ถาีี่ คุณพูด ภาษาไทยคุณสามารถใชบั รก ิ ารชว ่ ยเหลอ ื ทางภาษาได้ฟ ร ี โทร 855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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。855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。

What's in This Member Handbook

Welcome to Community Health Options!

Dear Member,

Welcome to Community Health Options. We are a nonprofit, Member-led health plan providing comprehensive, Member-focused health insurance benefits for individuals, families, and businesses. As a Consumer Operated and Oriented Plan (CO-OP) licensed in Maine, we believe that healthcare can be both better and more affordable when providers, patients, health insurers, and employers all work together.

We regard our relationship with you as a vital partnership and want to be a part of improving your health and wellbeing. We will partner with you by providing prompt, accurate information about your health plan to make sure you get the most out of your coverage. We want to make sure you are treated with respect and that you have access to quality healthcare in your community.

This Member Handbook contains important information about your health plan. It is important to understand all you can about how your health plan works, so please take some time to read this handbook.

Thank you for entrusting us to provide your health insurance coverage.

Sincerely,

Kevin Lewis

President and CEO

About Us

Community Health Options is a nonprofit, Member-led health plan providing comprehensive, Member-focused health insurance benefits for individuals, families, and businesses. As a Consumer Operated and Oriented Plan (CO-OP) licensed in Maine, we are dedicated to providing affordable, high-quality health benefits through productive partnerships with our Members and our broad network of providers. We are also focused on strategies such as aligned and effective care management and care integration to improve the health and wellbeing of our Members.

Our Mission

To partner locally with Members, businesses and health professionals to provide affordable, high-quality benefits that promote health and wellbeing.

Our Vision

To be a leader in transforming and improving individual and community health and positively affecting the local economy.

Getting Started

Your Member materials include

- This Member Handbook
- Member Benefit Agreement
- Schedule of Benefits
- Summary of Benefits and Coverage

We're here to help you stay healthy by taking full advantage of your health plan. Get started by taking a few minutes to:

1 Review your Member Benefit Agreement

The Member Benefit Agreement is the legal contract that governs your health plan. It can be found in your Member portal or you can request a printed copy from Member Services. Read through this document to understand how your coverage works.

2 Create your secure, online Member portal account

You can create your online account by visiting our website: HealthOptions.org/Registration

3 Choose or verify your primary care provider (PCP)

Once you are logged in to your secure Member portal account, click on 'Medical Benefits' and then again, on 'Select a Primary Care Provider' on the right side of the green ribbon. Follow the instructions to complete the form. If you have already selected a PCP, you will not need to do this again. If you do not have access to a computer, you can assign a PCP by calling Member Services at (855) 624-6463.

4 Activate your Express Scripts online portal

Setting up your Express Scripts online portal gives you the ability to locate a retail pharmacy near your home, review your prescription coverage, receive automatic health and safety alerts, and discover ways you can save money. To activate your account go to Express-Scripts.com/Activate. When you activate online, make sure you have your Member ID number handy. PLEASE NOTE: You will be required to set up a separate username and password to access your Express Scripts online portal. You can also go to HealthOptions.org for instructions. If you have questions or don't have internet access, call Member Services toll free at (855) 624-6463.

5 Sign up for automatic payment of your premiums

For Members enrolled in a non-group plan, we want to make it easy and worry free for you to make premium payments. For your convenience, you are able to set up an auto-payment plan through your secure Member portal.

Our Member Service Associates are happy to assist you in assigning your PCP or with questions you may have regarding your health insurance plan. Please call us at (855) 624-6463.

Community Health Options may not cover all your healthcare expenses. Please read your Member Benefit Agreement carefully so you will know what is covered and what is not covered.

How Your Insurance Works

We recognize that getting health insurance coverage is important to you and want to be sure you know how to use your health insurance to stay healthy and help save money.

Using your health insurance effectively means understanding some basic terms. These terms are used throughout your Member Benefit Agreement.

Primary Care Provider

Your Primary Care provider (or PCP) is a family doctor, nurse practitioner, pediatrician or other provider with whom you maintain a long-term relationship. Your PCP is a partner in your healthcare who will advise you and provide treatment on a range of health-related issues. He or she may assist you in your interactions with specialists.

Prescription Drug Formulary

We cover prescription medicines that are proven effective and list these drugs on a "formulary." Go to HealthOptions.org/Formulary to see our complete formulary.

Out-of-Pocket Costs

Out-of-pocket costs are the costs you pay. Maximum out-of-pocket costs are the total of your copays, coinsurance, and deductible payments that you will be expected to pay.

Copayments (Copays)

A copayment is a fixed amount (for example, $15) you pay for a covered healthcare service, usually at the time you receive the service. Unless specified on your *Schedule of Benefits*, the deductible does not have to be met for the application of a copayment. The amount can vary by the type of covered healthcare service. Copayments do not count toward your deductible. Copayments do count toward your out-of-pocket maximum.

Deductible

The deductible is the amount you pay for certain covered services before the plan pays benefits. If your plan covers more than one person, there will be both an individual deductible and a family deductible. Any one Member covered under your policy only needs to meet the individual deductible, while the other Members of your family combine to meet the remainder of the family deductible.

Coinsurance

Coinsurance is a percentage (for example 30%) you pay toward the cost of certain Covered Services. The plan will pay the remaining amount. Unless specified on your *Schedule of Benefits*, coinsurance begins once you have met your deductible.

Covered Services

Covered services are the goods or services that the plan will help you pay as outlined in the Member materials. Your Member materials include this Member Handbook, your Member Benefit Agreement, Schedule of Benefits, and your Summary of Benefits and Coverage.

Your Community Health Options health insurance may not cover all your healthcare expenses. Please read your Member Benefit Agreement carefully so you will know what is covered and what is not covered.

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How Your Insurance Works

Choose In-Network Providers

Whether your plan is a PPO or an HMO, as a Community Health Options Member, you have access to the same broad network of Primary Care Physicians, Nurse Practitioners, Specialists, Mental Health and Substance Abuse Service providers, Pharmacies, Clinics, and Hospitals in Maine and New Hampshire, as well as select facilities in Massachusetts. These 'in-network' or 'plan' providers contract with Health Options to provide Covered Services to Members at agreed-upon rates, and also to meet certain quality and service measures.

It is your responsibility to confirm that the providers you use are in-network. Please contact Member Services or utilize the on-line provider Directory to confirm your provider is in-network.

If you receive care outside of the Health Options Network, or from an out-of-network provider, you may be subject to higher out-of-pocket cost-sharing as well as charges that may be billed directly to you by that provider.

Community Health Options determines the maximum allowed amount for out-of-network services to calculate what the plan will pay on your behalf. The out-of-network provider may hold you financially responsible for any charges above that amount. When a provider bills you for this difference, it is called balance billing. In-network providers are not allowed to balance bill.

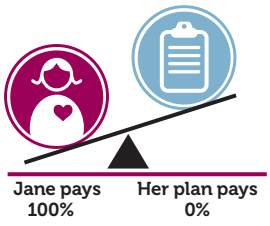
Important Note: HMO plans have no coverage out-of-network and you will be responsible for 100% of the costs incurred. For PPO plans, out-of-network cost-sharing responsibilities and annual limits are calculated separately from in-network cost-sharing annual limits. You can review these amounts on your Schedule of Benefits in your Member portal or call Member Services for more information.

How You and Community Health Options Share Costs

Jane's In-Network Cost Sharing ▸ Jane's Plan Deductible: $1500
Coinsurance: 20%
Out-of-Pocket Limit: $5000

January 1st — Beginning of Coverage Period

December 31st — End of Coverage Period

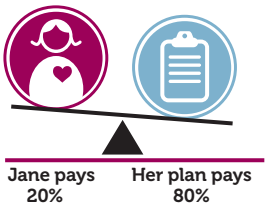


Jane hasn't reached her deductible yet.

She pays a set copay for some provider visits and medications.

Jane pays 100% for other costs, such as lab work or out-patient services.

more costs

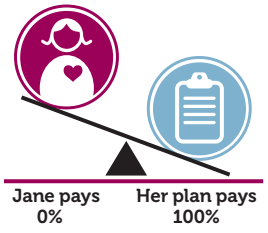


Jane reaches her $1500 deductible, 20% coinsurance begins.

She still pays a set copay for some provider visits and medications.

For other healthcare costs, Jane now pays 20%, and her insurer pays 80%.

more costs



Jane reaches her $5000 out-of-pocket limit.

Jane has seen her providers often and had some surgery. She has paid $5000 on her OOP total. Her plan now pays 100% of all covered costs for the rest of the year, including office visits and medications.

Source: U.S. Department of Labor, 2013. http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Click Here to Return to Table of Contents

How to Save Money

1. Staying Healthy

The best way to save money on healthcare is to not spend it in the first place. The amount of advice available on how to be healthy can be overwhelming. Your Member Portal includes tools and resources to help you focus on what you need to stay healthy.

2. The Right Plan

Choosing an insurance plan based on your specific healthcare needs, compared to plan coverage, is important. If you need help comparing plans, please contact a local broker or call Member Services.

3. Medication Costs

Medications can be expensive, and costs can vary. You can compare medication costs at different pharmacies through the Express Scripts Online Portal and find additional discounts with the Rx Savings Solutions benefit (see the Pharmacy section starting on page 14 for more information). Choosing generic equivalents and opting for mail order services may also save money.

4. Urgent Care or Emergency Department?

Sometimes it is an emergency; sometimes you simply need care fast. Talk to your Primary Care provider about accessing care after hours, where to go, and how to determine when Urgent Care is more appropriate than the Emergency Department.

5. Costs of Service

Finding out the costs of services may take time and effort, but it can certainly be worthwhile. Research has found that the costs of procedures can vary between service locations, sometimes by as much as $1,000 or more. To find the location with the lowest cost procedure, you can call the billing office of the facilities you are considering, or use an online tool. CompareMaine.org provides estimates on the cost of procedures at different locations throughout the state. Please Note: It is best to confirm costs with each facility.

6. In-Network vs. Out-of-Network

Receiving services from an out-of-network provider can be much more costly than an in-network provider. While Health Options offers a comprehensive network in Maine and New Hampshire, some providers are not in our network. HMO plans have no out-of-network coverage and you will be responsible for 100% of the costs incurred. Search for in-network providers using the Health Options' provider Directory, at HealthOptions.org, or call Member Services at (855) 624-6463.

7. Necessary Treatment?

Ask your Provider whether a test, prescription, or procedure is really necessary. Health Options recognizes the benefits of Choosing Wisely – a site that offers guidance on important questions to ask your Provider – so you receive the most appropriate care for your situation. Go to http://www.choosingwisely.org/patient-resources/ for more information.

8. Review Medical Bills for Error

It is important to review your bills from all sources for accuracy. Errors, fraud, waste, and abuse happen. Being a vigilant consumer can help identify these costly occurrences.

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You can get the most from your healthcare by being a partner in your care. Here's how:

Ask questions before you choose a PCP, so you find a provider that's a good match for your needs. Some questions to consider might include:

- What are your office hours? Do you see patients on weekends or at night?
- Will you talk about problems with me over the phone? Who should I contact after hours if I have an urgent situation?
- How long do I have to wait for an appointment?

Prepare for medical visits so you can share decisions with your provider

- Make a list of questions or things you want to talk about and bring it with you.
- Don't assume that all of your healthcare providers share your medical records. Be proactive and ask.
- When talking with your provider about medical tests or treatments, share your views about what's right for you. Your provider is an expert in medical science but you are the expert about yourself.
- A national campaign called Choosing Wisely encourages you to talk with your provider about medical tests and procedures that may not be needed. Go to ChoosingWisely.org/doctor-patient-lists/ for a list.

Learn about Preventive Healthcare Services you can receive at no cost

- Your provider may order a test as 'routine' or 'preventive,' but it may not meet the criteria for waived cost-sharing. Go to HealthCare.gov/Coverage/preventive-care-benefits/ to see what services or tests are included.

Note: With some exceptions, preventative healthcare services must be provided by your assigned PCP for waived cost-sharing.

Make sure you understand what you need to do after a medical visit

- One good way to do this is to repeat back what you understand before you leave the office. You might say: "I want to make sure I understand next steps. I need to ..." This gives you and your provider a chance to make sure you agree on any plans.
- Ask for written instructions before you leave.

Receiving Healthcare Services

Your Network of Providers

Community Health Options works with a broad network of healthcare providers in Maine and New Hampshire as well as select facilities in Massachusetts. By choosing an in-network healthcare provider you will save money. Providers include primary care doctors, nurse practitioners, specialists, mental health and substance abuse service providers, pharmacies, clinics, and hospitals. Go to HealthOptions.org to find a searchable version of our Provider Directory.

Medical Services

Your Primary Care Provider's (PCP) office is your medical home. You and your PCP will work together to help you stay healthy. When you enroll, you will need to choose an in-network PCP for yourself and your covered dependents. You can choose a different PCP for yourself and each dependent. If you do not choose a PCP when you first enroll, or if the PCP you choose is not available, we will assign one for you.

If your PCP is new to you, be sure to have your medical records sent to him or her, and consider making an appointment to discuss your medical needs. Your PCP can help arrange care with Specialists, laboratory services, and for hospital stays. While we do not require referrals, some services require prior approval or notification. Call Member Services for the most current list.

You can change your PCP at any time by using the form on the Member Portal or by contacting Member Services. If you find that you do need a new PCP, you can use the provider Directory to find a PCP in the network who is accepting new patients. The directory includes information to help you choose, such as address, gender, hospital affiliation(s), office hours and more.

Some services, such as diagnostic imaging and surgery, may be performed and billed by multiple providers.

It is your responsibility to ensure that all providers participating in your care are in-network providers. You may need to ask the provider requesting or organizing the service to determine if all providers involved are in-network providers. Any provider not in the network may result in out-of-network costs. See Page 7 for a discussion of in-network vs. out-of-network.

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Behavioral Health Services

Mental health and substance abuse services fall under a category of care called Behavioral Health. Behavioral Health is an important part of your overall health. Some plans include the benefit of no out-of-pocket costs for the first three Outpatient office visits when you see an in-network behavioral health and/or substance abuse service provider in the same calendar year (as indicated in your Schedule of Benefits). Ask your Behavioral Health provider to share medical records with your Primary Care provider and vice versa to assure the best healthcare and medication management.

Some of the behavioral health services we cover include:

- Behavioral health assessment and/or psychological evaluation
- Medication management
- Therapy/counseling

Some of the substance abuse services we cover include:

- Outpatient treatment
- Inpatient treatment
- Day treatment
- Detoxification
- Psychiatric evaluation

As with Medical Services, while we do not require referrals, certain services require prior approval or Notification and may be subject to limitation or exclusion. Call Member Services for the most current list.

Accessing Care after Hours

When you choose a PCP, ask your provider's office about what to do when you have an urgent care situation after hours. Community Health Options requires PCPs to provide or arrange for their patients' care 24 hours a day, 7 days a week. Planning ahead may save you money by preventing an unnecessary visit to the Emergency Department.

Emergency Care

If you need Medical Emergency Services, call 911 or go immediately to the nearest emergency department. You do not need prior approval for Medical Emergency Services.

If you are hospitalized, you or your Designee must call your PCP and Community Health Options within 48 hours after receiving Medical Emergency Services. If you or your Designee cannot call within 48 hours, then we should be called as soon as possible. If your Medical Emergency Services provider tells your PCP and Community Health Options that you have been hospitalized, you do not need to call your PCP and Community Health Options. Your PCP will arrange for any follow-up care you may need.

Emergency Services provided in an emergency department or urgent care facility outside of Maine and New Hampshire will be covered as if they are in-network. However, when the charge for services exceeds the maximum allowed amount determined by Health Options as 'reasonable and customary,' the billing entity may hold the Member responsible for the difference. It is also important to note that treatment or care received after your condition is stabilized is not Emergency Care and will be subject to the terms of your plan. Refer to your Member Benefit Agreement for additional information.

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Utilization Management

People often misunderstand the need for prior approval (PA) or notification and the process of utilization management. At Community Health Options, our goal is to encourage the highest quality of care in the most appropriate setting, from the most appropriate provider, for the appropriate length of time. Utilization management supports this goal by ensuring that: 1) you are eligible to receive services at the time of the request; 2) the requested service is a covered service; 3) the services you receive are medically necessary; 4) you receive the appropriate level of care in the appropriate setting; 5) information is shared with your providers so that your care can be coordinated; and 6) we pay the correct amount of benefits.

If you use a plan provider, he or she is responsible for obtaining prior approval for you. If your plan provider fails to acquire prior approval for you, you will not be financially responsible for this failure. If you use an out-of-network provider or your services are ordered by an out-of-network provider, you (or your designee) are responsible for ensuring prior approval is obtained for any services requiring prior approval. Call Member Services for more information.

The PA forms are available to providers on our website, HealthOptions.org, by navigating to the 'Healthcare Professionals' page and choosing the 'Professional Documents and Forms' tab, or by contacting Health Options at (855) 624-6463 (TTY/TDD: 711). Requests for prior approval require review of clinical information from your provider. Health Options will not accept prior approval requests from Members or non-provider Designees. If you have questions, or need assistance to determine which services require prior approval or notification, please review your Member Benefit Agreement or call Member Services at (855) 624-6463 (TTY/TDD:711).

Responses (both approval and denial) are provided in writing unless the request for services is determined to be urgent, in which case we will contact your provider by telephone. If the request for service is denied, you are notified of your right to appeal the decision and your provider may submit additional information for us to consider.

Population Health

The Medical Management team provides services to Members who need an extra level of support to manage their health and healthcare. Care Managers are available to answer general or complex medical questions, help Members navigate the sometimes confusing processes, such as obtaining medical equipment for the home or ordering specialty medications, and can help if you experience a critical event or diagnosis that requires extensive use of health services or resources.

Care management does not replace the routine healthcare provided by your PCP. Rather, the team works closely with PCPs, local care managers, and other community resources, to better understand your specific needs and the best way to support them.

Members, caregivers, and providers can make referrals or self-refer to the Medical Management team by calling Community Health Options Member Services at (855) 624-6463. This is a voluntary program with no out-of-pocket costs. If you decide you no longer want to participate, you can use this same number to opt out.

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Chronic Illness Support Program (CISP)

Some plans include our Chronic Illness Support Program (CISP) that provides cost-savings and self-management support to our Members with Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), and Hypertension (High Blood Pressure). If you have one of these chronic illnesses and your plan includes CISP benefits, reduced cost-share benefits will be automatically applied to your claims (refer to Section 2 of your Member Benefit Agreement to determine if your plan includes CISP).

With CISP, Members save money through significantly lower out-of-pocket costs for medically necessary services from in-network providers. Out-of-pocket costs are reduced through lower copays, deductibles, and coinsurance for routine disease management services. Routine services include office visits, prescription medications, certain lab services, and medical supplies necessary to control your chronic illness.

Select medications included in the reduced out-of-pocket cost benefit will be designated on the formulary as Chronic Illness Support Program medications and must be filled through the Express Scripts Home Delivery Program to receive the cost-share reduction. Medications we specify for inclusion under this program are among the most effective and of the highest value to treat the Chronic Illness as determined by us. For more information on CISP or the Home Delivery Program, refer to Section 2 of your Member Benefit Agreement or contact Member Services at (855) 624-6463.

Eye Care Services

In general, routine eye exams for adults are not covered. Refer to your Member Benefit Agreement for complete information.

- For children, all plans cover one routine eye exam and refraction once per year, as well as **basic** frames and contact lenses.

Routine eye exams are subject to the cost-sharing described in your Schedule of Benefits when performed by an in-network provider. Plans that include the Chronic Illness Support Program (CISP) provide additional eye exam benefits for people with diabetes. Refer to your Member Benefit Agreement for information about CISP.

Dental Services

Most plans do not cover routine or regular dental care. Community Health Options does **not** provide benefits for dental damage that occurs as a result of normal activities of daily living or extraordinary use, such as injury to teeth from biting or chewing.

The plan provides benefits only for the following, when medically necessary:

- Removing a tumor (but not a root cyst);
- Setting a jaw fracture;
- Removing impacted or unerupted teeth;
- Treatment, not to include dental implants, received or authorized within three months after an Accidental Injury to repair or replace natural teeth or within three months after the effective date of coverage, whichever is later; and
- Repairing or replacing dental prostheses caused by an Accidental Injury within six months after the injury or within six months after the effective date of coverage, whichever is later.

Note: Some plans include pediatric dental coverage provided in partnership with Delta Dental. For information on pediatric dental coverage, contact Delta Dental at (800) 253-7852.

Pharmacy Services

The Health Options Drug Formulary is a list of covered generic and brand-name medications that are approved by the Food and Drug Administration (FDA) and are eligible for coverage under the Community Health Options Outpatient prescription drug benefit.

The Community Health Options Drug Formulary serves as a guide for Members, providers and other healthcare professionals in the selection of cost-effective drug therapy. To ensure that the medications prescribed are covered, and to minimize your out-of-pocket expenses, we recommend that you consult HealthOptions.org for the Community Health Options Drug Formulary.

How to use the Formulary

Table of Contents: The Table of Contents provides a list of drug categories and the page number where that drug category is listed.

List of Abbreviations: The list of Abbreviations is a guide to help you understand what each of the abbreviations in the Requirements/Limits column means. Use this as a reference when reviewing Requirements/Limits.

Index: The Index provides an alphabetical listing with associated page numbers of all drugs listed on the formulary. It is found toward the end of the formulary document after the Drug Table.

Formulary – Drug Table: The formulary Drug Table lists drugs that are covered by the Health Options pharmacy benefit. The medications in the Drug Table are listed by drug classification. The Drug Table has three columns: Drug Name, Drug Tier, and Requirements/Limits.

Drug Name: The first column lists the drug name. The BRAND name drugs are listed in UPPER CASE font, and the generic drugs are listed in lower case font.

Drug Tier: The second column lists the Drug Tier. Out-of-pocket costs are determined by the Drug Tier. Health Options has Tiers associated with costs outlined in each plan. Take special note of the Tier listed for each medication. Some generics have the same active ingredients as the name brand, but with a dramatically lower cost. Generally, the lower the Tier, the lower the cost for the Member and your insurance company.

Requirements/Limits: The third column is Requirements/Limits which describes rules and considerations for that medication or supply. Some of the rules only apply to certain benefit plans. Refer to the top of the Drug Formulary under List of Abbreviations for an explanation of each rule listed under Requirements/Limits.

Searching the Formulary: Due to the length of this document, you may want to use the search function to look up your medications. Do this by pressing and holding the Ctrl key and F key (or Command F key for Mac users). A command box will open. Type the name of your medication in the box, press Enter to initiate the search, and then click through the results.

See your Schedule of Benefits to determine your cost-sharing responsibility for Covered Prescriptions. The pharmacy portal, located on our website, can also give you a cost estimate. Additional savings may be found by registering with Rx Savings Solutions at CHO.RxSavingsSolutions.com.

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Pharmacy Services

Filling Prescriptions

The Health Options Pharmacy Benefit Manager makes it easy to compare prices and fill prescriptions through:

- **Retail Pharmacy:** You may fill your prescriptions at any pharmacy in the Community Health Options Plan Network listed on our website. To find the cost, check the Benefits and Prescription Drugs section of your Member Benefit Agreement and call Express Scripts at (800) 922-1557 to compare prices.
- **Mail Order:** You may see a cost savings by using mail order services (for example, you may be able to receive three months of your prescription medications for the cost of two copays). For more information about how to have your prescriptions delivered to your door, visit our website, call Member Services at (855) 624-6463, or call Express Scripts at (800) 922-1557.
- **Specialty Pharmacy:** You and your provider must order Specialty Drugs from our designated specialty pharmacy. Get a list of these partners at our website or by calling Member Services at (855) 624-6463.

Prescription Drug Costs

Many prescription drugs, especially brand name medications that are subject to deductible and coinsurance, may have different costs at different pharmacies. You can use the "Price a Medication" tool in the Pharmacy Benefits section of your Member Portal to compare prices at pharmacies near you, or call Express Scripts at (800) 922-1557. The Rx Savings Solutions benefit may provide other discounts. Register to use this service at CHO.RxSavingsSolutions.com.

Waiting Period for Prescription Refills

If your provider indicates refills are available for your prescription, the refill will not be covered until you have taken 75% of the medicine, based on the prescribed dosage. Our plans do not provide Benefits for refills that are filled sooner.

Step-Therapy Program

A step-therapy program requires a "step" approach to covering certain drugs. This means that to receive coverage, you may need to first try a proven, safe, and cost-effective medicine before moving to a more costly treatment. If your provider wants you to "skip" steps, he or she will need to seek prior approval for the drug to be covered.

Prescriptions when Traveling

If you are traveling, a pharmacy can arrange an extended-day supply for you. You can also request that your pharmacy transfer your prescription order to another pharmacy where you will be traveling. The applicable out-of-pocket costs will apply. Controlled substances may be excluded.

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Pharmacy Services

90-Day Supplies of Prescription Medicines

To help you save money, we offer a discounted price on a 90-day supply of many prescription medicines when you fill the prescription through the Express Scripts mail order pharmacy. If you take certain medicines on a regular basis, use your Member Portal or call Express Scripts to see if the discount is offered. If it is, ask your provider for a 90-day prescription.

Off-Label Use of Prescription Medicines

Coverage is provided for off-label use for a particular condition if a drug is recognized for treatment in medical literature as recommended by current American Medical Association policy. Coverage is also provided for Medically Necessary services associated with the administration of the drug.

What if a Medication is Not Listed on the Formulary?

If a drug is not listed in the formulary, contact Member Services at (855) 624-6364 (Monday through Friday, 8am-6pm) and ask for a list of alternative drugs that are covered.

If you purchase a drug that is not covered, you will be responsible for the full cost of the prescription. These incurred costs will not count towards your deductible or out-of-pocket maximum.

Medications that Require Prior Approval (PA)

Drugs that include the special code "PA" on the formulary require prior approval. If the drug requires prior approval, your provider must complete the appropriate notification and prior approval form and submit it to our pharmacy benefit partner, Express Scripts (ESI), for review and approval.

- The PA forms are available to providers on our website, HealthOptions.org, by navigating to the 'Healthcare Professionals' page and choosing the 'Professional Documents and Forms' tab. The prescriber can also call ESI Customer Care at (800) 922-1557 for assistance.
- The PA forms are available to Members on the HealthOptions.org website or by contacting Member Services at (855) 624-6364 (Monday through Friday, 8am-6pm).
- **Requests for prior approval require review of clinical information from your provider. Health Options will not accept prior approval requests from Members or non-provider Designees.**

If you have received prior approval for a prescription drug from a previous insurance plan, we will need to review and approve it again. If your provider requests that the approval continue, we will extend your existing approval for a short time while we perform a review.

Health Promotion and Wellness

We want to support and encourage your efforts to protect and promote your health.

Preventive Care

Many preventive healthcare exams and vaccines cost you nothing.

A few examples include:

- 'Shots' for children to protect them against diseases such as measles, mumps and more
- Annual mammograms for women age 40 and older
- Annual flu shots each year

Some laboratory tests recommended by a provider may not be considered Preventive Services under the Affordable Care Act requirements and may be subject to cost-sharing. To see a complete list of covered preventive health services visit HealthCare.gov/Coverage/preventive-care-benefits/ or call Member Services at (855) 624-6463.

Medicine and Support to Quit Tobacco

Some of our plans cover the costs of nicotine replacement products or any medications approved by the FDA for tobacco cessation – both prescription and over-the-counter.

- Over-the-counter medicines covered at no out-of-pocket cost may include nicotine patches, gum, or lozenges.
- Prescription, FDA-approved medications are covered for two 90-day treatments for a total of a 180-day supply with no out-of-pocket costs.
- Also covered are "quit tobacco" programs, education, and counseling. For additional support quitting tobacco, call (800) QUIT-NOW (784-8669) to reach the Maine Tobacco Quit Line.

Refer to your Member Benefit Agreement for additional information or call Member Services at (855) 624-6463.

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Healthy Options Program

Community Health Options Members who are 18 years of age or older can take advantage of the Healthy Options Health and Wellness Program. With the expertise of the Medical Management team and an online resource of educational tools and topics, Healthy Options can offer guidance for making healthy lifestyle changes and support for managing current health conditions.

Healthy Options Care Managers and Navigators are registered nurses, dietitians, and social workers who can answer questions, provide information, and assist you in making health choices that are based on your personal preferences and values. They can help when:

- You are diagnosed with an ongoing health condition such as Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (Heart Disease), Congestive Heart Failure, and/or Hypertension (High Blood Pressure)
- You want to make a healthy change in your life, such as managing weight, quitting tobacco, or lowering stress
- You need additional support during your pregnancy
- You are preparing for upcoming tests or procedures
- You are thinking about treatment choices, including surgery
- You have questions about your medications
- You need support in preparing for conversations with your healthcare providers

Online Health and Wellness Resources within your Member Portal include:

- Facts on over 6,000 health topics
- Decision support tools and videos
- An index of searchable topics
- Interactive, self-management and decision-making tools, including a Health Risk Assessment to help you understand your personal health strengths and weaknesses

Visit HealthOptions.org for more information or call Member Services.

Enrollment and Eligibility

This section explains when you can purchase new insurance, when you can change your existing insurance, and who is eligible to be on your plan.

Open Enrollment

Each year, during the Open Enrollment Period, you can review your existing Community Health Options plan and determine if you need to make changes. Open Enrollment is also an opportunity for non-Community Health Options Members to purchase a Community Health Options plan.

Special Enrollment

If you have an event that triggers a Special Enrollment Period (SEP), you must contact Community Health Options or the Health Insurance Marketplace. Visit HealthOptions.org to complete enrollment information for the life change. If you do not have internet access, contact us to get a paper application.

Throughout the year, if you have certain life-changing events, you and your dependents can adjust your existing insurance during a 60-day "Special Enrollment Period." Events, such as birth or adoption of a child, marriage, loss of other insurance coverage because of divorce or change in employment status, or changes in eligibility for other public service programs will trigger Special Enrollment. For a full list of these qualifying events, visit HealthOptions.org or contact Member Services.

Please Note: If you currently receive a tax credit that helps pay for your insurance, you will need to update your information with the Health Insurance Marketplace (Healthcare.gov or (800) 318-2596) and then call Community Health Options for next steps.

Birth or Adoption

A newborn dependent of a Member is automatically covered for 31 days from the moment of birth.

A newly adopted child of a Member is automatically covered for 31 days from the date of adoption unless the Subscriber notifies us that the adopted child should not be covered under this Agreement.

To continue coverage beyond the 31 days, you must submit a completed Application to the Health Insurance Marketplace or, if you enrolled directly, to Community Health Options within the 60-day Special Enrollment Period window. Coverage will be effective on the date of birth or date of adoption. Refer to your Member Benefit Agreement for more detail.

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Who is a Dependent?

1. Your legal spouse or legal Domestic Partner (as recognized under state law),
2. Your unmarried child who is under age 26,
3. A child eligible for medical coverage described in a Qualified Medical Support Order (QMSO).
4. Your child, age 26 or older, who meets **all** of the following requirements:
   a. is currently disabled,
   b. was disabled prior to his or her 26th birthday,
   c. remains financially dependent on you.

We may ask you to submit evidence of eligibility for dependent coverage. This evidence may include a marriage certificate, divorce decree, or birth certificate. If you have questions about dependent eligibility, please contact Member Services at (855) 624-6463.

Effective Dates

If you add new dependents through a Special Enrollment Period, the start of coverage depends on the type and date of event, as well as when we receive a completed enrollment information form for the new dependent and premium payment.

Paying your Premium

A premium is the monthly amount you will pay for your insurance coverage. If you qualify for the Advance Premium Tax Credit (APTC), then this amount is applied to your premium, and you pay the remaining cost. This amount will appear on your invoice as the amount due.

Community Health Options mails invoices around the 10th business day of every month for the following month. Your payment is due by the first of the month, in advance of the month of coverage. It is important to pay your health insurance premium to keep your coverage from lapsing.

There are Three Ways to Make a Payment:

1. Log into your Member Portal and click on the "Online Payment" button.

2. Call the automated payment line at (844) 722-6243.

- For **debit card payments**, please have your member identification number and debit card account number, security code and expiration date ready.
- For **payments by check**, please have your member identification number, bank routing number and account number ready.
- **Please note:** Community Health Options does not accept credit card payments.

3. Mail a check to Community Health Options, P.O. Box 326, Lewiston, Maine 04243. Be sure to include your policy number on the check or money order and include your invoice coupon.

How do I Set Up, Edit, or Delete my Auto Pay Plan?

If you already have an auto pay account set up in your Member portal and need to change it, follow the directions provided here: https://www.healthoptions.org/setting-up-your-auto-pay-account.

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Paying your Premium

Late or Partial Payments

If you have an outstanding premium balance with Community Health Options from coverage effective July 1, 2017 or after, this prior balance will be due as part of the Binding Premium Payment. If the full amount due (including the prior balance) is not paid prior to the effective date of coverage, your coverage will not go into effect.

If you miss a monthly premium payment your health insurance coverage may be canceled. If you have a Marketplace plan and qualify for advance payments of the premium tax credit, and you've already paid at least one full month's premium during the benefit year, you will have three months to bring your payments current. This three-month period of time is called a 'grace period. Claims will be paid in full for dates of service within the first 31 days of the grace period, including pharmaceutical benefits. Claims for dates of service between days 32 and the end of the grace period will be denied. These claims will be reprocessed if/when the Member pays all outstanding premiums. Pharmaceutical claims that are denied during the grace period must be resubmitted (via pharmacy reimbursement request form) by the Member after he or she has cleared the grace period by paying all outstanding premiums.

Note: If you don't qualify for a premium tax credit and/or purchased your plan off Exchange, your grace period is in effect for 31 days. Claims will be paid in full for dates of service within the 31-day grace period, including pharmaceutical benefits.

Termination of the Health Plan for Non-payment

For Marketplace Members, termination of the Member's health insurance plan will occur if payment is not received by the last day of the third month of the grace period and claims for dates of service after day 31 will not be paid.

Plan termination for off-Exchange Member will occur if payment is not received by end of business on day 31. Claims will not be paid for dates of service after day 31.

If you have questions or concerns about paying your premium, contact Community Health Options Member Services at (855) 624-6463.

Complaint and Appeal Process

Member Services Associates are available to assist Members in the resolution of complaints. If you have a complaint about a claim denial, we recommend that you contact a Member Services Associate before filing an Appeal. Sometimes, a claim denial is caused by a minor error or problem that can be resolved by a Member Services Associate without having to go through the Appeal process.

Complaints

If you have a complaint about Health Options' services or your plan, please contact Member Services at: (855) 624-6463 (TTY/TDD: 711). You may also make a written complaint by mailing it to:

Community Health Options
Attn: Member Services
P.O. Box 1121
Mail Stop 100
Lewiston, ME 04243

Health Options will respond to you as quickly as we can. Most complaints can be investigated and responded to within 30 days.

Appeals

If you disagree with our response to your complaint, you may be able to file an Appeal of the decision. Decisions subject to the Appeal process are: Adverse Benefit Determinations, Adverse Healthcare Treatment Decisions, and Adverse Benefit Determinations not involving Healthcare Treatment Decisions. You must submit the Appeal to Health Options within 180 days from the date of the decision you wish to Appeal. For more detailed information about the Appeal process and your rights, please consult your Member Benefit Agreement or call Member Services.

Members who are visually and/or hearing impaired, have special cultural needs, or require translation services may request Complaint and Appeal process materials in an appropriately accessible format by contacting Health Options Member Services at (855) 624-6463 (TTY/TDD: 711).

Appeals may be submitted in writing by mail or fax to:

Community Health Options
Attn: Appeals Coordinator
P.O. Box 1121
Mail Stop 100
Lewiston, ME 04243

Fax: (207) 402-3947

Legal Notices

If you have questions about any of these notices, please do not hesitate to contact Member Services.

HIPAA Privacy Statement

Community Health Options takes Member privacy very seriously. Our policies are compliant with all local and federal guidelines. To obtain a copy of our privacy statement, visit our website or call (855) 624-6463.

Notice Regarding the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, please contact Member Services at (855) 624-6463.

Notice Regarding the Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Statement for New Technology

Health Options policies exclude coverage for new technology that is experimental, investigational or not deemed medically necessary. However, we recognize the need to evaluate new developments in clinical technology and new applications of existing technology to determine clinical utility, safety and value for inclusion as a covered benefit. We review requests to evaluate new technologies to assist benefit coverage decisions from a variety of sources. If you would like a copy of our procedure for reviewing new technology, please call Member Services at (855) 624-6463.

Covered Services

Below is a summary of many of the services, supplies, and other items covered by your plan. In order to be covered they must meet the criteria described in the Member Benefit Agreement (including Medical Necessity). For full details, please see your Member Benefit Agreement.

Allergy Testing and Injections

Ambulance Service, Non-emergent (1)

Ambulatory Surgery Center Services

Asthma Education (2)

Autism Spectrum Disorders

Breast Cancer Treatment

Breast Reconstructive Surgery in Connection with a Mastectomy

Chemotherapy Services (3)

Chiropractic Care and Manipulative Therapy (1+3)

Colorectal Cancer Screening

Contraceptives/Family Planning

Day Treatment Program Services for Mental Health and Substance Disorders (1+3)

Diagnostic Services (1)

Dialysis (3)

Durable Medical Equipment (DME) + Prostheses (1)

Early Intervention Services (3)

Emergency Services and Emergency Transportation

Enteral Formulas (3)

Eye Care (2+3)

Foot Care (3)

Hearing Aids (3)

Home Healthcare Services (2+3)

Hospice Care (1)

Hospice Respite (1)

Hypertension (High Blood Pressure) (2)

In-Home Biometric Monitoring (1)

Inpatient Hospice Services (1)

Inpatient Services (Medical, Mental Health and Substance Abuse) (1+3)

Medical Supplies (1+2+3)

Morbid Obesity (1+3) Diabetes Services + Supplies (2)

Nutritional Counseling

Obstetrical Services and Newborn Care (1+3)

Office Visits

Outpatient Services (Medical, Mental Health and Substance Abuse) (1+3)

Physical and Occupational Therapy (1+3)

Pediatric Vision (3)

Prescription Drug Benefits (1+2+3)

Preventive Care (1+3)

Prostate Cancer Screenings (1+3)

Prosthetic Devices (1+3)

Radiation Therapy

Screening Mammograms (1+3)

Skilled Nursing Facility Services (1+3)

Speech Therapy (1+3)

Surgical Services (1)

Second Opinions (1)

Telemedicine Services (1)

Tobacco Cessation (3)

(1) Prior approval or notification may be required. Refer to your Member Benefit Agreement for more information on Prior Approval and Notification Requirements.

(2) Additional benefits may be available under plans that include our Chronic Illness Support Program (CISP). Refer to your Member Benefit Agreement for more information on your plan's coverage.

(3) Limitations or Exclusions apply. Refer to your Member Benefit Agreement for more information.

Services Not Covered

Services Not Covered by your Community Health Options Plan

If you choose to obtain services that are not covered by your plan, you will be responsible for the full cost of those services. Costs incurred for non-covered services will not count towards your deductible or out-of-pocket maximum.

Generally, the plan does not provide benefits for:

- Anything that is not Medically Necessary
- Anything provided before or after the effective dates of coverage (except as required by law)
- Items and services related to inpatient hospital stay beyond the approved time period
- Non-Covered Services and any services, items, or charges related to Non-Covered Services
- Items and services furnished outside the United States (except for Emergency Services covered by some plans)
- Services and supplies to the extent that you do not have to pay or you have the right to recover expenses through a federal, state, county, or local law (even if you do not assert your rights)

Some of the services that are specifically excluded are routine dental services, infertility testing and treatment, food or dietary supplements, routine foot care, and cosmetic services.

Please see your Member Benefit Agreement or our website for a complete list of Exclusions and services that are not covered. If you have questions, contact Member Services at (855) 624-6463.

Directory of Helpful Numbers

My Community Health Options Member ID Number:

My Primary Care Provider (PCP):

My Child's Pediatrician:

My Dentist:

Other:

Community Health Options Office Hours Monday–Friday (except holidays) 8am–5pm	
Community Health Options Member Services	(855) 624-6463
Community Health Options Automated Payment Line	(844) 722-6243
Community Health Options Population Health Team	(855) 624-6463
Community Health Options Provider Services	(855) 624-6463
Community Health Options Utilization Management	(855) 624-6463
Community Health Options Utilization Management 24/7 FAX	(877) 314-5693
Pharmacy Provider: Express Scripts	(800) 922-1557
Behavioral Health Providers	(855) 481-7047

Important Mailing Addresses

Medical Claim:
Community Health Options
P.O. Box 1121
Mail Stop 200
Lewiston, ME 04243

Behavioral Health Claim:
Behavioral Health
P.O. Box 1121
Mail Stop 200
Lewiston, ME 04243

General Correspondence:
Community Health Options
P.O. Box 1121
Mail Stop 100
Lewiston, ME 04243

Premium Payments:
Community Health Options
P. O. Box 326
Lewiston, ME 04243

Stay up to date by visiting our website. Community Health Options also communicates with Members through our website.